RESEARCH NOTE

Social Work Workforce Development and Medicaid Expansion: Mapping Areas of (Mis)alignment

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Enacted in 2010, the Patient Protection and Affordable Care Act (ACA) included several provisions to increase health insurance coverage for low- and moderate-income individuals (Mazurenko, Balio, Agarwal, Carroll, & Menachemi, 2018). A key mandate of the ACA required states to expand Medicaid eligibility for adults who lived at or below 138% of the federal poverty level (Medicaid and CHIP Payment and Access Commission [MACPAC], 2019). However, a 2012 U.S. Supreme Court ruling allowed states to opt out of Medicaid expansion. To date, 36 states and Washington, DC, have expanded Medicaid eligibility, whereas 14 states have not expanded. Currently, Medicaid serves as the nation's largest source of health coverage, providing care to about one in five Americans (Mazurenko et al., 2018), and recent estimates suggest that over 20 million Americans have gained health insurance access due to Medicaid expansion (MACPAC, 2019).

Despite efforts to dismantle the ACA (Kirzinger, DiJulio, Wu, & Brodie, 2017), Medicaid expansion continues to make advancements in meeting population health needs and more holistically addressing the health of individuals. In a systematic review comparing the effects of Medicaid expansion to the goals of the ACA, Mazurenko and colleagues (2018) found that Medicaid expansion was associated with increases in health care coverage, utilization, and quality. Medicaid expansion has increased access to primary care (Angier et al., 2015; Han, Luo, & Ku, 2017), as well as increased availability of behavioral health services, including treatment for both mental health and substance use disorders (SUD) (Han et al., 2017; McMorrow, Kenney, Long, & Goin, 2016). However, increasing the availability of health and behavioral health services requires an increase in providers. Several federal programs support training providers to meet the growing need of a trained health workforce. This column will evaluate whether one training program supporting MSW specialized training in integrated health care settings is aligned with state Medicaid expansion.

MEDICAID EXPANSION AND ACCESS TO BEHAVIORAL HEALTH SERVICES

The ACA prioritized the coverage of both physical and behavioral health services, highlighting to health systems the importance of providing comprehensive, "whole health" care. Medicaid expansion is associated with a reduction in unmet behavioral health needs (U.S. Department of Health and Human Services, 2016) and increased mental health services utilization (Han et al., 2017). McMorrow, Gates, Long, and Kenney (2017) found decreased rates of psychological distress among Medicaid patients. One way in which access to behavioral health services has grown is through the integration of physical and behavioral health services, commonly referred to simply as "integrated care" (Waddington & Egger, 2008). Integrated care clinics are typically housed in traditional outpatient primary care settings but incorporate screening and treatment of mental health and SUD by including behavioral providers on the interprofessional team. Evidence supports models of integrated primary care to expand screening and treatment of depression and other mental health diagnoses (Fraser et al., 2018). Integrated services have been further implemented, delivered, and financed with the increased adoption of patient-centered medical homes—a model of integrated care that prioritizes patient-centered,

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team-oriented, and coordinated care to treat the whole patient and their behavioral health needs (Hinton, Musumeci, Rudowitz, Antonisse, & Hall, 2019; Philip, Govier, & Pantely, 2019).

Improved access to medication-assisted treatment for people with opioid use disorder has also been attributed to Medicaid expansion (Mojtabai, Mauro, Wall, Barry, & Olfson, 2019). Changes by the Centers for Medicare and Medicaid Services approved pilot or demonstration projects called Section 1115 waivers to help increase access to SUD treatment. These waivers allowed approved states additional payment mechanisms for Medicaid recipients to seek SUD treatment in institutional settings with reformed financing mechanisms to pay for integrated services (Hinton et al., 2019). Increases in SUD treatment are due to both an expanded Medicaid client base and the integration of behavioral health and primary care services (Olfson, Wall, Barry, Mauro, & Mojtabai, 2018).

ACA to Grow the Health Workforce

The ACA has stimulated job growth and helped spur the creation of new types of jobs across the health sector (Spetz, Frogner, Lucia, & Jacobs, 2014). For example, "community health workers, patient navigators, health coaches, care coordinators, and more are attempting to create their own space in the health care delivery system as their contributions to the new payment and organizational models become more apparent" (Ricketts & Fraher, 2013, p. 1877). It is projected that, by 2022, the health care industry would need nearly 4 million additional workers to meet the care needs of the United States (Frogner, Spetz, Parente, & Oberlin, 2015). Most of this job growth is expected in outpatient settings (Frogner et al., 2015) and will likely include a more diverse workforce comprising increasingly younger, female, and racially and ethnically diverse personnel who are not U.S. born (Frogner et al., 2015). Although there is a significant need for more health providers, the availability of a qualified workforce to fill this need does not always align.

The behavioral health sector continues to be an area that faces extreme shortages for all types of behavioral health providers, including social workers (Health Resources and Services Administration [HRSA] & National Center for Health Workforce Analysis, 2016; Mace & Dormond, 2018). Shortages of behavioral health providers in rural areas is of particular concern. A recent study of the geographic variation of behavioral health providers reported that 65% of all nonmetropolitan counties had no psychiatrist and that 47% had no psychologist (Andrilla, Patterson, Garberson, Coulthard, & Larson, 2018). Workforce shortages of qualified behavioral health providers occur for a multitude of reasons, including lack of education and training gaps, high turnover, and burnout (Garner, Hunter, Modisette, Ihnes, & Godley, 2012; Knight, Becan, & Flynn, 2012; Substance Abuse and Mental Health Services Administration [SAMHSA], 2013).

The ACA and Social Work Workforce Development

The social work workforce warrants particular attention as one of the nation's largest group of behavioral health providers and given recent workforce expansion initiatives specific to the social work profession. Current estimates suggest that the health and behavioral health social work workforce will increase nearly 20% by 2024 (U.S. Bureau of Labor Statistics, 2017)—growth and change that has led to a renewed emphasis on the role of social workers as members of integrated health care teams (Fraser et al., 2018; Stanhope, Videka, Thorning, & McKay, 2015).

Compared with privately insured individuals, beneficiaries of Medicaid are more likely to have complex chronic health conditions that include physical comorbidities and psychosocial needs related to social determinants of health such as poverty and housing (Benjamin, 2010; Jackson, Trygstad, DeWalt, & DuBard, 2013; Kronick, Bella, & Gilmer, 2009; Ward & Schiller, 2013). Recent work has highlighted the success of integrated care teams that include social workers in addressing physical and behavioral health needs and targeting psychosocial factors that affect health without increasing costs (Fraser et al., 2018). Social workers' skills allow for a myriad of tasks and activities that contributed to integrated care teams, such as screening and assessment, brief behavioral intervention, and care management (Fraser et al., 2018; Zerden, Lombardi, Fraser, Jones, & Garcia Rico, 2018).

In an effort to develop a sizable and well-trained behavioral health workforce, in 2014 HRSA awarded over $26 million to 62 MSW programs to train MSW students to provide behavioral health services in integrated primary care settings (Kepley & Streeter, 2018). To date, this funding mechanism

known as the Behavioral Health Workforce Education and Training (BHWET) program has trained over 3,500 new social workers for integrated care (Kepley & Streeter, 2018). In 2017, the BHWET mechanism was reauthorized and funded integrated care training in 59 MSW programs across 33 states (HRSA, n.d.). The purpose of the BHWET program was to increase the behavioral health presence in integrated settings across the life course, with the broad focus of serving underserved and vulnerable communities.

Expanding Medicaid requires a larger and, in particular, a well-trained workforce to provide integrated care that focuses on behavioral health services. However, the extent of state-level coordination of workforce planning needs and Medicaid expansion has not been extensively examined. In this study, researchers evaluated whether and where Medicaid expansion has aligned with social work workforce training initiatives to build the capacity of the social work behavioral health workforce. This column compared social work workforce development with Medicaid expansion status at the state level to identify areas in need of, and prepared for, the expanded social work behavioral health workforce produced by the 2017 BHWET HRSA-funded mechanism.

METHOD

Data

Two sources of data were used for our analyses. First, we determined which states expanded Medicaid as of May 4, 2019, based on data from the Henry J. Kaiser Family Foundation (KFF) Web site (KFF, 2019). Next, we collected a list of 2017 BHWET grantees that included social work as of April 12, 2019, from HRSA's data warehouse (HRSA, n.d.). This data included the number of BHWET-funded programs in each state.

Analysis

To visualize the geographic distributions of states that have adopted Medicaid expansion and states that received HRSA BHWET funding to expand the behavioral health workforce, we mapped these state-level data and included the number of funded programs in the state, where applicable. We created this map with the data-mapping software Tableau. In addition, we conducted cross-tabulation analysis to examine the areas of overlap, disparity in coverage, and growing workforce demands by state and region.

RESULTS

Twenty-five states (49.0%) had both BHWET funding and Medicaid expansion, whereas six states (11.8%) had neither (see Table 1). In addition, 12 states (23.5%) had no HRSA-funded BHWET MSW programs but have adopted Medicaid expansion; eight states (15.7%) received HRSA-funded BHWET grants but did not expand Medicaid. Thirty-three states received at least one BHWET-funded grant to expand the future behavioral health social work workforce, compared with 18 states that had no BHWET social work funded programs (see Table 1). Figure 1 displays a map of the United States and shows how some states received multiple BHWET grants through various social work programs and schools. These findings highlight the uneven distribution of social work behavioral health workforce training in the United States. However, workforce expansion efforts are not necessarily aligned with states' Medicaid expansion status.

For example, despite being the state with the highest number of BHWET awards granted to social work programs—five grants across the state—North Carolina did not adopt Medicaid expansion. Likewise, Texas, Illinois, Pennsylvania, and New York each received four BHWET grants. However, of these, Texas has not adopted Medicaid expansion, whereas Illinois, Pennsylvania, and New York have. Regionally, southern and midwestern states are the least likely to have adopted Medicaid expansion, and the least likely to have received HRSA-funded BHWET grants specific to social work. There is a swath in the western United States that includes Idaho, Nevada, Utah, and Arizona as states that expanded Medicaid but had no BHWET training grants. Furthermore, western and northeastern states show a higher congruence between the prevalence of BHWET workforce development grants and the expansion of Medicaid coverage (see Figure 1).

DISCUSSION

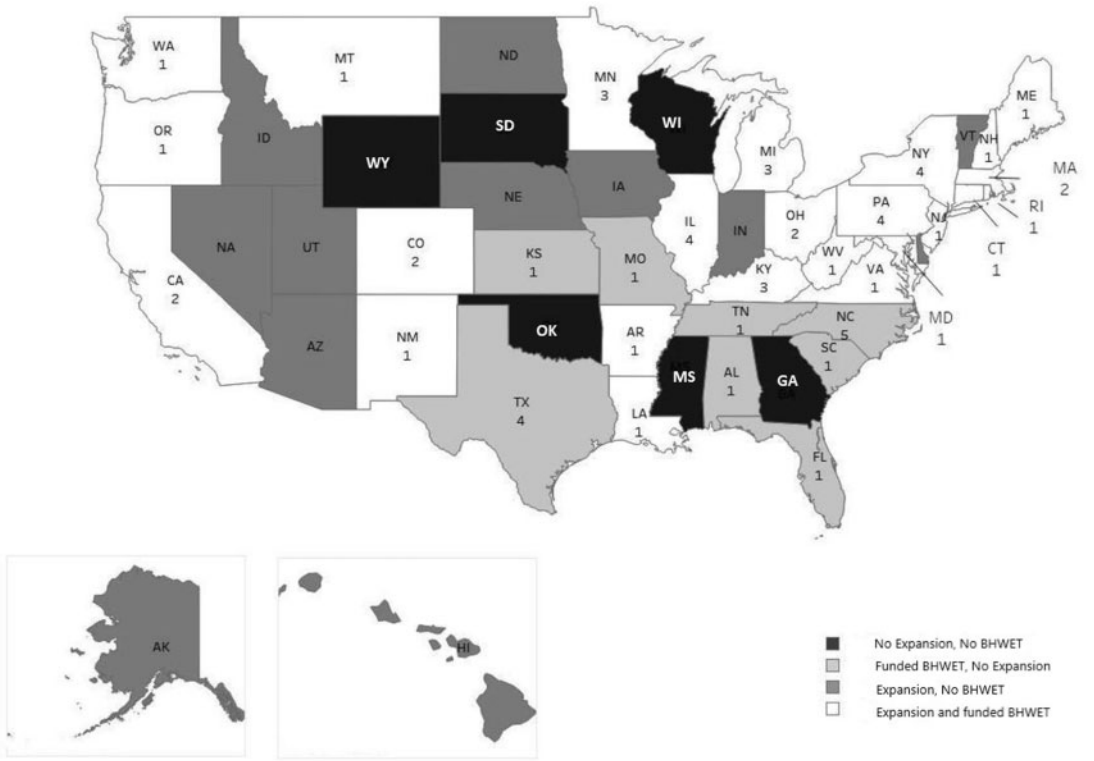
This study found substantial discrepancies in social work workforce development and training, and states' expansion of Medicaid, which would include increased access to behavioral health services. Findings offer a macro view to assess which states expanded Medicaid but did not obtain BHWET funding to expand the social work behavioral health workforce. Conversely, several states that

Table 1: Cross-Tabulation of State Medicaid Expansion Status and BHWET Funding

	BHWET Grants	No BHWET Grants	Total
Medicaid expansion	($n = 25$; 49.0%) AR, CA, CO, CT, DC, IL, KY, LA, ME, MD, MA, MI, MN, MT, NH, NJ, NM, NY, OH, OR, PA, RI, VA, WA, WV	($n = 12$; 23.5%) AK, AZ, DE, HI, ID, IN, IA, NE, NA, ND, UT, VT	$n = 37$ (72.5%)
No Medicaid expansion	($n = 8$; 15.7%) AL, FL, KS, MO, NC, SC, TN, TX	($n = 6$; 11.8%) GA, MS, OK, SD, WI, WY	$n = 14$ (27.5%)
Total	$n = 33$ (64.7%)	$n = 18$ (35.3%)	$N = 51$ (100%)

Note: BHWET = Behavioral Health Workforce Education and Training.

Figure 1: Comparing State Medicaid Expansion and Number of Funded BHWET Social Work Programs (2017)



Note: BHWET = Behavioral Health Workforce Education and Training.

received BHWET funding did not expand Medicaid. In the former case, this may lead to states with an insufficient number of social workers prepared to serve a larger population of recipients receiving Medicaid as integrated services expand. In the latter case, this may lead to states with a surplus social work workforce without as many job opportunities to practice their behavioral health and integrated care skills. Aligning federal workforce training with state-level Medicaid expansion policies is essential

for providing appropriate care to clients by optimally distributing trained social workers across the United States.

Although an evaluation of all BHWET-funded social work programs is not available, there are preliminary findings from specific programs that help us understand how the HRSA-funded workforce training grants may be affecting states' workforce deployment postgraduation. As an example, West Virginia adopted and implemented Medicaid expansion in 2014, and West Virginia University's School of Social Work received the state's only BHWET funding in 2014 and again in 2017. Upon graduation, Rishel and Hartnett (2019) reported impressive employment outcomes for their 2016 BHWET trainees one-year postgraduation ($n = 19$). Of the graduates they were able to track, 18 were employed in behavioral health services in medical and integrated settings and 84% were currently employed in West Virginia; three had obtained work in other states (Rishel & Hartnett, 2019).

Another example is from Massachusetts, a state that adopted Medicaid expansion in 2014. Under the HRSA-funded BHWET training program, Simmons College has collaborated with community stakeholders such as the Massachusetts' Department of Mental Health, Department of Public Health, and Community Health Center to identify field placement and employment opportunities in local integrated settings (Putney et al., 2017). Although specific numbers were not reported, these findings demonstrate how the BHWET training has forged collaborative relationships with state agencies delivering individual and population health within the state.

North Carolina serves as a different example in that it was the state with the highest number of BHWET grants for social work workforce development (five social work programs funded across the state). Although competency and skills have been demonstrated among this specialized training program (Zerden, Jones, Day, & Lombardi, in press), it remains unknown how the hundreds of BHWET MSW graduates in North Carolina have fared in terms of employment opportunities within the state overall. North Carolina remains an interesting state to see how social work behavioral health workforce training initiatives will affect integrated service delivery, given that it has been fierce in its opposition to adopted Medicaid expansion. However, through the North Carolina Department of Health and Human Services, North Carolina is trying to move forward with innovative statewide transformation efforts that may allow for creative and innovative ways to bridge social work and health care delivery (Lohr, 2019).

Given that the national and state-level health landscape remains in flux, it will be critically important to pay attention to how workforce training initiatives, such as BHWET, align with the delivery of integrated health services within each state and throughout the United States, overall. As Kepley and Streeter (2018) noted, "Shortages and maldistribution of behavioral health providers further complicate the behavioral health landscape by constraining access to essential care and treatment for millions of individuals with mental illness or substance use disorders" (p. S190). Although the BHWET program has bolstered the behavioral health workforce, there is still a significant workforce shortage of trained social workers in integrated care. For example, only 34% of primary care physicians are physically colocated with social workers (Lombardi, Zerden, & Richman, 2019). Although the ACA increased health care coverage, health care reforms were made without mandating state-level policies to expand services or develop a sufficiently large social work workforce to implement services.

Overall, there appears to be substantial misalignment of the social work behavioral health workforce and the expansion of Medicaid services in the middle and southeastern United States. The ACA's purposes include increasing the accessibility of services, enhancing quality of care, and lowering the cost of care (Andrews, Darnell, McBride, & Gehlert, 2013; Bachman, 2011). However, unmet behavioral health needs have long-term effects on life course outcomes and collective public expenditures for housing, education, employment, disability, income support, criminal justice, and other social welfare services (SAMHSA, 2014). Without Medicaid expansion and a sufficiently trained social work workforce, behavioral health needs will continue to be unmet.

Limitations

Though this study reveals the misalignment of BHWET-funded initiatives and Medicaid expansion in many states, these findings should be considered within their limitations. Other types of behavioral health professions may be expanding

but are not addressed in our analysis, which focuses on social work BHWET grantees alone. This study did not account for Medicaid patient population rates per state, as our objective was to determine the extent to which social work workforce growth initiatives and Medicaid expansion status align state-by-state. Although states that received BHWET funding are discussed, the analysis did not take into account grants for funding that were submitted and not funded. In addition, this study did not examine other factors that could affect workforce development such as state-level economic factors or population density distributions.

CONCLUSION

Further research is needed to evaluate social work BHWET programs' impact on workforce numbers, service delivery, and employment trends within each state. Given that BHWET funding focused on MSW students and not on professionals already working in the field, efforts to retool the existing workforce to work within integrated models of care will be necessary to meet the increased demand for behavioral health and psychosocial services by Medicaid recipients. Additional research is also needed to assess how individual- and population-level outcomes are affected by social work services, as well as how behavioral health treatment is used and reimbursed in states that have and have not expanded Medicaid coverage. Paying attention to the social work workforce and aligning workforce training initiatives with service delivery goals will help ensure that behavioral health needs can be met and that increased service demands will be addressed by a sufficiently large and well-trained workforce. Although the fate of the ACA remains unknown, the deleterious consequences of untreated behavioral health needs are not. SWR

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