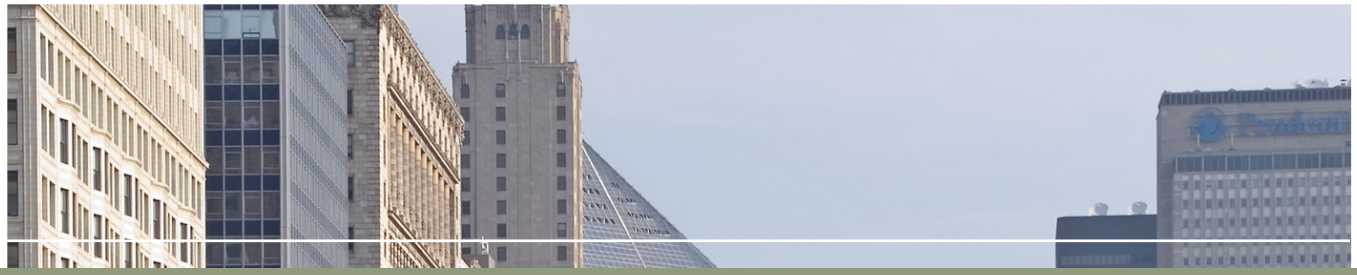

IMPROVING ACCESS: EXPANDING ACCEPTABLE MEDICAL SOURCES for the SOCIAL SECURITY ADMINISTRATION DISABILITY DETERMINATION PROCESS

NATIONAL LAW CENTER
ON HOMELESSNESS & POVERTY

ADVOCACY and TRAINING CENTER

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I INTRODUCTION

Social Security disability benefits, including Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), provide beneficiaries with critical access to income and health insurance—key components to ending homelessness and living successfully in the community. Ensuring timely access to such benefits is, therefore, critically important. Currently, the process for obtaining SSI and SSDI can be cumbersome and, too often, there are unnecessary delays. Allowing nurse practitioners, physician assistants, and licensed clinical social workers to provide diagnostic evidence of certain medical conditions would streamline the process for obtaining benefits, ensuring that eligible individuals gain access to these critical benefits in a timely manner.

For individuals who are homeless, such expansion would have an especially meaningful impact. Currently, many people who are homeless and who are generally uninsured have great difficulty accessing assessment, treatment, and care from physicians and, for mental health problems, psychologists and psychiatrists. Programs and services dedicated to serving homeless people are increasingly overwhelmed by the tremendous need for treatment and services, and many programs cannot meet this rising demand. Even if individuals who are homeless were able to access these programs, they would still struggle to obtain SSI and SSDI in a timely manner, since most programs are staffed by health and mental health professionals other than physicians and psychiatrists. In addition, applying for Social Security disability benefits requires extensive medical documentation that is challenging to access.

By expanding the types of practitioners permitted to provide definitive diagnostic evidence of certain conditions, the federal government can uphold its existing commitments to end homelessness and to promote access to healthcare. In 2010, the United States Interagency Council on Homelessness ("Council") published its strategic plan for ending homelessness, formalizing the federal government's commitment to end all forms of homelessness.[1] Also, in 2010, President Obama signed the landmark Patient Protection and Affordable Care Act of 2010 ("ACA"), increasing access to health insurance and strengthening America's primary care and mental health provider networks.[2] Taking steps to streamline the process for obtaining SSI and SSDI benefits, while also providing for the expansion of the primary care workforce, supports these efforts.

BENEFITS OF SOCIAL SECURITY DISABILITY INSURANCE AND SUPPLEMENTAL SECURITY INCOME.

SSDI and SSI provide beneficiaries with critical access to income and health insurance -- necessities for maintaining housing. Additionally, Social Security benefits provide a source of income that helps homeless persons access supportive housing, where they can receive social services in addition to a place to live. Individuals in supportive housing frequently fare dramatically better then they did before they entered. For example, one study showed that, in the year after formerly homeless individuals entered supportive housing, these individuals had 77% fewer inpatient hospitalizations and 62% fewer emergency room visits.[3] For many, access to supportive housing leads to increased stability and improved quality of life in the community.

Social Security benefits also provide access to health care—another factor leading to increased well-being for homeless individuals. Most individuals receiving Social Security Disability Insurance are eligible for Medicare after two years;[4] individuals receiving Supplemental Security Income are immediately eligible for Medicaid in most states.[5] Through Medicare and Medicaid, Social Security benefits provide access to treatment, medication, and supportive services for a wide range of conditions.

CURRENT PROCESS FOR OBTAINING SSDI AND SSI.

To obtain SSDI or SSI, applicants must document that they meet both the medical and non-medical eligibility criteria. Applicants document disability by describing their impairments, providing treatment sources, and submitting medical records. If there is evidence that supports the finding of a disability in the medical record, then the applicant's disability can be approved without an independent examination. But, if the evidence in the medical record is not sufficient to support the finding of a disability, the Social Security Administration (SSA) may arrange for a consultative examination with specific medical providers who have agreed to perform these examinations for SSA.

Only diagnostic evidence from an "acceptable medical source" can be relied on to support a finding of a disability without an independent examination.[6] Currently, the following medical professionals are the acceptable medical sources: (1) licensed physicians, (2) licensed or certified psychologists, (3) licensed optometrists, for the purposes of establishing visual disorders, (4) licensed podiatrists, for the purposes of establishing impairments of the foot and ankle only, and (5) qualified speech-language pathologists, for the purposes of establishing speech or language impairments only.[7] If an applicant's medical record contains diagnostic evidence only from a nurse practitioner or a physician assistant, for example, then that applicant will need to attend a consultative examination to have the acceptable professional provide the required information.

CHALLENGES OF LIMITED ACCEPTABLE MEDICAL SOURCES.

The current narrow list of acceptable medical sources creates unnecessary delays in processing the applications of low-income individuals. For many low-income individuals—even those with health insurance—nurse practitioners, physician assistants, and licensed clinical social workers provide most of their primary physical and mental health care. And many low-income individuals may be unable to schedule an appointment with a physician, psychiatrist, or psychologist. Approximately 22% of adults with mental illness and/or substance use disorders are uninsured, and roughly 30% of individuals with co-occurring mental illness and substance use disorders lack health insurance. Finally, one in three uninsured adults with mental illness and/or substance use disorders has an income under 100% of the federal poverty line.[8] In other words, individuals with mental illness or substance use disorders are likely to be uninsured or low-income—or both—meaning that they likely have limited access to care from physicians, psychiatrists, or psychologists.

As a result, many low-income individuals will only begin receiving Social Security benefits after SSA schedules a consultative examination. In addition to delaying benefits, the need for a consultative examination creates logistical hurdles for many applicants—especially those in rural areas. Often, consultative examinations may be scheduled many miles away, and low-income individuals may be

unable to afford or have health problems that impede traveling long distances to these examinations. For individuals with mental health problems, consultative examinations can present additional barriers to gaining access to SSI and SSDI. Often, individuals with mental illness may attempt to conceal their mental health issues.[9] Typically, they present well and, for the brief period of time of any one examination, an individual with mental illness may appear to function quite effectively. It is often only over time that one learns of the dramatic struggles and challenges that people with serious mental illness face. Even though homeless individuals may not see one mental health care professional on a regular basis,[10] they may have had at least irregular contact with a mental health clinic and have begun to trust the professional they have seen. The regular mental health care professional or mental health clinic can, over time, gain insights into the individual's mental health problems, despite an individual's attempts to conceal them. During a consultative examination, by contrast, the individual will speak with the examining mental health professional for the first time. Without the benefit of multiple opportunities to examine the individual, the mental health professional may be unable to identify the true extent of the individual's mental health problems and impact on functioning, leading to inaccurate diagnoses and, potentially, inaccurate denials of benefits.

For people who are homeless and who have serious mental health disorders, the problems are compounded. Since homeless individuals lack a permanent address, they frequently do not receive notices for consultative examinations. As a result, many individuals who are homeless miss their appointments. When an appointment is missed, frequently only one more will be scheduled. If an individual misses the rescheduled appointment, then the person receives a technical denial. And, even if the individual receives notice of the scheduled appointment, many individuals who are homeless may struggle to arrange for transportation to the consultative examination. Therefore, for people who are homeless and who have serious mental illnesses, the consultative examination is generally a barrier in the process rather than a tool that helps secure necessary information.

In this paper, we argue that expanding the list of acceptable medical sources to include nurse practitioners, physician assistants, and licensed clinical social workers will allow more low-income individuals to begin receiving Social Security disability benefits without the unnecessary delay (and expense to the government) of consultative examinations, while still ensuring that only individuals who meet SSA's medical criteria receive these important benefits.

This paper will first provide an overview of the current network of providers across the country and discuss the shortages of providers in various settings. Next, the paper will assess trends in the healthcare workforce, including recent federal policies encouraging a shift toward primary care as well as integrated primary/behavioral health care and medical homes The paper will then discuss the licensure and practice standards for nurse practitioners, physician assistants, and licensed clinical social workers, as compared to optometrists and speech-language pathologists, to assess whether licensure and practice standards for these professions are sufficiently standardized and rigorous to prevent individuals from improperly receiving Social Security benefits. In sum, licensure and practice standards for nurse practitioners, physician assistants, and licensed clinical social workers are sufficiently standardized and rigorous to ensure that only individuals entitled to SSDI or SSI benefits receive them.

II THE HEALTHCARE WORKFORCE TODAY

PRIMARY CARE PROVIDER LANDSCAPE

Primary care providers are the frontline of America's medical workforce, providing care for a wide range of chronic and acute medical conditions. But fewer recent medical school graduates are entering the primary care field, causing shortages of primary care physicians. Nurse practitioners and physician assistants are becoming an increasingly important part of the primary care workforce, especially in low-income urban and rural areas.

Nurse practitioners are registered nurses who, after completing advanced training, become certified to have an expanded scope of practice. In most states, nurse practitioners may take detailed patient histories, perform physical examinations, diagnose conditions, and prescribe a wide range of medications. Nurse practitioners often work closely with a physician under the terms of a written agreement authorizing the nurse practitioner to perform certain tasks, though the exact degree of supervision varies from state to state.

Today, there are roughly 140,000 nurse practitioners providing care across the county. Nurse practitioners may specialize in a particular subset of the medical field, and many nurse practitioners choose to specialize in primary care. Approximately 68% of nurse practitioners practice in adult or family primary care,[11] and another 9.4% practice in pediatric primary care. Nationwide, there are more nurse practitioners practicing primary care (roughly 95,000) than there are physicians (approximately 82,000).[12]

Nurse practitioners currently work in a wide variety of practice sites and communities. Specifically, 27.9 % work in a physician's private practice, 21% work in hospitals (both in-patient and out-patient departments), and 9% work in community and rural health centers.[13] Many nurse practitioners work in smaller communities—45.5% work in communities with fewer than 100,000 residents, 29.9% work in communities with fewer than 50,000 residents, and 18% of nurse practitioners work in rural areas.[14]

Physician assistants, comparable to nurse practitioners, also take comprehensive histories and perform physical examinations. In most states, physician assistants may make differential diagnoses and prescribe certain medications. Physician assistants also work under the supervision of a physician but, unlike nurse practitioners, physician assistants are ordinarily not permitted to practice independently.

There are approximately 72,000 physician assistants practicing in the United States today. Nearly one quarter of physician assistants practice in primary care.[15] Most physician assistants—55.8%—practice in a physician's private office, and 24.3% practice in a hospital.[16]

Both nurse practitioners and physician assistants currently provide critical primary care services in a variety of settings throughout the country. Taken together, there are significantly more—roughly 38% more—nurse practitioners and physician assistants practicing primary care today than there are physicians. In other words, nurse practitioners and physician assistants are the majority of the primary care workforce in the United States.

TABLE 1 | PRIMARY CARE PROVIDER WORKFORCE OVERVIEW

	Number	% Primary Care	Est. # Primary Care	% Rural	Est. # Rural
Physicians	661,000	12.4%	82,000	10%	66,000
Nurse Practitioners	140,000	68%	95,200	18%	25,200
Physician Assistants	72,000	24.8%	17,900	15%	10,800

MENTAL HEALTH PROVIDER LANDSCAPE

There are approximately 350,000 clinically active mental health providers currently practicing in the United States,[17] including counselors, therapists, psychologists, psychiatrists, and licensed clinical social workers. Since 1990, the number of clinical social workers relative to psychiatrists has increased dramatically.[18] Today, nearly 45% of mental health care providers are licensed clinical social workers, whereas psychiatrists are only 19% and psychologists are only 36%.[19] In other words, licensed clinical social workers are an increasingly important part of the mental health care workforce in the United States.

According to SAMHSA, professional associations have historically not collected workforce information, and standardized data have been difficult to access. The table below, though somewhat dated, identifies the major mental health disciplines, the number of professionals in the respective disciplines, and the number of professionals per 100,000 U.S. residents.[20]

TABLE 2 | CLINICALLY ACTIVE AND CLINICALLY TRAINED MENTAL HEALTH PERSONNEL BY DISCIPLINE

Discipline	Number	Rate per 100,000
Psychiatry	38,436	13.7
Psychology	88,491	31.1
Social Work	99,341	35.3
Psychiatric Nursing	18,269	6.5
Counseling	111,931	49.4
Marriage & Family Therapy	47,111	16.7
Psychological Rehabilitation	100,000	37.7
School Psychology	31,278	11.4

HEALTHCARE PROFESSIONALS SHORTAGES

Health care professionals are unevenly distributed across the country, leading to significant shortages of providers in both rural and urban areas. Currently, 66.5 million Americans live in primary care healthcare professional shortage areas (HPSAs); 94.6 million live in a mental health HPSA.[21] Put in context, nearly *one-third* of Americans live in an area with an insufficient number of mental health professionals, and over one-fifth live in an area that lacks enough primary care providers.

HPSAs are found in both rural and urban areas. Based on the Health Resources and Services Administration's estimates, nearly two-thirds of primary care HPSAs are in non-metropolitan areas, and over sixty percent of mental health HPSAs are in non-metropolitan areas.

TABLE 3 | HEALTHCARE PROFESSIONAL SHORTAGE AREAS

	Population of HPSAs	Estimated Underserved Population	% Metropolitan	% Non-Metropolitan
Primary Care HSPA	66.5 M	38.6 M	35%	65%
Mental Health HPSA	94.6 M	68.8 M	39%	61%

Rural areas, in particular, suffer from a severe shortage of mental health professionals. Figure 1 illustrates the uneven distribution of mental health professionals across the country. The rural portions of the country, including the Great Plains, Appalachia, and the interior West, have significantly fewer mental health professionals on a per capita basis than the more populous portions of the country.[22] Figure 1 also illustrates the distribution of all mental health professionals, including psychiatrists, psychologists, counselors, and social workers practicing in mental health. Figure 1, therefore, provides evidence that individuals living in rural areas have limited access to all mental health professionals, but does not distinguish between access to mental health professionals who are currently included as acceptable medical sources (*i.e.*, psychiatrists and clinical psychologists) and those mental health professionals who are not currently included as acceptable medical sources (*e.g.*, licensed clinical social workers).

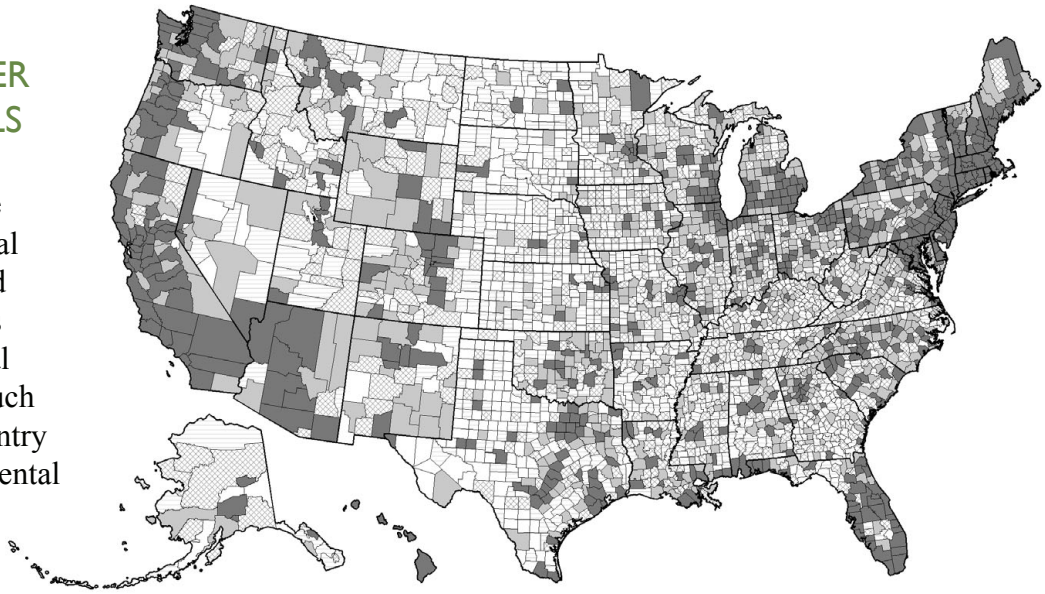
Other data indicate, however, that roughly three-quarters of all smaller rural counties with populations between 2,500 to 20,000 lack a psychiatrist—providing evidence that individuals in rural areas may lack access to mental health professionals currently listed as acceptable medical sources.[23] In any event, homeless and low-income individuals living in rural areas with low densities of mental health professionals are likely to face challenges in obtaining mental health care, leading to difficulties in confirming a diagnosis of mental illness sufficient to warrant the award of SSI and SSDI.

For many low-income and homeless individuals in rural and urban areas alike, Federally Qualified Health Centers (FQHCs), community health centers, and other health care programs for homeless individuals are critical health care providers. But few FQHCs and community health centers have

psychiatrists or psychologists providing mental health care. In general, these programs provide critical health care services, on both an emergent and non-emergent basis,[24] to all patients regardless of their insurance status or ability to pay. Typically located in medically underserved areas, there are over 1,250 health centers with 8,000 sites throughout the United States and its territories.[25] FQHCs, a subset of community health centers, were estimated to serve twenty million patients in 2010 and, with the passage of the Patient Protection and Affordable Care Act, FQHCs may serve as many as forty million patients by 2015. According to the Uniform Data System, over 70% of health centers provide mental health services. With respect to the FQHC workforce, social workers are the most predominant discipline.[26] The same is likely true for other community health centers. In other words, for the millions of Americans receiving health care at FQHCs and community health centers, social workers—and not psychologists and psychiatrists—are the most likely providers of care.

FIGURE 1 | MENTAL HEALTH PROFESSIONALS PER 10,000 INDIVIDUALS BY COUNTY.

Darker counties indicate higher numbers of mental health professionals, and lighter shading indicates lower numbers of mental health professionals. Much of the middle of the country has lower numbers of mental health professionals per capita.



A.R. Ellis *et al.*, "County-Level Estimates of Mental Health Professional Supply in the United States," Psychiatric Services, 60:1315 (2009).

In sum, millions of Americans live in medically underserved communities where there are insufficient numbers of primary care physicians and psychiatrists to meet the needs of the population. For individuals living in medically underserved communities, nurse practitioners, physician assistants, and licensed clinical social workers often provide critical, frontline care. For some, nurse practitioners, physician assistants, and licensed clinical social workers may be the only local source of care. Expanding the list of acceptable medical sources to include these critical providers would acknowledge the important role these providers currently play in America's health care system.

III Future Health Care Workforce Trends

Nurse practitioners, physician assistants, and licensed clinical social workers are currently a vital part of the nation's network of healthcare providers, and these providers will likely become increasingly important as occupational trends and federal policies lead to expanded numbers of nurse practitioners, physician assistants, and licensed clinical social workers.

WORKFORCE TRENDS

If current trends hold, the Bureau of Labor Statistics projects significant growth in the numbers of registered nurses, physician assistants, and social workers over the next ten years. By 2018, the Bureau of Labor Statistics projects that there will be a 39% increase in the number of physician assistants.[27] Similarly, the number of registered nurses is projected to increase by 22% by 2018.[28] The Bureau of Labor Statistics considers nurse practitioners as a subset of registered nurses, and thus does not make separate projections for nurse practitioners. In any event, the nursing field, generally, is expected to grow significantly. Finally, the Bureau of Labor Statistics projects that there will be a 20% increase in mental health and substance abuse social workers by 2018.[29] For context, the number of physicians employed in the United States is expected to also increase by 22% by 2018.[30] Although these are only projections, the projections provide evidence that health professionals other than physicians are highly likely to continue as an important, and expanding, part of the country's health care workforce.

FEDERAL INITIATIVES TO PROMOTE HEALTH CARE WORKFORCE EXPANSION

Several federal policy initiatives promoting the expansion of the health care workforce are likely to further the existing trend of increasing numbers of nurses, physician assistants, and licensed clinical social workers. Recognizing the drastic shortages of primary care and mental health providers across the country, the federal government is implementing several new policy initiatives to bolster America's network of providers. Importantly, the federal government has not limited its attention to increasing the numbers of physicians and psychiatrists; instead, the recently enacted policies also promote the increased use of nurse practitioners, physician assistants, and licensed clinical social workers.

Patient Protection and Affordable Care Act of 2010. On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act of 2010 ("Affordable Care Act").[31] This landmark piece of legislation will reform both public and private health insurance with the goal of improving the cost, quality, and accessibility of health care for all Americans. In addition to the health insurance reform provisions, the Affordable Care Act contains numerous provisions to expand the primary care workforce.

Section 5316 establishes a demonstration program to award grants for family nurse practitioner training programs.[32] Under the demonstration program, grantees, including federally qualified health centers (FQHCs) and nurse-managed health centers (NMHCs), will receive three years of funding to provide one year of training to nurse practitioners for careers as primary care providers in FQHCs and NHMCs.

Section 5315 creates the United States Public Health Sciences Track. This program provides grants to accredited schools that award advanced degrees emphasizing public health and epidemiology. Nursing and physician assistant students, among others, are eligible to receive a stipend and funding for tuition. The Affordable Care Act specifies that at least one hundred nurse practitioner or physician assistant students receiving funding through the program must graduate each year, ensuring that the next generation of nurse practitioners and physician assistants benefits from this program.

Appendix A provides a complete overview of the workforce provisions in the Affordable Care Act.

American Recovery and Reinvestment Act of 2009.[33] The American Recovery and Reinvestment Act of 2009 ("ARRA") also provided federal funds to increase the primary care workforce. ARRA allocated $300 million to expand the National Health Service Corps, funding loans and scholarships for health care professionals that work in underserved areas. ARRA also provided an additional $200 million for a variety of primary care training programs in the Public Health Services Act. In July 2009, Health and Human Services ("HHS") Secretary Kathleen Sebelius announced the allocation of $200 million for various primary care training programs would be divided as follows[34]:

- **Scholarships, Loans, and Loan Repayment Awards.** $80.2 million total. Of these funds, $39 million was targeted to nurses and nurse faculty; $40 million to disadvantaged students in a wide range of health professions; and $1.2 million to health professions faculty from disadvantaged backgrounds.
- **Primary Care Training Programs.** $47.6 million to support primary care training programs for residents, medical students, physician assistants, and dentists. It is unclear how much of this funding has been targeted toward physician assistants.
- **Public Health Workforce.** $10.5 million to support public health traineeships and increase the number of individuals trained through preventive medicine and dental public health residencies.

Many of the ARRA initiatives focused on expanding and improving the primary care workforce, generally, but millions of dollars were targeted toward increasing the numbers of nurses and physician assistants providing primary care. By including nurses and physician assistants among the types of providers eligible to receive ARRA funding, the federal government has implicitly acknowledged that both nurses and physician assistants are a core component of America's portfolio of primary care providers.

In sum, nurse practitioners, physician assistants, and licensed clinical social workers will continue to become increasingly critical parts of the healthcare workforce, spurred in large part by federal initiatives that recognize the importance of these professionals for ensuring access to high quality healthcare.

IV Expanding Acceptable Medical Sources Will Promote Program Integrity

As discussed above, nurse practitioners, physician assistants, and licensed clinical social workers are an increasingly important part of the country's healthcare workforce and, for many, these professionals are the primary, if not only, source of medical care. By expanding the list of acceptable medical sources to include nurse practitioners, physician assistants, and licensed clinical social workers, SSA can acknowledge the changing composition of the healthcare workforce, how that changing composition affects individuals applying for SSI/SSDI, and how relevant such professionals are to providing diagnostic and other clinical information needed to resolve claims.

SSA is understandably concerned with protecting the integrity of its programs and, thus, is reluctant to alter the current application process in any way that may enable ineligible individuals to receive benefits through the program. By limiting the types of professionals who can provide definitive diagnostic evidence of certain medical conditions to those with the highest levels of training, SSA ensures accuracy in the diagnosis of a medical condition that would entitle an individual to SSI and/or SSDI.

Having rigorous standards for acceptable medical sources does protect program integrity by ensuring that only eligible individuals receive these benefits, but protecting program integrity also requires that eligible individuals *do* receive benefits. Currently, the narrow list of acceptable medical sources only ensures that ineligible individuals do not receive benefits; it does nothing to ensure that eligible individuals do receive benefits in a timely manner.

An overview of the approval rates at various stages of the application review process illustrates how challenging it can be for individuals to secure benefits. In federal fiscal year 2010, 35% of initial applications for SSI or SSDI were approved after the initial review. Of the denied applications, 36% of applicants apply for reconsideration. During the reconsideration phase, 13% of the applications being reconsidered are approved. Approximately 99% of applicants whose applications are denied during reconsideration then appeal for further review before an Administrative Law Judge (ALJ). ALJs approve 62% of the applications that they review. Fifty-four percent of applicants who are denied by the ALJ then appeal to the Appeals Council, where 2% are approved. Twenty percent of applicants denied by the Appeals Council further appeal to Federal Court, where another 4% are approved. Overall, just over 50% of applicants had their applications approved at some point throughout the process.[35] Of the 50% of applicants who are successful, 31% of those applicants require some form of appeal to win approval.

Delay in the SSDI or SSI application process results in prolonged suffering for people who are homeless and can also contribute to homelessness for low-income people. A significant percentage of individuals who are homeless are scheduled for consultative examinations and are routinely denied after those exams due to the barriers discussed above.[36] Hearings currently take one to three years to be held. In the meantime, in most states, applicants have no source of income, often exacerbating their underlying physical and mental health conditions, and resulting in homelessness.

When considering whether to expand the list of acceptable medical sources, we believe that SSA must address two significant questions: (1) the overall level of training of a group of professionals and (2) the consistency of those training requirements across states. If entry into a profession requires rigorous training that meets a consistent professional standard, then evidence submitted by members of that profession should be considered as acceptable medical sources by SSA.

SSA should first ensure that the professionals providing definitive evidence of disabling condition are adequately trained to assess and diagnose those conditions. Second, SSA should ensure that licensure and practice standards are generally consistent across the country, so that documentation of a certain diagnosis by a nurse practitioner in one state is as credible as a diagnosis of that condition by a nurse practitioner in another state. Since there is no direct way to compare the credibility of diagnoses across states, SSA must use states' licensing and practice standards. In other words, if two states have similar licensing and practice standards, then SSA can assume that the expertise of professionals in both states and, thus, the credibility of their diagnoses, is roughly comparable.

Charts attached at Appendix 1 provide a comprehensive overview of licensing and practice standards in ten states throughout the country for several types of healthcare professionals. The ten states chosen were selected in order to provide a representative sample. We chose states that have geographic diversity, as well as diversity in size of population.

In addition to identifying the licensing and practice standards for nurse practitioners, physician assistants, and licensed clinical social workers, the charts also identify the licensing and practice standards for optometrists and speech language pathologists. Since optometrists and speech language pathologists are currently listed as acceptable medical sources, these professions function as a control group for our analysis, illustrating, in effect, the degree of uniformity in licensing and practice standards that SSA has previously deemed sufficient. Table 3 summarizes the degree of consistency in practice standards across a ten state survey, and Table 4 illustrates the degree of consistency in licensing standards across the surveyed states.

TABLE 4 | SURVEY OF PRACTICE STANDARDS

Ten State Survey: Practice Standards*

	Authority to Prescribe?	May Create Independent Practice?	Authority to Diagnose?
Optometrists	9/9 States (TX standards not clear)	10/10 States	10/10 States
Speech Therapists	0/10 States	10/10 States	10/10 States
Physician Assistants	10/10 States	1/10 States	10/10 States
Nurse Practitioners	9/9 States (One state unknown)	7/8 States (TX and AL standards not clear)	8/8 States (MI and MO standards not clear)
Social Workers	0/10 States	10/10 States	10/10 States

TABLE 5 | SURVEY OF LICENSING STANDARDS

Ten State Survey: Licensing Standards *

	National Exam Required?	State Exam Required?	Internship/Onsite Training Required?	Specialized Degree Required?
Optometrists	10/10 States	7/10 States	1/10 States	10/10 States
Speech Therapists	9/10 States	6/10 States	10/10 States	10/10 States
Physician Assistants	10/10 States	0/10 States	4/10 States	10/10 States
Nurse Practitioners	9/10 States	1/10 States	7/7 States (IL, MO, and WA standards not clear)	9/10 States
Social Workers	9/10 States	2/10 States	10/10 States	10/10 States

NURSE PRACTITIONER PRACTICE AND LICENSING STANDARDS

Practice standards for nurse practitioners are fairly consistent across the ten states surveyed. In all ten states, nurse practitioners may diagnose medical conditions and prescribe medications. In eight states, nurse practitioners may create an independent practice site; in the remaining two states, it is unclear whether nurse practitioners may have an independent practice site. In all states, nurse practitioners may only practice under a written agreement with a physician, but a nurse practitioner could practice without the direct supervision of a physician.

License standards for nurse practitioners are also fairly consistent. Nine states require that an applicant have a specialized degree, such as a master's degree, to be permitted to practice as a nurse practitioner. New York, by contrast, permits an applicant without a specialized degree to demonstrate that he or she possesses equivalent experience. Similarly, nine states require that an applicant pass a national examination before obtaining a license as a nurse practitioner. All states require that nurse practitioners renew their licenses biennially, and nine states impose continuing education requirements on license holders.

PHYSICIAN ASSISTANT PRACTICE AND LICENSURE STANDARDS

Practice standards for physician assistants are also consistent across the states surveyed. All ten states permit physician assistants to prescribe medications, and nine states permit a physician assistant to diagnose medical conditions.[37] Only one state permits physician assistants to practice independently of physicians, and that state only permits physician assistants to have an independent practice site in limited circumstances.[38] Physician assistants must practice under a written agreement with a physician in all ten states, but the physician need not be physically present when the physician assistant cares for patients.

We found a high degree of consistency with respect to licensing standards for physician assistants. Eight states require that physician assistants have a specialized degree, and all ten states require that physician assistants pass a national examination. All states require physician assistants to renew their licenses biennially, and nine states impose continuing education requirements on licensees.

LICENSED CLINICAL SOCIAL WORKERS PRACTICE AND LICENSURE STANDARDS

The scope of practice of licensed clinical social workers differs significantly from that of physician assistants and nurse practitioners, but the scope of practice for licensed clinical social workers was consistent across the ten states surveyed. All ten states do not permit licensed clinical social workers to prescribe medications, but all ten states do permit licensed clinical social workers to diagnose mental health conditions. All ten states permit licensed clinical social workers to practice independently without any supervision by a physician.

Licensure standards were similarly consistent across states. All ten states require a specialized degree. Nine states require that licensed clinical social workers pass a national examination, and the tenth state, California, instead requires that licensed clinical social workers pass a state examination. All states require that licensed clinical social workers renew their licenses—nine states on a biennial basis and one state on a triennial basis. Nine states also impose continuing education requirements as a prerequisite for license.

OPTOMETRIST PRACTICE AND LICENSURE STANDARDS

Practice standards for optometrists had a similar degree of consistency as those for nurse practitioners, physician assistants, and licensed clinical social workers. Optometrists in nine states may prescribe eye-related medications; in the remaining state, it was unclear whether optometrists had such authority. All ten states permit optometrists to diagnose certain eye conditions. Finally, all ten states permit optometrists to practice independently without any supervision from a physician.

We observed a similar degree of consistency in licensing standards across states. All ten states require that optometrists have a specialized degree, and all ten states require that optometrists pass a national examination. All states require that optometrists renew their licenses, but the renewal period varies from once per year to once every three years. All ten states impose continuing education requirements on optometrists seeking to renew their licenses.

SPEECH-LANGUAGE PATHOLOGIST PRACTICE AND LICENSURE STANDARDS

We observed a similar degree of consistency in practice standards for speech-language pathologists. No state permits speech-language pathologists to prescribe medications, but all ten states permit speech-language pathologists to diagnose certain conditions. Similarly, all ten states permit speech language pathologists to practice independently. Nine states permit speech-language pathologists to practice with limited supervision and, one state, Illinois, requires a moderate amount of supervision.

Licensure standards for speech-language pathologists are also consistent across the surveyed states. Eight states require that speech-language pathologists have a specialized degree. Nine states require that speech-language pathologists pass a national examination; one state, California, requires that they pass a state examination instead. All ten states require speech-language pathologists to renew their licenses biennially, and all ten states impose continuing education requirements on individuals seeking to renew their licenses.

In sum, there is no significant difference in the degree of consistency of practice or licensure standards between the professionals currently listed as acceptable medical sources (*i.e.*, speech-language pathologists and optometrists) and the professionals that we propose be listed as accepted medical sources (*i.e.*, nurse practitioners, physician assistants, and licensed clinical social workers). In both groups of professionals, the standards are generally consistent, with no more than one or two occasional outliers. And, perhaps most importantly, in both groups of professionals, the standards for licensing are generally high.

Our ten-state survey of licensure and practice standards supports our contention that SSA would not jeopardize the integrity of its programs by expanding the list of acceptable medical sources to include nurse practitioners, physician assistants, and licensed clinical social workers. Instead, the Social Security Administration could promote the integrity of its programs by ensuring that eligible individuals receive their benefits in a timely manner without an increased administrative burden in this time of limited resources.

V Conclusion

For many individuals who are homeless, receiving SSDI or SSI—and the steady stream of income and access to health benefits that they provide—is one of the first steps on the path out of homelessness and on the road to recovery. Since receiving these benefits is a critical lifeline for many individuals, the federal government should ensure that all eligible individuals receive these benefits as quickly as possible. Too often, eligible individuals encounter delays in the application process, leading to needless extra months if not years without safe shelter. Some of the delays in the application process may be unavoidable but, as discussed in detail above, many delays arise when SSA requires a consultative examination to confirm the diagnosis made by a nurse practitioner, physician assistant, or licensed clinical social worker.

Streamlining the application process by expanding the list of acceptable medical sources to include nurse practitioners, physician assistants, and licensed clinical social workers is an important step that SSA can take immediately to improve the lives of many homeless and low income individuals. Further, expanding the list of acceptable medical sources is a sound policy decision for several reasons.

First, and perhaps most importantly, the federal government, including SSA, has committed to end homelessness. Since SSDI and SSI are critical tools in the fight to end homelessness, the federal government should take all feasible steps to promote access to these benefits for eligible individuals. Expanding the list of acceptable medical sources is consistent with the federal government's broad policy goals, protects program integrity, and recognizes the changing nature of the country's healthcare workforce. It is a reasonable step SSA can take to promote access to SSDI and SSI, thereby upholding its commitment to help end homelessness.

Second, expanding the list of acceptable medical sources recognizes that non-physician healthcare professionals are increasingly becoming the primary providers for many Americans. Millions of Americans rely on nurse practitioners, physician assistants, and licensed clinical social workers today to be their primary providers of physical and mental health care. Based on current trends, these health professionals will continue to become an increasingly important part of the nation's healthcare workforce, meaning that, increasingly, more individuals will rely on nurse practitioners, physician assistants, and licensed clinical social workers for care. Excluding these professionals from the list of acceptable medical sources, then, will likely affect increasing numbers of SSDI and SSI applicants in years to come.

Third, the federal government has expressed a commitment to promoting non-physicians as important parts of our network of health care providers. Including nurse practitioners, physician assistants, and licensed clinical social workers among the list of acceptable medical sources confirms this commitment.

Finally, expanding the list of acceptable medical sources to include these professionals protects the integrity of the SSDI and SSI programs. Nurse practitioners, physician assistants, and licensed clinical social workers are all highly trained professionals who provide excellent primary physical and mental health care. Practice and licensing standards are generally consistent across states, so SSA can be assured that all nurse practitioners, physician assistants, and licensed clinical social workers are held to appropriately high standards.

APPENDIX A
PROVISIONS IN THE AFFORDABLE CARE ACT TO IMPROVE THE HEALTH CARE WORKFORCE

TABLE 1 | GRANT-BASED PROGRAMS

ACA Section	Grant Program	Federal Funding	Eligible Entities
5301	Primary Care Training Programs	$125 million for 2010 and additional sums as necessary through 2014	A Public or Nonprofit Hospital, Medical School, PA Training Program, or Public or Nonprofit Entity
5302	New Training Programs for Direct Care Workers in Long-Term Care Settings	$30 million	Higher Education Institutions
5303	Dentistry Training Programs	$30 million for 2010 and additional sums as necessary through 2014	Higher Education and Health Care Provider Institutions
5305	Geriatric Education Center Fellowship Programs	$10.8 million	Higher Education and/or Health Care Provider Institutions
5306	Mental and Behavioral Health Training Programs	$35 million	Higher Education Institutions
5309	Nurse Retention Improvement Initiatives and Programs to Promote Nurse Involvement in Clinical Decision-Making Processes	Appropriations as necessary	Nursing Schools and/or Health Care Facilities
5314	Public Health Fellowship Training	$158 million	Expansion of existing programs
5307	Development of Training Curricula Related to Cultural Competency, Prevention, Public Health, and Working with Individuals with Disabilities	Appropriations as necessary	As determined by the Secretary
10501	Preventative Medicine and Public Health Residency Programs	$43 million for 2010 and additional suns as necessary through 2015	States Health Departments, Higher Education Institutions, Health Care Institutions
10501	Rural Physician Training	$16 million	Higher Education Institutions
5313	Community Health Worker Training Programs	Appropriations as necessary	Public or Nonprofit Private Entity including a State, Public Health Department, Free Health Clinic, Hospital, or FQHC
5304	Alternative Dental Health Care Provider Demonstration Project	$300 million	Safety Net Providers or Higher Education Institutions
5316	Demonstration Grants for Family Nurse Practitioner Training Programs	Appropriations as necessary	FQHCs and Nurse Managed Health Centers who employ NPs.
5508	Teaching Health Centers Development (for the purpose of establishing new accredited or expanded primary care residency programs)	$125 million	Community-based Health Centers
5509	Graduate Nurse Education Demonstration Program (Medicare)	$200 million	Up to five hospitals or Critical Access Hospitals
5507	Demonstration Projects to Address Health Professions Workforce Needs (Occupational Health and Personal and Home Aides)	$85 million	1. Demonstration project for up to six states 2. Demonstration for wide range of entities able to manage and evaluate such a demonstration
5402	Health Professions Training for Diversity	$60 million for 2010 and additional sums as necessary through 2014	Disadvantaged students who commit to work in medically underserved areas, faculty at schools for PAs

TABLE 2 | LOAN-BASED PROGRAMS

ACA Section	Program	Federal Funding	Eligible Entities
5203	Pediatric Specialties Loan Repayment Program	$210 million	Eligible Professionals
5202	Nursing Student Loan Program	not specified	
5311	Nursing Faculty Loan Program	not specified	Nursing Schools
5204	Public Health Workforce Loan Repayment Program	at least $195 million	
5207/10503	National Health Service Corps Increased Funding and Loan Repayment Program Expansion	$1.5 billion	
5201	Federal Health Professionals Student Loan Program Modifications		
5205	Allied Workforce Loan Repayment Program		Allied Health Professionals
5206	Mid-Career Allied Health Scholarships Grant Program	$30 million for 2010 and additional sums as necessary through 2014	Eligible Professionals
5206	Scholarships for Federal, State and Local Officials for Public and Allied Health Training	$30 million for 2010 and additional sums as necessary through 2014	Accredited educational institutions
5305	Geriatric Career Incentives Grant	$10 million	Eligible Professionals

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[1] United States Interagency Council on Homelessness, *Opening Doors: Federal Strategic Plan To Prevent and End Homelessness* (2010).
[2] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148.
[3] Mondello, M., Gass, A., McLaughlin, T., & Shore, N. *Cost of Homelessness: Cost Analysis of Permanent Supportive Housing, State of Maine—Greater Portland* (2007).
[4] Social Security Act § 1811.
[5] Social Security Act § 1902. Individuals receiving SSI are also entitled to receive Medicaid, unless their state has elected to use more stringent eligibility criteria for disabled individuals. As of 2001, eleven states (Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia) had elected to apply more stringent criteria. As a result, individuals living in those eleven states who receive SSI may or may not be eligible for Medicaid, depending on whether they meet the state's other eligibility criteria.
[6] 20 C.F.R. § 404.1513
[7] 20 C.F.R. § 404.1513
[8] National Council for Community Behavioral Healthcare, http://www.thenationalcouncil.org/cs/healthcare_reform.
[9] Dennis, D., Perret, Y., Seaman, A., & Wells, S. M. (2007). Expediting Access to SSA Disability Benefits: Promising Practices for People Who Are Homeless. Delmar, NY: Policy Research Associates, Inc.
[10] Whitbeck, Les B. Mental Health and Emerging Adulthood Among Homeless Young People. 2009.
[11] 2009-2010 American Academy of Nurse Practitioners, *National Nurse Practitioner Sample Survey*.
[12] 2009-2010 American Academy of Nurse Practitioners, *National Nurse Practitioner Sample Survey*.
[13] American Academy of Nurse Practitioners, *2009-2010 Overview*.
[14] 2009-2010 American Academy of Nurse Practitioners, *National Nurse Practitioner Sample Survey*.
[15] American Academy of Physician Assistants, *2009 National Physician Assistant Census Report* (2010).
[16] American Academy of Physician Assistants, *2009 National Physician Assistant Census Report* (2010).
[17] A.R. Ellis *et al.*, "County-Level Estimates of Mental Health Professional Supply in the United States," Psychiatric Services, 60:1315 (2009).
[18] R. M. Scheffler and P. B. Kirby, The Occupational Transformation of the Mental Health System, *Health Affairs*, 22, no. 5 (2003):177-188.
[19] R. M. Scheffler and P. B. Kirby, The Occupational Transformation of the Mental Health System, *Health Affairs*, 22, no. 5 (2003):177-188.
[20] The information is adapted from Table 3 in *Mental Health, United States, 2002* (Manderscheid & Henderson, 2004, p. 332). The interested reader should consult the original source material to better understand the limitations of the data.
[21] Health Resources and Services Administration, http://www.hrsa.gov/index.html.
[22] A.R. Ellis *et al.*, "County-Level Estimates of Mental Health Professional Supply in the United States," Psychiatric Services, 60:1315 (2009).
[23] L. Gamm *et al.*, "Mental Health and Mental Disorders—A Rural Challenge: A Literature Review," *Rural Healthy People 2010, Volume 2*, 97 (2003).
[24] It is particularly noteworthy that FQHCs provide non-emergent care to all individuals, regardless of ability to pay. Most hospitals are required to provide emergency care, regardless of ability to pay, under the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Hospitals, however, are not obligated to provide non-emergent care to uninsured patients. See generally 42 U.S.C. § 1395dd.
[25] National Association of Community Health Centers. "NACHC 2010 Assessment of Behavioral Health Services in Federally Qualified Health Centers," (2011).
[26] National Association of Community Health Centers. "NACHC 2010 Assessment of Behavioral Health Services in Federally Qualified Health Centers," (2011) p. 5.
[27] Bureau of Labor Statistics, *Occupational Outlook Handbook, 2010-2011 Edition* (2011).
[28] Bureau of Labor Statistics, *Occupational Outlook Handbook, 2010-2011 Edition* (2011). The Bureau of Labor Statistics does not provide projections for subsets of registered nurses, such as nurse practitioners or nurse midwives.
[29] Bureau of Labor Statistics, *Occupational Outlook Handbook, 2010-2011 Edition* (2011). Not all mental health and substance abuse workers are necessarily licensed clinical social workers, but many likely are.
[30] Bureau of Labor Statistics, *Occupational Outlook Handbook, 2010-2011 Edition* (2011).
[31] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148.
[32] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 5316.
[33] American Recovery and Reinvestment Act, Pub. L. No. 111-5.
[34] Department of Health and Human Services, "Secretary Sebelius Makes Recovery Act Funding Available to Expand Health Professions Training," July 28, 2009, *available at* http://www.hhs.gov/news/press/2009pres/07/20090728c.html.
[35] All data from personal communication with the Social Security Administration, January 2012. Data is on file with author.
[36] This information is anecdotal because SSA does not routinely track it.
[37] Florida does not permit a physician assistant to make a final diagnosis. FLA. ADMIN. CODE ANN. r. 64B8-30.012
[38] TEX. REV. CIV. STAT. ANN. § 204.204; 185 TEX. ADMIN. CODE §185.2.