STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

SEAN PARNELL, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

January 31, 2011

Briefing: Consideration for Adding Licensed Marriage and Family Therapists As Eligible Medicaid Providers

Introduction

The Department of Health & Social Services is providing this brief in response to an inquiry received asking for the inclusion of Licensed Marriage and Family Therapists as providers eligible to render and bill for Medicaid funded services as independent practitioners.

Background

Currently, the **independent licensed** practitioners eligible by Statute to provide behavioral health services and directly bill Medicaid are:

- Physicians and advanced nurse practitioners - current regulations mandate that all services must be provided directly by the licensed professional
- PhD psychologists - services limited to testing and assessment services based on appropriate referrals
- Licensed clinical social workers (LCSW) - although included in Statute since 1991, funding has never been authorized; currently not a State Plan service.

Clinic providers approved to provide behavioral health services and bill Medicaid for are:

- Community mental health centers (CMHC) - must be approved grantees of the Division of Behavioral Health
- Physician mental health clinics - require the supervision of an on-site psychiatrist
- Rural health clinics and federally qualified health centers (FQHC) - allowed to bill for services provided by the federally mandated professionals: physicians, nurse practitioners, physician assistants, PhD psychologists, and LCSW's.
- Designated tribal outpatient clinics - limited to services provided directly by physicians, nurse practitioners and physician assistants.

Within the clinic categories listed above, Licensed Marriage and Family therapists are allowed to provide Medicaid services only in Community Mental Health Clinics or Physician Mental Health Clinics.

Issues

For years, the department has received requests to expand the scope of behavioral health services from individual practitioners, professional organizations and advocacy groups. These requests and the related issues below should be considered in this program expansion discussion:

1. Cost. Initial service cost projections and numbers of people served are included below.

2. Medicaid State Plan. Changes to the Medicaid program require submission of an Amendment to the State Plan for consideration and approval by CMS.

3. Program Coverage. When a new eligible provider group is added, regulations must be developed which outline scope of services, service definitions and documentation requirements, place of service requirements, service limits, service authorization requirements and rates.

4. Access to care. Addition of new or revised Medicaid benefits improves access to care for beneficiaries who have more options for care or more available service providers.

5. Medical Necessity. Coverage and services descriptions must support "medical necessity". The practice of marital and family therapy is defined as: "the diagnosis and treatment of mental and emotional disorders that are referenced in the standard diagnostic nomenclature for marital and family therapy, whether cognitive, affective, or behavioral, within the context of human relationships, particularly marital and family systems"[1]. Very often, the diagnostic codes referenced are the V-Codes[2] which describe factors influencing health status and are generally not approved diagnoses for Medicaid coverage. If the State were to revise the "medical necessity" definition to account for the scope of practice of LMFT's all other qualified behavioral health providers would also be eligible to similarly expand services. This would allow for the provision of services to recipients who do not currently qualify for services.

6. Medicaid Management Information System (MMIS). The MMIS must be redesigned.

7. Rates. The development of a rate methodology including a concurrent rate review is required.

8. Service Authorization/Service limits. If program coverage guidelines include service limits or the need for service authorization, the department must develop the clinical guidelines for use in approving services.

9. Staff. Whenever a program expansion or redesign occurs the State must assign staff to oversee the program design, development, and implementation, and to maintain on-going operations.

10. Workforce. One possible effect of adding a new provider group is the potential migration of employees from grant funded non-profit agencies to the private sector

---

[1] AS 08.63.900(5)
[2] Diagnostic and Statistical Manual of Mental Disorders, 4th Ed., Text Revision; Relational Problems (pg.736 – 743)

11. Eligible providers. A primary concern regarding the addition of a new provider type is the consequent inclusion of other licensed providers. As noted above, LCSW's have not been included as providers though they have requested coverage. Likewise psychologists have requested to expand the type of services they may provide. Independent physicians have requested the ability to bill for services provided under their direction by psychologists, LCSW's, LMFT's and licensed professional counselors (LPC). FQHC's have also requested the ability to add both LMFT's and LPC's as eligible practitioners. In general, approving one or more new licensed professional groups would in all likelihood stimulate other licensed professional groups to question why they were not considered.

12. Impacts to other initiatives. Any modifications to the State Medicaid Plan will affect and be affected by system related projects

13. Transportation/telemedicine. Changes in program coverage always have some impact on Medicaid transportation costs. Because savings in the transportation budget historically have not offset costs associated with new programs, transportation has generally not been used as a primary factor in support of new services. Medicaid coverage (with few exceptions) allows practitioner services to be provided via telemedicine. The department continues to support the use of telemedicine as an alternative to transportation whenever possible.

Impact and Cost Analysis

- DBH has established a prevalence rate of 25% of the population that has a need for a behavioral health service under the current "medical necessity" definition.
- In FY 10 approximately 120,000 individuals were eligible for Medicaid and approximately 23,000 Medicaid recipients received at least one behavioral health service.
- Based on the prevalence rate, about 30,000 Medicaid clients are actually in need of behavioral health services which indicates approximately 7,000 recipients have an unmet need.
- **If all licensed LMFT's (93) enrolled and increased their case load to serve 50 clients per year, they would serve 4,650 clients. At a rate of $1000 per recipient the increase in program costs would be $4,650,000.**

Conclusion

Based on the complicating factors listed and budget impact the department is not proposing the addition of LMFT's at this time.