The Impact of the Patient Protection and Affordable Care Act on Behavioral Health Workforce Capacity: Results from Secondary Data Analysis

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KEY FINDINGS

The Affordable Care Act's expansion of Medicaid eligibility among participating states has increased the number of per-capita behavioral health providers more significantly than increases seen in states that did not expand Medicaid eligibility. Further examination of the relationship between Medicaid and behavioral health workforce is necessary given the important role that Medicaid plays in financing behavioral health services across our nation.

Study findings support the National Health Service Corps Loan Repayment Program as an effective incentive to increase rates of behavioral health providers in underserved and high-need areas. However, this program could be made more effective with increased funding, improved behavioral health recruitment and retention strategies, and expanded participant eligibility for substance use disorder treatment facilities and providers.

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INTRODUCTION

The Impact of the Affordable Care Act on Behavioral Health Workforce Capacity

In March 2010, the Patient Protection and Affordable Care Act (ACA) was enacted into law, putting into place sweeping reforms to the nation's healthcare system, including behavioral health services. Specifically, numerous ACA provisions directly and indirectly impact behavioral health workforce capacity. For example, the ACA increases the demand for health professionals through provisions like expanded Medicaid eligibility, and also provides direct incentives and financial support to increase healthcare workers in health professional shortage areas (HPSAs).

With the Medicaid expansion provision, some states expanded their Medicaid programs to cover all individuals with household incomes below 133% of the federal poverty level.[1] States that have opted to expand their Medicaid program have seen increases in healthcare coverage, utilization of services, and access to care. In fact, roughly 20 million previously uninsured people have gained health insurance since the enactment of the ACA.[1] The National Center for Health Statistics reports that in 2016, adults under age 65 years residing in Medicaid expansion states were less likely to be uninsured than those residing in non-expansion states.[2] In Medicaid expansion states, the proportion of uninsured adults decreased, from 18.4% in 2013 to 9.2% in 2016. In non-expansion states, the percentage of uninsured adults also decreased, from 22.7% in 2013 to 17.9% in 2016. With the increased number of people with insurance and access to healthcare services comes an increased demand for providers to meet demands.

In anticipation of the increased demand in behavioral health services due to ACA provisions, the Health Resources and Services Administration (HRSA) developed projections using a workforce simulation model to better understand behavioral health workforce needs.[3] HRSA estimates that by 2025 there will be shortages for all types of behavioral health professions and shortages of more than 10,000 full-time equivalent employees among:

- Psychiatrists;
- Clinical, counseling, and school psychologists;
- Substance abuse and behavioral disorder counselors;
- Mental health and substance abuse social workers;

- Mental health counselors; and
- School counselors.

Implementation of the ACA also increased Medicaid funding for behavioral health services. Following the expansion of Medicaid eligibility in some states in 2014, funding for behavioral health increased by 23% for mental health services and 43% for substance use disorder services between 2009 and 2014, totaling $53.6 billion in 2014.[4] The increases allowed formerly uninsured clients to enroll in Medicaid, providing reimbursement to behavioral health practitioners for services that otherwise would have gone uncompensated. This increased revenue could help stabilize other workforce factors that lead to shortages, for example, increasing salaries.

In addition to impacts related to increased demand and revenue, the ACA provided direct funding to increase behavioral health workforce capacity through investments made in the National Health Service Corps (NHSC). The NHSC was founded in 1972 to expand access to healthcare professionals in underserved areas. The program was designed to prevent future healthcare shortages as experienced in the 1950s and 1960s, and to ensure access to adequate care across the U.S. Prior to the time when Medicaid expansion provision went into effect, it was estimated that there were 91 million individuals living in mental health HPSAs.[5] To become an NHSC-approved site, an organization must: be located in an HPSA; offer discounted care or accept patients who are unable able to pay; accept Medicaid, Medicare, and the Children's Health Insurance Program; and offer primary, dental, or mental health care services. The NHSC Loan Repayment Plan (LRP) offers behavioral health providers up to $50,000 toward student loans in exchange for a 2-year commitment at an NHSC-approved site. Currently, there are more than 10,000 NHSC members providing care to 10.7 million people at more than 5,000 NHSC-approved sites.[6] Between 2008 and 2011 the total number of NHSC sites more than doubled, largely due to an investment of $234 million appropriated by the ACA.[7]

Purpose of the Paper

The ongoing need to strengthen the nation's behavioral health workforce capacity calls for an examination of existing policies to better understand the impact of expanded access to care and effectiveness of programs developed to improve the behavioral healthcare

workforce. To better understand the effect that the ACA has had on the behavioral health workforce, the National Council for Behavioral Health, in partnership with the University of Michigan Behavioral Health Workforce Research Center, conducted a two-part research study. First, a comparative analysis of existing labor data in states that did and did not expand Medicaid eligibility was conducted. Second, the impact of the ACA's increased funding to the NHSC on the behavioral health workforce was analyzed. Findings inform policy recommendations that, if implemented, could address the behavioral health workforce shortage.

METHODS

The first analysis examined state-based licensing trends to compare behavioral health workforce differences between states that expanded Medicaid eligibility and states that did not. The second analysis investigated the impact the NHSC LRP had on nine qualified behavioral health disciplines over the last 8 years.

Impact of Medicaid Expansion

Data on active behavioral health professional licenses between 2010 and 2015 from the Bureau of Labor and Statistics were analyzed to look for trends of behavioral health licensing in ten states: five that expanded Medicaid eligibility (Arkansas, Arizona, Connecticut, Iowa, and West Virginia) and five that chose not to expand (Georgia, Mississippi, Missouri, Oklahoma, and Wyoming). Active licenses are an important regulatory statistic used to identify total workforce numbers recognized by states. The licensure of the following behavioral health practitioners was analyzed: physician assistants, clinical psychologists, psychiatric nurse practitioners, licensed clinical social workers, psychiatrists, and primary care physicians. Four of these roles were selected for more in-depth analysis (primary care physicians, physician assistants, clinical psychologists, and psychiatrists).

Impact of the National Health Service Corps Loan Repayment Program

To assess the impact of the NHSC LRP on the behavioral health workforce, the LRP awardee data of nine qualified health disciplines were analyzed between 2009 and 2015 (Table 1). Award data were analyzed by year, discipline, and state to identify trends in awards, particularly focusing on total award amount, number of awardees, as well as average, most frequent, and minimum and maximum award amounts. The data did not differentiate new awardees in the LRP or continuation year awards offered to eligible practitioners who

recommit for another NHSC year through a continuation contract. Data were provided by HRSA and analyzed in Excel.

Table 1. Qualified Disciplines Examined in the National Health Service Corps Loan Repayment Program From 2009 to 2015

Allopathic Psychiatrists	Health Service Psychologists	Licensed Clinical Social Workers
Licensed Professional Counselors	Marriage and Family Therapists	Nurse Practitioners
Osteopathic Physicians	Physicians Assistants	Psychiatric Nurse Specialists

RESULTS

Impact of Medicaid Expansion

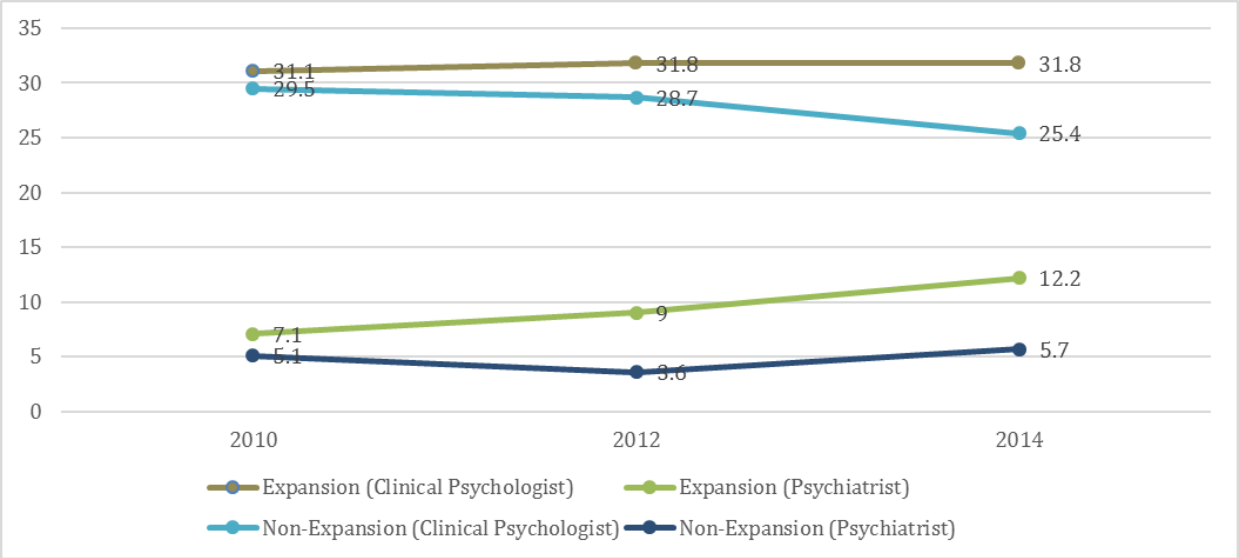
There was variation in the number of active behavioral health licenses in both Medicaid expansion and non-expansion states; however, the five states in this study that expanded Medicaid eligibility (Arkansas, Arizona, Connecticut, Iowa, and West Virginia) saw greater increases of active licenses than the five states in this study that did not. Medicaid expansion states experienced an across-the-board positive per capita (per 100,000 population) increase of active licenses for primary care physicians, physician assistants, clinical psychologists, and psychiatrists between 2010 and 2015. Clinical psychologists experienced a 68% increase, while psychiatrists experienced a 45% increase. Among non-expansion states, there was also a positive per capita increase of primary care physicians, physician assistants, and psychiatrists, but at notably lower levels than expansion states. Furthermore, data from non-expansion states showed a negative per capita change in the number of clinical psychologists over the 5-year period.

Among Medicaid expansion states, Arizona experienced the most significant per capita positive change between 2010 to 2015 for clinical psychologists and psychiatrists, with a 43% and 97% per capita increase, respectively. Iowa experienced the lowest level of per-capita change from 2010 to 2015, with three disciplines showing a negative per capita

change including a -14% change in clinical psychologists, a -37% change in psychiatrists, and a -15% change in primary care physicians. The only other expansion state to experience a negative per capita change from 2010 to 2015 was Connecticut, with an -8% change in clinical psychologists.

Among the five non-expansion states (Georgia, Mississippi, Missouri, Oklahoma, and Wyoming), Georgia, Missouri, and Mississippi all experienced a decrease of actively licensed clinical psychologists per capita from 2010 to 2015. Wyoming only experienced a 0.2% growth for licensed clinical psychologists. Oklahoma had the highest rate of growth, with a 13% per capita increase. All five non-expansion states analyzed experienced a per capita decrease in active licenses from 2010 to 2015 in at least one of the four disciplines analyzed in depth. Missouri experienced the highest positive per capita change from 2010 to 2015 for primary care physicians, physician assistants, and psychiatrists at rates nearly twice as high as the next-highest rate of change in another non-expansion state.

Figure 1. Per Capita Percentage Change in Expansion and Non-Expansion States in 2010, 2012, and 2014



Medicaid expansion states maintained or experienced more-consistent growth in increasing their total number of licensed providers, whereas non-expansion states failed to meet the growth rates required to adequately care for the client population. Both expansion and non-expansion states faced challenges with maintaining or increasing the number of licensed

clinical psychologists. Non-expansion states showed a 14.5% decrease of per capita clinical psychologists and expansion states experienced only a moderate increase of 5.6%.

Results suggest that Medicaid expansion states have better success at maintaining or increasing per capita rates of licensed behavioral healthcare professionals when compared with non-expansion states. The research team assumes that increased funding in the form of Medicaid reimbursement as well as the increased demand for services due to a higher number of individuals seeking services could have led to the increase in behavioral healthcare professionals.

Impact of National Health Service Corps Loan Repayment Program

As expected, results showed a positive relation between the amount of funding appropriated to the program and the amount of awards provided to healthcare professional participants. As shown in Figure 2, the largest number of LRP awards for mental health disciplines were given in Fiscal Year 2011 (FY11) due to increased program appropriations from the ACA. FY12 and FY13 experienced significant decreases in awards, which correlate to the decrease in appropriated funds those years. Implementation of most of the ACA's major provisions, like Medicaid expansion, took place in FY14 and the data show awardee totals increased steadily in FY14, FY15, and FY16. The lowest award amount total for the nine mental health disciplines since enactment of the ACA was FY13 at $44,827,964.89. The highest award amount was in FY11 for a total of $69,893,463.55, followed by FY16 at $60,406,700.84 (Figure 3).

Figure 2. Total NHSC Loan Repayment Program Awardees for 9 Behavioral Health Disciplines by Fiscal Year, 2009-2016

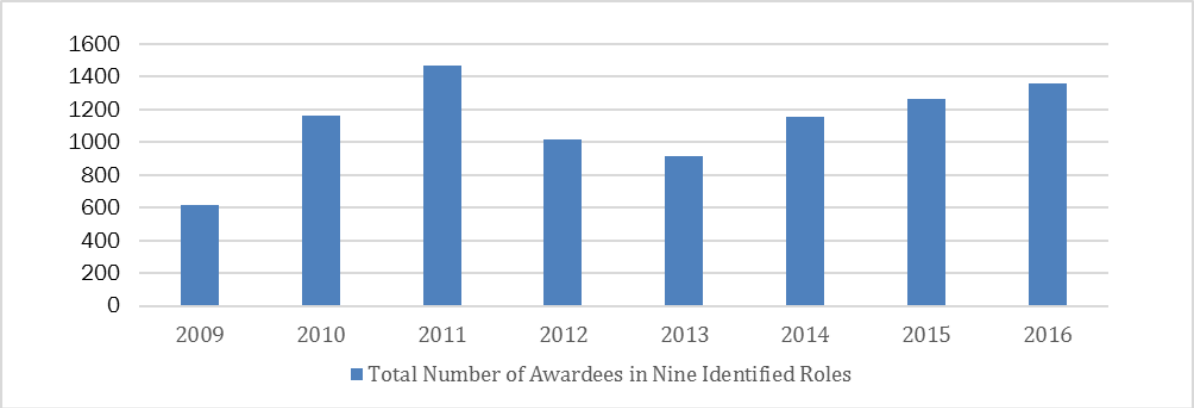
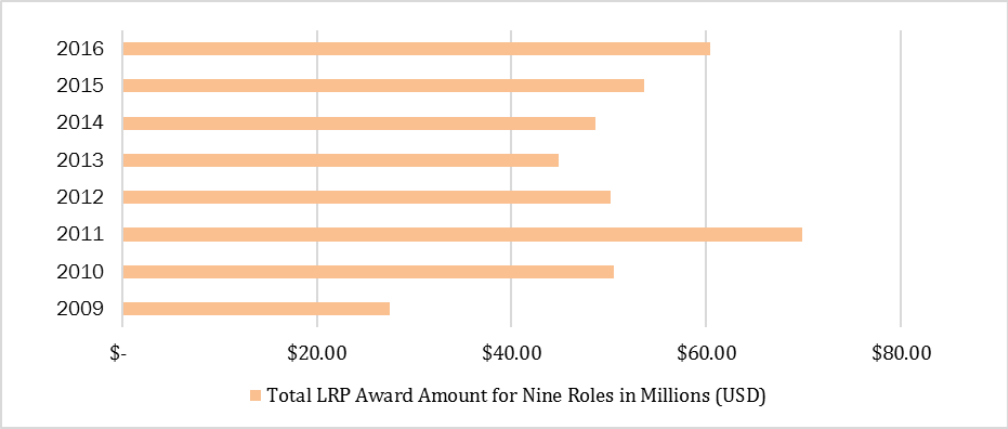
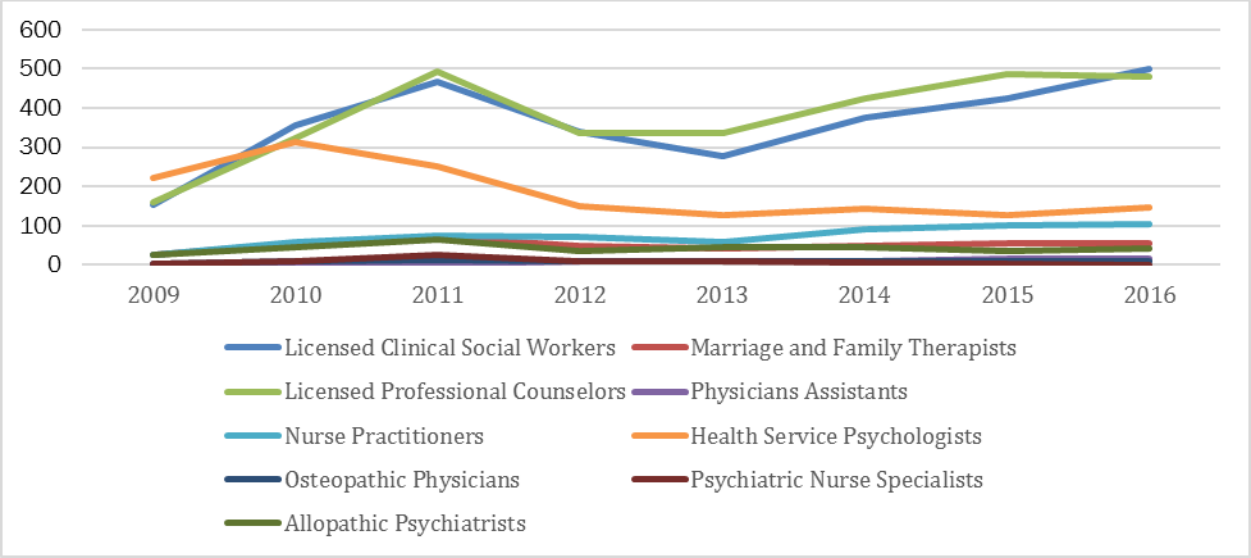


Figure 3. Total Loan Repayment Program Awards for 9 Behavioral Health Disciplines in Millions (USD) By Fiscal Year, 2009- 2016



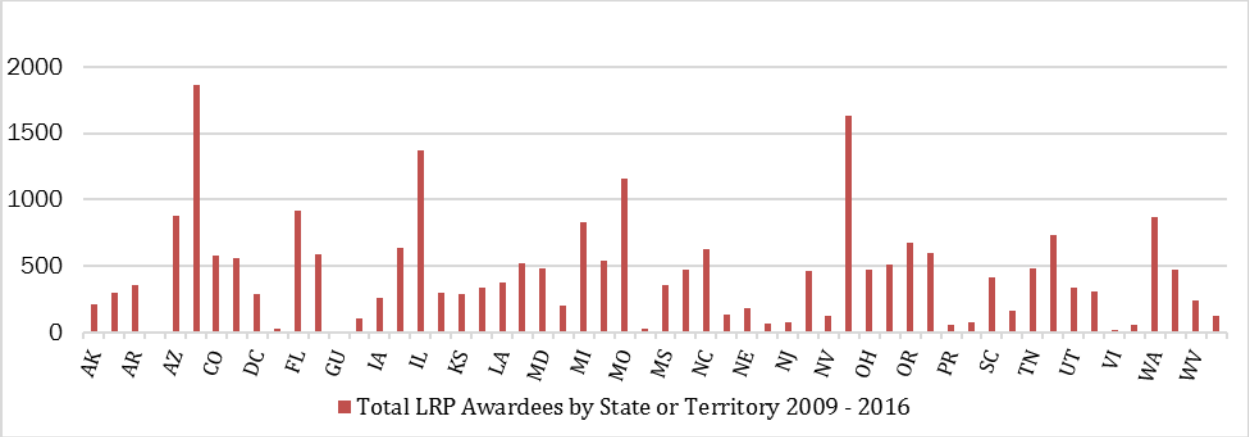
In an effort to better understand the specific types of mental health disciplines that are impacted by the program, researchers analyzed trends of each of the nine mental health disciplines (Figure 4). Study results show licensed clinical social workers and licensed professional counselors have the highest consistent usage of the program. Psychiatric nurse specialists, osteopathic physicians, and physician assistants have the lowest participations rates with LRP awardees averages of 9.6, 8.25, and 10.5 awardees, respectively, per year from 2009 to 2016. Each year, the most common amount of LRP award per individual was the maximum of $50,0000. The lowest average LRP award amount across the disciplines of interest from 2009 to 2016 was $42,020.65 in FY2014 and the highest average LRP was $49,373.05 in FY2012. As 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 organizations rather than continuing to receive second-year LRP funds. Annual salaries for NHSC participation are pre-determined by the federal government and could be lower than salaries at competing provider organizations.[9] Additional data and analysis are required to better understand if a significantly higher salary is perceived as more valuable than loan repayment causing participants to leave the program after the first year.

Figure 4. Number of Awardees by Behavioral Health Discipline, 2009-2016



From 2009 to 2016, 25% of licensed professional counselor LRP awardees were in the ten states with the most HPSAs, not specific to mental health HSPAs. According to the Kaiser Family Foundation, as of 2016 the five states with the greatest shortage of mental health providers, thus requiring the highest number of professionals to remove the HPSA designation, included Texas, Florida, California, Arizona and Wisconsin.[10] These five states represented 36% of the total need for mental health providers in the U.S., but they only received 19.6% of all LRP awards and 20% of total funding for the nine designated mental health disciplines in the NHSC program between 2009 and 2016.[11] The total number of LRP program awardees by state or territory for the years from 2009 to 2016 is shown in Figure 5. These results identified a gap between the highest professional workforce shortage need areas and the distribution of awards to NHSC sites.

Figure 5. Total Loan Repayment Program Awardees by State or Territory, 2009 - 2016



Impact on Telehealth Modifier Codes

Telehealth is an opportunity to stretch the capacity of the existing healthcare workforce by increasing access to providers and care. The ACA encourages the use of telehealth by, in some cases, permitting the Centers for Medicare and Medicaid Services to pay for it and setting up innovation and demonstration projects. To investigate this hypothesized increase in the utilization of telehealth codes, the research team analyzed the use of specific Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) modifier codes from 2010 to 2015. Codes of interest can be seen in the Appendix.

Rates of usage in the codes of interest over time in the ten-state cohort did not yield any statistically significant increase (p=0.236). This could be due to several reasons: 1) data were only available through 2015, while the ACA was not fully realized until 2014. This may not be enough time to detect a discernable change in the data. 2) This analysis was restricted to ten states, and broadening the sample may yield different results.

DISCUSSION

Although the findings of this study provide insight on the trends and patterns of the ACA's impact on the behavioral health workforce, it is subject to research limitations. The researchers utilized data from secondary sources, were not able to verify the accuracy of this data, and were subject to the limitations of this data. For example, the NHSC data provided by HRSA does not differentiate between the initial year and subsequent years of LRP funding awards. Analyzing award information by year could inform policy

recommendations to lead to increased participation and retention in the NHSC program. Additionally, the researchers chose a sample of only ten states for the Medicaid eligibility expansion analysis, thus limiting the generalizability of these findings. The ten states included in the study could have unique characteristics that skewed applicability of findings widely. Furthermore, the findings of the Medicaid expansion analysis, though informative, were not significant owing to the variation in licensure among both groups, the Medicaid expansion states and the non-expansion states. This analysis could be improved upon by analyzing the number of active licenses against the number of Medicaid enrollees over time to determine if the behavioral health workforce can adequately meet the increased demand.

The results of this study identified trends related to the impact of the ACA on the behavioral health workforce. Specifically, researchers identified a slight positive correlation between increased behavioral health workforce capacity and Medicaid eligibility expansion over a 5-year period. Clinical psychologists and psychiatrists experienced the highest increases in per capita rates in states that expanded Medicaid eligibility whereas the per capita rate of clinical psychologists declined in non-expansion states. Furthermore, NHSC LRP funding was correlated to positive increases of mental health professionals serving in HPSAs. The most common types of mental health disciplines receiving LRP awards over the 8-year period were licensed clinical social workers and licensed professional counselors. The number of LRP awards for mental health disciplines varied by state and data revealed that the award distribution is not meeting the needs of the HPSAs with the greatest workforce shortages.

The study results show that the NHSC LRP is having a positive effect on behavioral health workforce capacity; however, there are actions that could improve the efficacy of the program. NHSC program participation is limited to certain types of mental health provider organizations and does not include substance use disorder treatment facilities as NHSC-eligible sites. It is estimated that the addiction services field will need more than 330,000 additional workers by 2020 to meet treatment demands.[8] Substance abuse treatment facilities largely provide the core behavioral health services as defined in the NHSC program (screening and assessment, treatment plans, and care coordination); however, NHSC specifically designates substance abuse treatment facilities as “specialty clinics” regardless of their ability to meet the HPSA and NHSC Behavioral Health Services Checklist criteria.

On June 28, 2017, the Strengthening the Addiction Treatment Workforce Act, a bipartisan-sponsored bill, was introduced in the Senate that would amend the Public Health Service Act to designate substance use disorder treatment facilities as eligible for NHSC participation.[9] Enacting this legislation could increase the number of behavioral health providers serving high-need areas, which is especially critical as the nation continues to face an opioid use and overdose epidemic.[11] States that are facing the highest incidence of opioid overdose deaths could benefit from increased NHSC LRP participation. For example, West Virginia had the highest rate of opioid overdose deaths in the nation in 2014[11] and received only 47 NHSC LRP awards for behavioral health disciplines between 2009 and 2016.

Similarly, the scope of NHSC participation is limited in the types of healthcare professionals that are eligible for LRP awards. Expanding award eligibility to include substance use treatment professionals (that are not otherwise eligible) could increase the number of professionals serving in high-need areas. The substance use disorder treatment field as a whole is challenged by a lack of standardized scopes of practice, roles and responsibilities, and defined provider types. One way to begin to address the shortage of addiction professionals would be the standardization of the licensed addiction counselor role across states for eventual inclusion as an NHSC LRP eligible provider.

Participation in the NHSC LRP varied by type of behavioral health provider, indicating a need to assess and evaluate recruitment strategies and retention patterns of provider disciplines. Licensed clinical social workers and licensed professional counselors had the highest participation rates and psychiatric nurse specialists, osteopathic physicians, and physician assistants had the lowest participation rates in the program. These data could indicate that the NHSC salaries offered for these professions are not competitive even when taking the loan repayment incentive into consideration. Additionally, as mentioned above, other recruitment and retention efforts should be evaluated and improved upon to increase participation of these disciplines.

In addition to expanding the types of facilities and professions that are eligible for NHSC participation, our findings demonstrated that the amount of annual funding NHSC receives is directly correlated to the number of awards for behavioral health professionals. Although

this finding was not unusual, it supports increased NHSC LRP funding and shows that the NHSC is effectively meeting its intended goal—to increase health professionals in HPSAs.

Though the application of the study's findings related to Medicaid expansion is limited, the correlation between expansion of Medicaid eligibility and per capita behavioral health workforce calls for further investigation and analysis. Medicaid is the single largest payer for behavioral health services in the U.S.[14]; therefore, understanding the impact Medicaid has on the behavioral health workforce is critical to improve access to and quality of care of behavioral health services. In addition to choosing to expand Medicaid eligibility, states are given considerable deference and flexibility in the establishment of Medicaid programs including the use of Section 1115 Medicaid waivers that allow states to test demonstrations or pilot projects waiving certain requirements of the Medicaid program as long as the overall goals of the demonstration meet the intention of Medicaid. As of November 2017, there were 22 states with approved or pending behavioral health Section 1115 waivers. These waivers provide states an opportunity to improve the behavioral health workforce through a variety of means. Several states are using funds for workforce development and training, and the state of New Hampshire is using performance-based incentive payments for providers who integrate behavioral health and physical healthcare services.[14] Section 1115 waivers are rigorously evaluated and provide an opportunity to further study the relationship between Medicaid and behavioral health workforce capacity.

CONCLUSIONS

The results of this study provide insights on the effects of the ACA on behavioral health workforce capacity and highlight areas of future research. Expansion of Medicaid eligibility among participating states has increased the number of per capita behavioral health providers more significantly than increases in states that did not expand Medicaid eligibility. Further examination of the relationship between Medicaid and behavioral health workforce is necessary given the important role Medicaid plays in financing behavioral health services. Furthermore, study findings suggest that the NHSC Loan Repayment Program is an effective incentive to increase rates of behavioral health providers in underserved and high-need areas. The effectiveness of this program could be enhanced with increased funding, improved behavioral health recruitment and retention strategies, and expanded participant eligibility for substance use disorder treatment facilities and providers.

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Appendix: Telehealth CPT and HCPCS Specific Codes

90791 GT	99210	99215 GT	99496	G0108
90832 GT	99211	99231	99497	G0109
90833 GT	99212	99232	99498	G0447
90834 GT	99213	99233	96116	G0436
90835 GT	99214	99307	G0436	G0437
90836 GT	99215	99308	G0437	99406
90837 GT	99201 GT	99309	G0459 GT	99407
90838 GT	99202 GT	99310	G0425	G0446
90845	99203 GT	99354	G0426	T1015
90846	99204 GT	99355	G0427	T1015 GT
90847	99205 GT	99356	G0406 GT	G0396
99201	99206 GT	99357	G0407 GT	G0397
99202	99207 GT	96150	G0408 GT	G0508
99203	99208 GT	96151	G0442 GT	G0509
99204	99209 GT	96152	G0443 GT	
99205	99210 GT	96153	G0444	
99206	99211 GT	96154	G0445	
99207	99212 GT	99406	G0446	
99208	99213 GT	99407	G0446	
99209	99214 GT	99495	G0459	