Senate Bill 966 (Limón)
Increasing Behavioral Health Access

April 11, 2022

OVERVIEW

Today, more than 1,300 community health centers (CHCs) in California provide high-quality, comprehensive care to 7.2 million people in California each year – that is roughly 1 in 5 Californians. For decades, community health centers have provided care to everyone, regardless of their ability to pay, their immigration status, or their individual circumstances. Community health centers provide the full spectrum of care, from primary care to dental to behavioral health care and a variety of enabling and wraparound services.

While the impacts of the COVID-19 pandemic on individuals and communities are varied, one of the most omnipresent issues is its impact on behavioral health. Our state is an extreme workforce shortage, leaving community health centers with decreased capacity to meet the increased demand of behavioral health services for California's vulnerable safety net. Additionally, the ramifications of COVID-19 on mental health are extensive, and often disproportionately harmful to populations that have historically been marginalized. This is especially concerning since one third of health center patients have limited English proficiency, requiring access to a diverse workforce that can provide linguistically responsive care (2020 UDS).

THE PROBLEM

In May 2020, DHCS (and pursuant to SPA 20-0024) temporarily allowed Associate Clinical Social Workers (ASWs) and Associate Marriage and Family Therapists (AMFTs) as billable provider types for FQHCs and RHCs, contingent on the declared COVID-19 public health emergency. This flexibility has increased access to behavioral health services and helped meet the increased patient demand during COVID-19. The looming concern for health centers is the inability to continue utilizing this workforce upon the expiration of the public health emergency decreasing the ability to offer access to care and certainly interrupting continuity of care for patients finally receiving treatment.

Unfortunately for Black, Indigenous, and People of Color (BIPOC), the pandemic has had a more adverse impact on them and their mental health. According to the California Health Care Foundation, 4 in 10 Black, Latino, or mixed-race individuals report symptoms of anxiety or depression at above-average rates. This is propelled by the fact that we continue to battle societal injustices and related inequities in access to overall healthcare services, including behavioral health.

Behavioral health care should not be separate from the rest of the body. Training Associates in community health centers allows the future workforce to have field training in integrated care, where Associates will be collaborating with a team to address both medical and behavioral health conditions. Health centers consider a patient's physical, behavioral, and social determinants of health and are positioned to treat the whole person, not just a single ailment or diagnosis. Fragmented care contributes to poor outcomes and harms people with co-occurring medical and behavioral health conditions. The ability to coordinate care under one roof as a medical home, helps lead people with dual diagnoses to achieve well-being.

THE SOLUTION

Senate Bill 966 would extend flexibilities allowed during the declared public health emergency to hire and bill for ASWs and AMFTs, therefore sustaining continuity of care for patients and increasing access to a diverse behavioral health workforce. This bill will also remove the current administrative barrier to utilizing LMFTs by aligning FQHC/RHC Medi-Cal Change in Scope-Of-Service Request (CSOSR) requirements for both medical and behavioral health services, ensuring that health centers are not disadvantaged when trying to bring in critical behavioral health workforce.

STATUS

Pending in Senate Appropriations Committee

CO-SPONSOR

- California Health+ Advocates
- California Association of Marriage and Family Therapists (CAMFT)

FOR MORE INFORMATION

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