



Health Workforce Policy Brief

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Impact of the Affordable Care Act on Behavioral Health Workforce Capacity

Katiri Zuluaga, MSW, Megan Dormond, MPH
National Council for Behavioral Health

BACKGROUND

According to an analysis by the Health Resources and Services Administration (HRSA), the nation needs to add 10,000 providers to each of seven separate behavioral health care professions by 2025 to meet the expected growth in demand prompted by the Patient Protection and Affordable Care Act (ACA).¹ The ACA was signed into law in 2010 with major provisions, such as Medicaid Expansion, enacted in 2014. States that have opted to expand their Medicaid program have seen increases in healthcare coverage, utilization of services, and access to care; however, a robust workforce is needed to meet these demands. In particular, recruiting and retaining the necessary behavioral health staff in rural areas both pre- and post-ACA remains a significant challenge. For years, the National Institute of Health has reported that 50 to 55% of U.S. counties have no access to mental health care.² In 2015, it was reported that 62 million people live in frontier or rural areas and 75% of the counties designated as rural or frontier have no behavioral health providers.³ Approximately 77% of all counties in the U.S. have a severe behavioral health prescriber shortage.⁴

The National Health Service Corps (NHSC), founded in 1972, was created to bring health care to those who need it most. Eligible providers may apply to the Loan Repayment Program (LRP) and receive payment in return for service at eligible sites. The NHSC aims to assist provider organizations in Health Professional Shortage Areas (HPSAs), as designated by HRSA. Between 2009 and 2013, the NHSC has supported over 14,000 health care providers that have delivered care to over 9.3 million individuals. This was made possible through a historic investment of more than \$234 million through the Affordable Care Act. Given the changes to the healthcare environment and this sizable investment, the research team at the Behavioral Health Workforce Research Center investigated how the ACA impacted the behavioral health workforce through the NHSC.

METHODS

To understand the impact of the NHSC LRP on the behavioral health workforce, the research team investigated awardee information for nine qualified disciplines over the past eight years. Qualified disciplines include:

CONCLUSIONS AND POLICY IMPLICATIONS

Key findings of this study show that behavioral health providers are leveraging the NHSC in high-need areas. The ACA has contributed to an increase in the number of specialty providers in HPSAs, yet an unmet need for care remains. Addiction treatment facilities have had limited ability to offer loan forgiveness incentives.

Additionally, licensed addiction treatment providers are missing from loan repayment programs. To properly address these needs, it is recommended to:

- Encourage increased funding for the NHSC and include a comprehensive behavioral health workforce recruitment strategy
- Encourage support for Senate Bill 1453: Strengthening the Addiction Treatment Workforce Act. This legislation would designate certain substance use disorder treatment facilities as eligible for NHSC service.
- Encourage the standardization of the Licensed Addiction Counselor role across states for eventual inclusion as an NHSC-eligible provider.

¹Heisler, E. (January 2013). Physician Supply and the Affordable Care Act. Retrieved from <http://healthcarereform.procon.org/sourcefiles/crs-physician-supply-and-affordable-care-act.pdf>

² <https://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>

³ Substance Abuse and Mental Health Services Administration. (October 2015). Workforce. <https://www.samhsa.gov/workforce>

⁴ Thomas, K., Ellis, A., Konrad, T., Holzer, C., & Morrissey, J. (2009). County-Level Estimates of Mental Health Professional Shortage in the United States. *Psychiatric Services* 2009 60:10, 1323-1328.

Table 1. Disciplines Included in Analysis

Allopathic Psychiatrists (AP)	Health Service Psychologists (HSP)	Licensed Clinical Social Workers (LCSW)
Licensed Professional Counselors (LPC)	Marriage and Family Therapists (MFT)	Nurse Practitioners (NP)
Osteopathic Physicians (OP)	Physicians Assistants (PA)	Psychiatric Nurse Specialists (PNP)

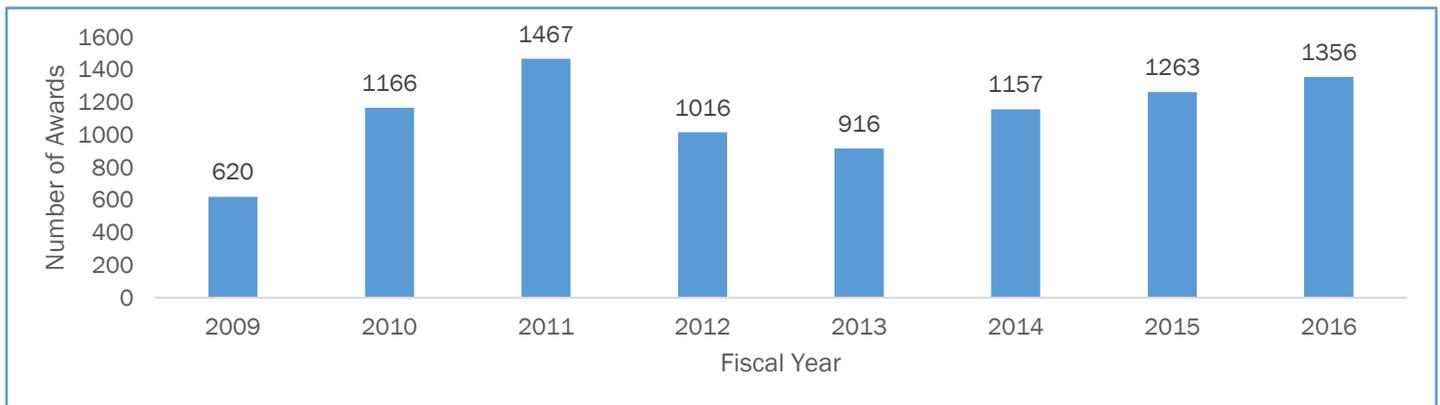
LRP award data were analyzed by year, role, and state to identify trends in awards, focusing on total award amount, number of awardees, as well as average, most frequent, and minimum and maximum award amount for each state. These data points were investigated to understand the impact ACA investments had over time on NHSC recipients. The data did not differentiate new awardees in the LRP or continuation year awards offered to eligible practitioners who recommit for another NHSC year via a continuation contract. Data were provided by HRSA and were analyzed using Excel.

Additionally, the research team investigated trends in active provider licenses for Primary Care Providers, PAs, Clinical Psychologists, and Psychiatrists through state licensing board information to determine trends over time. Ten states- five Medicaid expansion and five non-expansion states- were selected for analysis. Expansion states included: Arkansas, Arizona, Connecticut, Iowa, and West Virginia. Non- expansion states included: Georgia, Mississippi, Missouri, Oklahoma, and Wyoming.

KEY FINDINGS

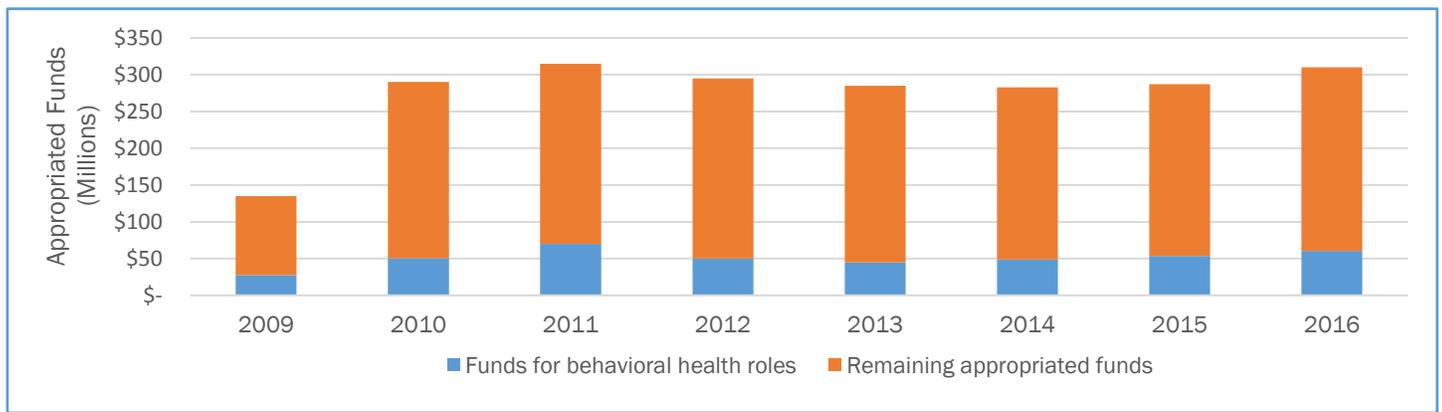
The NHSC combats shortages in HPSAs, but the impact is strongly effected by available funding. The largest number of LRP awards were given in Fiscal Year 2011 (FY11) due to increased program appropriations the year after the ACA was signed into law (Figure 1). FY12 and FY13 saw significant decreases in awards, which correlates with the decrease in appropriated funds those years. Most of the ACA's major provisions, like Medicaid expansion, took place in FY14 and the data shows awardee totals increased steadily in FY14, FY15 and FY16.

Figure 1. Total Loan Repayment Program Awardees for Nine Behavioral Health Related Roles by Year, 2009-2016



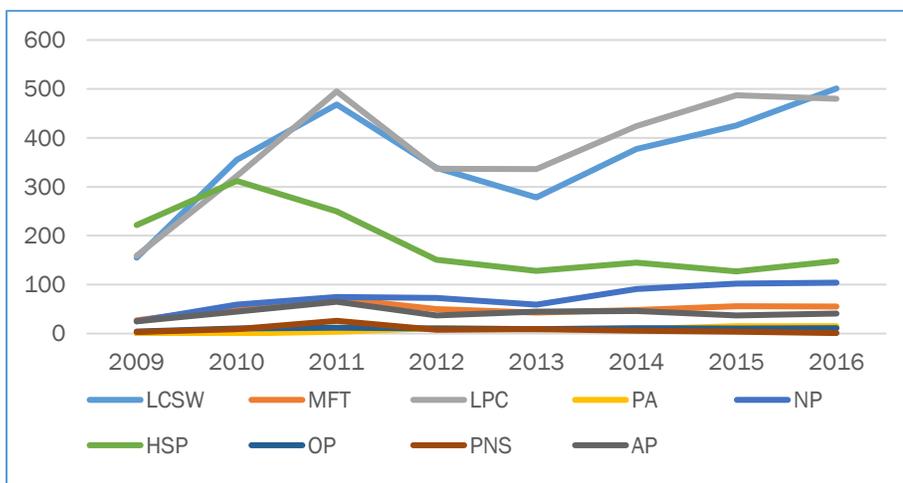
The lowest award amount total for the nine roles since the signing of the ACA was FY13 at \$44,827,965. The highest award amount was in FY11 for a total of \$69,893,464 followed by FY16 at \$60,406,701 (Figure 2). As these nine professions are only a part of the total pool of eligible professions, the percentage of total appropriated funds is low. FY11 and FY16 saw the largest proportional spending as compared to other years.

Figure 2. Amount of National Health Service Corps Loan Repayment Program Funds, 2009-2016



LCSWs and LPCs have the highest, consistent usage of the program (Figure 3). From year to year, the most frequently awarded amount for an LRP award per individual was the maximum of \$50,000. From 2009 to 2016, 25% of LPC LRP awardees were in the 10 states with the most HPSAs. Since the data did not differentiate between LRP first year awardees and continuation awards, it is possible that certain roles are leaving after the initial first year contract and receiving higher sign-on bonuses at other provider facilities rather than using continuation LRP funds. Additional information is required to determine if a significantly higher salary is perceived as more valuable than loan repayment⁵.

Figure 3. Number of Loan Repayment Program Awardees by Role, 2009-2016



Investigations into state licensing board data were inconclusive. Variation in number of active licenses occurred in both expansion and non-expansion states, and there was no discernible difference in average per capita change in number of licenses across any of the selected providers of interest. These analyses could be improved upon by analyzing the number of active licenses and Medicaid enrollees over time to determine if the workforce can adequately meet the increased demand.

CONCLUSIONS

Findings indicate that behavioral health-focused providers and specialty clinicians are leveraging the NHSC in high-need areas. The ACA has contributed to an increase in the number of specialty providers in HPSAs, yet unmet need remains. Role comparisons indicate that certain providers, such as PAs, have low adoption of LRPs. Additionally, addiction treatment facilities have had limited ability to offer loan forgiveness incentives to potential employees. By allowing substance use disorder treatment facilities to become eligible sites, the NHSC could strengthen workforce capacity by supporting specialty care providers in high need areas. Finally, a critical sector missing from this program is licensed addiction treatment providers. Addiction professionals are often bachelor’s level providers and are excluded from loan repayment programs due to the lack of standardized scope of practice, role, and definition of their work.

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⁵ National Health Service Corps. (2015). Participant Salary Reference Guide: Loan Repayment Program. <https://nhsc.hrsa.gov/currentmembers/loanrepaymentrecipients/faqs/participantsalaryreferenceguide.pdf>