

# Strategies for enhancing behavioral health workforce development

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Engrossed Substitute Senate Bill 6168; Section 215(57); Chapter 357; Laws of 2020

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## Executive summary

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Washington State is a leader in providing innovative medical and behavioral health treatment, investing millions of dollars annually at all levels of care. This includes inpatient psychiatric care, hospital diversion programs, peer services, crisis stabilization, housing supports, substance use disorder, outpatient and residential care, and many other evidence-based practices that promote recovery for persons experiencing substance use disorder and mental illness.

Even with legislation that promotes these innovations and investments, workforce shortages continue to be an issue for behavioral health providers in Washington State.

This report is provided to inform legislators of the activities related to ESSB 6168 Section 215(57), which appropriated funds for the Washington State Health Care Authority (HCA) to work with the actuaries responsible for establishing behavioral health capitation rates and specified stakeholders to identify strategies that enhance reimbursement to promote workforce development.

To complete this work, HCA contracted with Mercer Government Human Services to assist in developing strategies to address behavioral health provider reimbursement. To inform the report, stakeholder input was solicited via two meetings, as well as written feedback. The report provided by Mercer detailed actuarial assumptions related to clinical supervision within behavioral health capitation rates, a scan of how other states have addressed similar issues and provided three potential approaches for Washington State. The draft report was provided to a broad group of stakeholders at meetings held on October 27, 2020, and November 18, 2020. Utilizing feedback from stakeholders and HCA staff, Mercer finalized the report, which is provided in the appendix of this report.

## Background

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Amidst the COVID-19 pandemic, Washington continues efforts to integrate physical and behavioral health, while responding to the opioid epidemic and continually finding that the need for behavioral health services is increasing faster than the supply of behavioral health workers. This is not to say that workforce shortages are new. Even before Washington started down the path toward integrated managed care, workforce shortages across behavioral health occupations existed. This gap is widening, and although there are many efforts to narrow or close these gaps, effective solutions are difficult to find and even more difficult to achieve. Reasons for this include, but are not limited to, transitions across the behavioral health system, relatively low salaries for Bachelor and Master level education, Medicaid reimbursement, lack of provider familiarity with Managed Care Organization (MCO) contracting practices, college and university capacity and costs, and regulatory barriers and inconsistencies. Additionally, the contracting methodologies MCOs utilize for Medicaid services vary by region and provider type.

Without addressing the issues outlined above, workforce shortages are likely to persist and increase as the need for services grow. However, growing the workforce may not be easy. There is no simple fix to this issue. According to MCO and provider feedback, workforce development activities are rarely tracked or measured. Although increasing Medicaid rates may be necessary for growing the behavioral health workforce, it is only one of a number of actions that should be considered. Other actions to consider include:

- Provide training on billing and contracting specifics for MCOs and providers;
- Remove language in RCW 18.19.020 (2) that requires Agency Affiliated Counselors to be employed. This change would allow providers to bill Medicaid while ensuring Department of Health oversight of Agency Affiliated Counselors;
- Include language in HCA, MCO, and provider contracts around workforce tracking and reporting;
- Provide technical assistance on whole person integrated care, team-based care, and evidence based programming;
- Promote behavioral health careers to school age youth;
- Increase loan forgiveness and tuition assistance programs for an array of behavioral health professions;
- Invest in alternative training programs such as apprenticeships or training programs; and
- Provide behavioral health providers assistance in contracting with MCOs.

It should be recognized that other legislation has been enacted to assist in shoring up the system. [HB 1109 Section 215\(23\)](#), provided approximately \$69,000,000 in funding to assist community-based behavioral health services.

Accountable Communities of Health are required to invest financial resources in workforce efforts.

These financial and technical assistance resources and their impact should be considered as part of a comprehensive solution to workforce shortages.

## Definitions

**Agency affiliated counselor** means a person registered under chapter 18.19 Revised Code of Washington (RCW, and WAC 246-810-010 <https://app.leg.wa.gov/wac/default.aspx?cite=246-810-010>) who is engaged in counseling and employed by an agency listed in WAC 246-810-016 or an agency recognized under WAC 246-810-017 to provide a specific counseling service or services.

**Intern\*** means a student of an educational training institution required to complete supervised hours to complete certification.

**Trainee\*** is a post-graduate seeking licensure.

**Counselor** means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee. A “counselor” engaging in the practice of counseling can include an agency affiliated counselor, certified counselor, or certified adviser. Specific qualifications and licensing/certification requirements are described in chapter 18.19 RCW and chapter 246-810 WAC.

**Mental health care provider** means the individual with primary responsibility for implementing an individualized plan for mental health rehabilitation services. Minimum qualifications are B.A. level in a related field, or A.A. level with two years of experience in the mental health or related fields.

**Substance use disorder professional** means an individual certified in substance use disorder counseling under 18.205 RCW <https://app.leg.wa.gov/rcw/default.aspx?cite=18.205&full=true> and chapter 246-811 WAC <https://apps.leg.wa.gov/wac/default.aspx?cite=246.811>.

**Substance use disorder trainee** means an individual holding a credential as a substance use disorder professional trainee and working toward the education and experience requirements for certification as a substance use disorder professional under chapter 18.205 RCW and chapter 246-811 WAC.

\*These definitions were agreed upon during stakeholder meetings in order to distinguish between interns and trainees across behavioral health professions.

## Proviso 57

\$50,000 of the general fund—state appropriation for fiscal year 2021 and \$50,000 of the general fund—federal appropriation are provided solely for the authority to work with the actuaries responsible for establishing behavioral health capitation rates, the University of Washington behavioral health institute, managed care organizations, and community mental health and substance use disorder providers to develop strategies for enhancing behavioral health provider reimbursement to promote behavioral health workforce development efforts. The authority must submit a report to the office of financial management and the appropriate committees of the legislature by December 1, 2020, that identifies:

- (a) A description of the actuarial assumptions related to clinical supervision included in the development of calendar year 2020 managed care behavioral health capitation rates and the relative dollar value of these assumptions;
- (b) available information on whether and to what extent managed care organizations are accounting for clinical supervision in establishing behavioral health provider reimbursement methodologies and rates;
- (c) identification of provider reimbursement models through managed care organizations that effectively incentivize the expansion of internships and entry level opportunities for clinicians; and
- (d) recommendations for accountability mechanisms to demonstrate that amounts included in behavioral health capitation rates for clinical supervision are passed on to mental health and substance abuse agencies that provide internships and entry level opportunities for clinicians.

## MCO interviews

Mercer asked three questions of MCOs to gain a better understanding of the extent to which they reimburse and track workforce development efforts. The following is a summary of responses.

1. Does the MCO reimburse community-based behavioral health providers more or less than the unit costs built into the capitation rates?

**Response:** Agreements are negotiated with providers and vary by region. In general, negotiated rates (capitated and fee for service) follow historic arrangements established under Behavioral Health Agencies. One MCO stated that their Medical Loss Ratio exceeds 100 percent for behavioral health services.

2. Does the MCO track which community-based behavioral health providers participate in workforce development initiatives?

**Response:** MCOs stated they do not track workforce initiatives except for MCO sponsored training, or if it is required by contract with HCA, as in the case of HB 1109 Section 215(23). One MCO stated that some Accountable Communities of Health sponsor workforce development activities.

3. Do community-based providers receive additional reimbursement for providing workforce development including supervision of interns or licensure-seeking professionals?

**Response:** Workforce costs are built into rate structures (shadow pricing). We do not reimburse for workforce development beyond what is already built into the rates.



## Conclusion

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After meeting with stakeholders and reviewing the report prepared by Mercer, there are still some next steps that should be considered.

1. There is confusion around potentially conflicting language within RCW 18.19 (Sections 18.19.020(2), 18.19.030, and 18.19.040(2)). The requirement that an agency affiliated counselor must be an “employee” of the agency results in the inability to bill for services provided by those who are providing an internship and are not employed by the agency.
2. Bachelor’s level employees provide a great deal of the case management services in a community behavioral health center. Factors related to the requirement for supervision of these employees may be undervalued, which should be considered.
3. Some programs use interns for many of their services, such as WISe, which must be considered as we address the issues facing agencies. Suggestions include a funding mechanism and a “ramp up” period to ensure interns are trained and able to provide services.
4. Alternative pathways into behavioral health occupations, such as “registered apprenticeship,” a method used in the trades, could expand and diversify the workforce.
5. There is recognition that keeping licensed staff can be difficult. Once an agency invests the time and effort into an employee, it would be beneficial if there was additional monetary compensation allowed for retention purposes. This is difficult to achieve in most community behavioral health centers.
6. There is a significant need for dually licensed providers, having both mental health and substance use disorder expertise. It may be beneficial to provide additional compensation to individuals who maintain such status.
7. There is general agreement among stakeholders that there is substantial unmet need for behavioral health services, and that workforce shortages contribute to this unmet need.

It is difficult to predict the increase in utilization and quality of care that would result from these suggestions, although the workgroup is in favor of the removal of any language that confuses or restricts the availability of services. NAMI (2) reports that 1,139,000 adults have a mental health condition. In Washington State, 2,838,922 people live in a mental health professional shortage area. One out of eight emergency department visits involves a behavioral health condition. The sooner we resolve these challenges, the healthier our state will be.

- (1) [businessinsider.com/the-lowest-paying-jobs-that-require-a-masters-degree-2016-10#2-mental-health-counselors-12](https://www.businessinsider.com/the-lowest-paying-jobs-that-require-a-masters-degree-2016-10#2-mental-health-counselors-12)
- (2) [Nami.org](https://www.nami.org)

# Appendix A: Mercer actuarial report

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# Proviso 57 — Behavioral Health Workforce Report

**Washington State Health Care Authority**  
December 7, 2020

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# 1

## Introduction

The State of Washington (State or Washington) Health Care Authority (HCA) contracted with Mercer Government Human Services Consulting (Mercer) to assist with responding to Proviso 57 by developing strategies for enhancing Behavioral Health (BH) provider reimbursement to promote BH workforce development efforts. Based on discussions with HCA, Mercer focused on the following:

- Review historic cost models used to develop BH capitation rates to identify key assumptions related to non-billable clinical supervision activities.
- Identify provider reimbursement strategies around clinical supervision that incentivizes provider expansion in coordination with HCA.
- Assist HCA in developing questions to collect information from the Managed Care Organizations (MCOs) regarding Behavioral Health Administrative Service Organizations (BH-ASOs) and provider contracting approaches. While MCOs have autonomy in establishing provider contracts, HCA is aware that some MCOs have leveraged Mercer data books and other projections in establishing BH subcontracts.

## Terminology

For purposes of this report, “intern” refers to any degree-seeking student and “trainee” refers to a post-graduate individual seeking licensure, including associates. An associate is a pre-licensure candidate with a graduate degree in a mental health field ([RCW 18.225.090](#)) gaining the professional experience necessary to become a licensed independent clinical social worker, licensed advanced social worker, licensed mental health counselor or licensed marriage and family therapist.

## Background

Internships are an increasingly important career pathway for degree-seeking students (interns) and license-seeking professionals (trainees) to gain experience necessary for their career goals and for non-profit community-based providers to connect with high quality talent in a competitive labor market. This crucial workforce development allows interns and trainees to explore alternatives to large medical system networks or to reenter the workforce in community-based settings.

Billing for services provided by practitioners not employed by or contracted with agencies is not explicitly prohibited or permitted by Medicaid under federal guidance from Centers for Medicare & Medicaid Services (CMS). This federal policy is important because in Medicare, billing for services provided by practitioners that are not a cost to an entity is prohibited. Many state Medicaid programs rely on Medicare billing guidance and also do not permit practitioners that are not a cost to an entity to bill Medicaid. Because providers often bill both Medicare and Medicaid programs, Medicaid agencies must ensure that the cost of interns/trainees for Medicare beneficiaries is not paid by Medicaid.

Washington statute and regulations offer conflicting guidance regarding intern/trainee services to be billed under Medicaid.<sup>1</sup> State statute creates an exception for students and trainees to provide counseling, but regulations require employment arrangements. HCA has clarified that interns/trainees may bill under Medicaid. Because of the confusion regarding HCA policy, it has been difficult for internship sites such as community-based providers to establish a quality training program and support the costs of running such a program.

Clarifying how and in what circumstances Medicaid reimbursement for intern supervision or even permitting an intern to generate a billable encounter could stabilize community-based programs and consistently defray the costs of these training programs by covering additional costs experienced by the entity or by making an intern's work clearly reimbursable under Medicaid. Either of these approaches could alleviate workforce shortages and recruitment issues because surveys have determined that, regarding internships and postdoctoral fellowship locations, individuals tend to end up practicing where they intern/train.<sup>2</sup>

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<sup>1</sup> Chapter 18.19 RCW. This statute does not prohibit or restrict the practice of counseling by an employee or trainee of any federal agency, or the practice of counseling by a student of a college or university, if the employee, trainee or student is practicing solely under the supervision of and accountable to the agency, college or university, through which he or she performs such functions as part of his or her position for no additional fee other than ordinary compensation.

Chapter 246-810 WAC. Applicants for agency affiliated counselors must be employed by, or have an offer of employment from an agency or facility that is licensed, operated, certified by Washington, or a federally recognized Indian tribe located within the State or a county. Counselor means an individual, practitioner, therapist or analyst who engages in the practice of counseling to the public for a fee, including for the purposes of this chapter, hypnotherapists.

<sup>2</sup> Caroline Bergner, *Medicaid Reimbursement for Doctoral Psychology Interns: Practice and Education Collaboration*, American Psychological Association Practice Organization, February 29, 2016.  
<https://www.apaservices.org/practice/advocacy/state/leadership/medicaid.pdf>

## 2

### Actuarial Assumptions Related to Clinical Supervision

In this section, Mercer will review historic cost models used to develop BH capitation rates to identify key assumptions related to non-billable clinical supervision activities as required under the Proviso. We have also included questions for HCA to collect information from MCOs regarding BH-ASOs and provider contracting approaches.

#### Relationship between Managed Care Capitation Rates and Provider Fees

In a managed care environment, the MCO receives a fixed prepaid premium (capitation rate) to provide the contracted health services needed by plan members. The MCO contracts with the providers to negotiate fees for providing contracted services to the MCOs' members. While contracting strategies may vary, the negotiated fees are intended to fully cover the providers' costs, including any costs of supervising unlicensed staff and interns.<sup>3</sup>

Unfortunately, while more sophisticated or large providers may be able to negotiate more advantageous rates, smaller, non-profit or less sophisticated providers may not have the negotiating power to contract for robust fees that would cover these workforce development costs. While higher or increased negotiated fees may acknowledge the cost of supervising, some providers may attribute those revenues to other areas. Providers may be more incentivized to dedicate practitioner time to billable activities instead of areas that cannot be encountered.

#### Consideration for Supervision in the Behavioral Health Capitation Rates

Historically, Mercer has developed capitation rates for Behavioral Health Organizations (BHOs) using BH encounter data from provider organizations and submitted records through the State's Medicaid Management Information System. These records include information on rendering provider, service dates, services provided and units delivered. We note that, as regions have transitioned to Integrated Managed Care (IMC), MCOs have had the flexibility to utilize contracting approaches that have included subcontracts to prior BHO managing entities.

Community outpatient services may be covered under subcapitation or other non-traditional payment arrangements; however, these records have not historically included any cost or expenses associated with the service. As such, for managed care capitation rates, Mercer and the State have developed a 'shadow

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<sup>3</sup> James Hutchison, *Medicaid Managed Care Organizations and Providers Caught in Crossfire as States Cut Medicaid Budgets*, [https://katten.com/files/20943\\_Hutchison\\_AHLA\\_MedicaidMCOs.pdf](https://katten.com/files/20943_Hutchison_AHLA_MedicaidMCOs.pdf). MCOs may contract to pay their network providers for Medicaid covered services based on rates for services provided, using a percentage of billed charges or Medicaid fee tables or as a subcapitated arrangement. The MCO's profit is based on the difference between the aggregate payment received from Medicaid and the total amount paid to providers. The MCO's profit may rely on their ability to negotiate rates with their Medicaid providers, many of whom also participate in the MCO's private-pay programs.



pricing' approach consistent with a traditional fee schedule development methodology as part of the capitation rate development process. The process ensures efficient State purchasing of services in a Medicaid managed care environment and may not be applicable for other purposes.

The general components of the pricing approach are identified below:

- Staffing assumptions and staff wages
- Employee Related Expenses — benefits, employer taxes (e.g., Federal Insurance Contributions Act, unemployment and workers' compensation)
- Provider overhead expenses
- Productivity assumptions (billable versus non-billable time)

The productivity assumptions reflect a percentage of full time equivalent staff hours (2,080 hours per year), which translates into direct billable hours for each BH service modality. Mercer has historically modeled the productivity of staff separately by service modality to consider the differences in service delivery between office-based services and community-based services as well as the nature of each service as it relates to productive time.

Many of the service definitions indicate that services can be provided under the supervision of a BH professional, which is defined as at least master's level in the State Plan. To account for time spent by staff supervising or being supervised, Mercer has historically considered adjustments for non-billable time spent supervising and being supervised. The following assumptions were used:

- Five hours per week of supervision time for Master of Art (MA)/PhD staff.
- Two hours of time per week being supervised or supervising for psychiatrist and physician assistants.
- One hour of time per week being supervised or supervising for other staff.

For additional information pertaining to all assumptions, please refer to the Mercer Data Book issued in July 2018.

## **Do Provider Fees Reimbursed by MCOs Include Clinical Supervision?**

Regions in the State have been transitioning from the BHO care delivery system to IMC with MCOs, with the final regions completing their transition in 2020. Due to limited experience, MCOs have been known to rely on existing BHO reimbursement structures to determine provider reimbursement. Though, assumptions included in the capitation rate calculations may not directly correlate to provider reimbursement. In the absence of a managed care directed payment, MCOs have the flexibility to establish provider contracts in a way that meet access to care requirements. In order to understand the relationship between the reimbursement included in the capitation rates and the provider fees, HCA would need to answer the following questions from MCOs:

- Does the MCO generally reimburse community-based BH providers more or less than the unit costs built into the capitation rates?

- Does the MCO track which community-based BH providers participate in workforce development initiatives?
- Do community-based BH providers receive additional reimbursement for providing workforce development including supervising interns or licensure-seeking professionals?

# 3

## Potential Provider Reimbursement Strategies

In this section, Mercer has identified provider reimbursement strategies around clinical supervision that incentivizes provider expansion in coordination with HCA.

### Current Limitations

#### Employment Limitations

During the course of the project, HCA staff asked Mercer to focus on community-based providers' workforce development and their ability to receive reimbursement from MCOs to cover the costs of supervision for degree-seeking interns and professionals seeking licensure (trainees).

As noted in the introduction of this report, conflicting statutes and regulations have resulted in confusion among State staff and providers regarding whether or not providers may bill for intern and trainee services. State statute permits an exception allowing students and trainees to practice counseling, but State regulations limit provider to billing for only employed Agency Affiliated Counselors.<sup>4</sup>

Some provider agencies have received guidance from State licensure agencies, for example, that they may only bill for employed Agency Affiliated Counselors on approved agency affiliated lists. This guidance is correct for fee-for-service (FFS) delivery systems but there has been different informal guidance for managed care. In FFS, as defined in Washington Administrative Code (WAC) 246-810-016<sup>5</sup>, there are a number of agencies, facilities or counties that can employ Agency Affiliated Counselors including colleges, hospitals, counties and other healthcare agencies.

Under those FFS regulations, Agency Affiliated Counselors are required to register with the State consistent with Chapter 18.19 RCW<sup>6</sup> and Chapter 246-810 WAC<sup>7</sup>. Applicants for Agency Affiliated Counselors must be employed by or have an offer of employment from an agency or facility that is licensed, operated, certified by the State, or a federally recognized Indian tribe located within the State or a county. The counselor must have their employer complete and sign the Agency Affiliated Counselor Employment Verification Form<sup>8</sup> provided by the Department of Health. Washington staff utilize form 670-114 to verify that counselors are employed by agencies.

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<sup>4</sup> Chapter 18.19.040 RCW. This statute does not prohibit or restrict the practice of counseling by an employee or trainee of any federal agency, or the practice of counseling by a student of a college or university, if the employee, trainee or student is practicing solely under the supervision of and accountable to the agency, college or university, through which he or she performs such functions as part of his or her position for no additional fee other than ordinary compensation.

<sup>5</sup> Washington State Legislature, WAC 246-810-016, <https://apps.leg.wa.gov/WAC/default.aspx?cite=246-810-016>

<sup>6</sup> Washington State Legislature, Chapter 18.19 RCW, <https://app.leg.wa.gov/rcw/default.aspx?cite=18.19>

<sup>7</sup> Washington State Legislature, Chapter 246-810 WAC, <https://app.leg.wa.gov/wac/default.aspx?cite=246-810> and refer to RCW 18.19.040 Exemptions <https://app.leg.wa.gov/RCW/default.aspx?cite=18.19.040>

<sup>8</sup> Washington State Department of Health, Agency Affiliated Counselor Registration application Packet, <https://www.doh.wa.gov/Portals/1/Documents/Pubs/670110.pdf> (Refer to Agency Affiliated Counselor Employment Verification Form)

In addition, some agencies have received licensure guidance that they must meet strict guidelines for supervising interns who are not permitted to bill if they do not have an employment arrangement.<sup>9</sup> Licensed BH providers must ensure supervision requirements are met for trainees, interns, volunteers and students. Requirements include passing a background check; signing a confidentiality statement from the trainee, intern, volunteer and student, as well as the academic supervisor; and being assigned a supervisor approved by the agency administrator or designee. The assigned supervisor must be credentialed by the department for their scope of practice, be responsible for the individuals assigned and must review all clinical documentation with the individual as part of the supervision process.<sup>10</sup>

HCA might consider clarifying in writing and through statutory and regulatory changes that HCA managed care billing guidance does not require agencies to follow these regulations and would assist the industry in creating sustainable funding sources for workforce development. Ideally, regulations would be modified to allow a BH agency to support an intern as Agency Affiliated Counselor Intern without attesting the conventional "employee status". Under this scenario, the provider agency would complete the agency affiliated form and attest that the counselor in training was a student intern and "affiliated" to their agency as such. This may require a change to **RCW 18.19.020**, which requires a person to be "employed" by an agency in order to be an Agency Affiliated Counselor. This language creates a barrier to registering a student intern as an Agency Affiliated Counselor should an agency wish to do so per HCA's preference of including students under the Uniform Disciplinary Act.

## Unlicensed Practitioners May Bill

HCA has issued other guidance permitting trainees, interns and students to bill Medicaid according to their current credential. HCA already has billing codes and guidance permitting unlicensed, employed practitioners with Bachelor of Arts (BA) and MA education to bill Medicaid if the practitioner is credentialed by the Department of Health. BA and MA practitioners may bill for skill building or psychoeducation. Please note, however, that interns and trainees may not bill for their future credential that they have not yet obtained.<sup>11</sup>

## Other State Approaches

Other States have approached the supervision of trainees and interns in different ways.

Regarding psychologist trainees, in 2016, the American Psychological Association highlighted Arkansas, Ohio and Oklahoma as examples of states that have used regulatory authority to permit reimbursement of psychologist trainees. The Association highlighted Oregon and Texas as examples of states where the

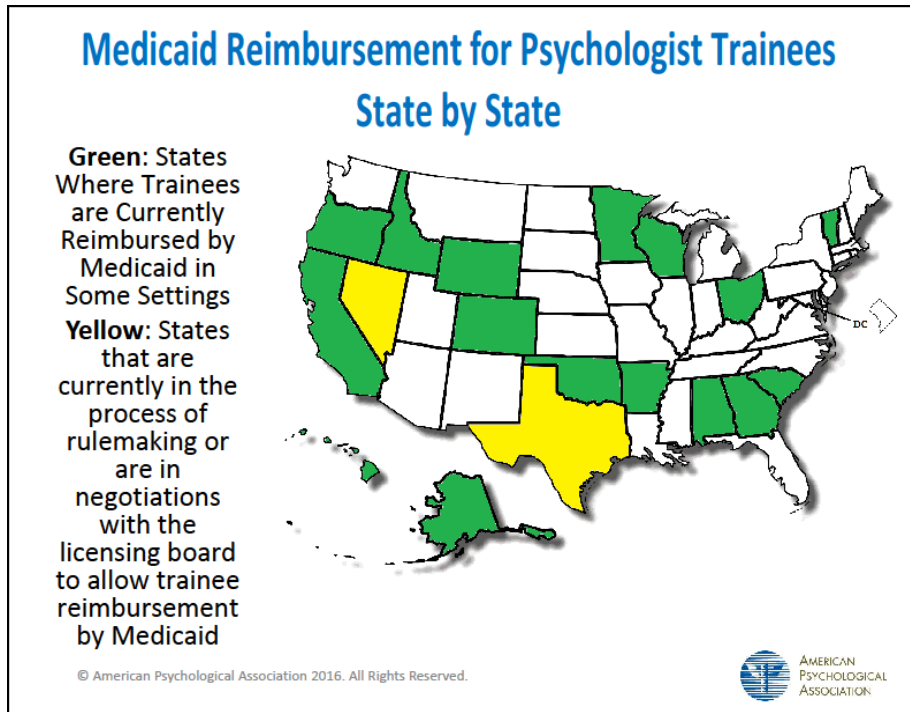
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<sup>9</sup> Washington State Legislature, Chapter 246-810 WAC, <https://apps.leg.wa.gov/wac/default.aspx?cite=246-810>

<sup>10</sup> *WAC 246-341-0520 Agency requirements for supervision of trainees, interns, volunteers and students* Statutory Authority: 2018 c 201 and 2018 c 291. WSR 19-09-062, § 246-341-0520, filed April 16, 2019, effective May 17, 2019.

<sup>11</sup> HCA workgroup meeting, November 18, 2020, Teresa Claycamp. E-mail from Ted Dale, Department of Health, February 25, 2020. "There is an exemption for students/interns found in **RCW 18.19.040** (2) and the requirement for Agency Affiliated Counselors (AACs) to be employed by an agency is in (2). While the department does provide guidance about the AAC registration not being required for students/interns, the department does not prohibit students/interns from applying for and obtaining the AAC registration. However, as stated in RCW, one of the credentialing requirements is that the student/intern must be an employee of the approved agency. The approved agency must provide an employment verification as part of the credentialing application. Ultimately the agency decides if they want to include students/interns as employees, but the statutory language for AACs clearly states they must be an employee."

state legislature was successful in changing state laws to permit intern billing. See Figure below for a map of state Medicaid programs allowing Psychologist Interns to bill in 2016.<sup>12</sup>



As noted in the case studies below, state Medicaid agencies have other initiatives for interns and trainees other than psychologist trainees.

### Case Studies: Ohio, Indiana and Georgia

#### Ohio<sup>13</sup>

Today, Ohio permits unlicensed practitioners seeking degrees, trainees, interns and assistants who are employed or contracted with licensed BH agencies to bill Medicaid. For individuals pursuing licensure, the state has regulations and established specific modifiers for Medicaid billing codes for practitioners with BA or MA degrees depending upon whether the practitioner is receiving direct supervision or general supervision. Unlicensed practitioners are also permitted to provide some limited services if they are employed or contracted with agencies providing supervision of their work. An unlicensed practitioner may bill for mental health services if the individual holds a valid high school diploma or equivalent and has both work experience and training related to the service(s) being provided, and is an employee or an independent contractor of an entity meeting the licensure requirements. These practitioners must operate under the general supervision of one of the licensed practitioners with an active provider agreement. See Appendix A for Medicare requirements for details on “incident to” billing.

**Table 1. Ohio Billing Chart of Trainees, Interns, Assistants and Unlicensed Practitioners**

<sup>12</sup> American Psychological Association, 2016

<sup>13</sup> Medicaid Behavioral Health, *Provider Manuals & Reimbursement Rates*, <https://bh.medicaid.ohio.gov/manuals> and BH Coding Workbook Final as of 8/1/2019-Excel

Type of Practitioner	Services Permitted to be Billed	Modifier in FFS or Managed Care	Direct Supervision <sup>14</sup>	General Supervision <sup>15</sup>
Psychologist Interns, Trainees and Assistants who already have a Master's or Bachelor's	Any CPT code for which a Psychologist can bill for	U1	Bill under "incident to" billing guidelines using the supervisors billing rate and National Provider Identifier (NPI)	Bill under their own NPI at a reduced rate for indirect supervision
Social Worker (SW) Trainees who already have a Master's or Bachelor's degree	Any CPT code for which a SW may bill for	U9	Bill under "incident to" billing guidelines using the supervisors billing rate and NPI	Bill under their own NPI at a reduced rate for indirect supervision
Marriage and Family Therapist (MFT) trainees who already have a Master's or Bachelor's degree	Bill under any CPT code for which a MFT may bill	UA	Bill under "incident to" billing guidelines using the supervisors billing rate and NPI for direct supervision	Bill under their own NPI at a reduced rate for indirect supervision
Chemical Dependency Counselor — Assistant	Bill under any CPT code for which a Chemical Dependency Counselor may bill	U6	Bill under "incident to" billing guidelines using the supervisors billing rate and NPI for direct supervision	Bill under their own NPI at a reduced rate for indirect supervision
Counselor — trainee who already have a Master's or Bachelor's degree	Bill under any CPT code for which a Counselor may bill	U7	Bill under "incident to" billing guidelines using the supervisors billing rate and NPI for direct supervision	Bill under their own NPI at a reduced rate for indirect supervision

<sup>14</sup> Supervising practitioner does not have to be physically present in the room while these services are provided but must be present in the office suite to be immediately available and interruptible to provide assistance if necessary.

<sup>15</sup> Means the supervising practitioner must be available by telephone to provide assistance and direction if needed.

Type of Practitioner	Services Permitted to be Billed	Modifier in FFS or Managed Care	Direct Supervision <sup>14</sup>	General Supervision <sup>15</sup>
Practitioners with less than Bachelor’s Degree Level including Case Management Specialist, High School Qualified Mental Health Specialist, Associate Qualified Mental Health Specialist Note: may be pursuing a degree	Case Management; Community Psychiatric Support and Treatment (Skill-building); Urine Drug Screening; Therapeutic Behavior Support; Day treatment; Psychosocial Rehabilitation; Crisis	HM	N/A	Supervising entity will bill on behalf of the entity
Practitioners with Bachelor’s or Master’s degrees not pursuing licensure Note: may be pursuing a degree	Assertive Community Treatment; Therapeutic Behavior Support; Crisis, Day Treatment	HN (Bachelors) HO (Masters)	N/A	Supervising entity will bill on behalf of the practitioner

### Indiana<sup>16</sup>

In January 2019, Indiana announced a new initiative to address the shortage of mental health professionals. The initiative allows community-based CMHCs to bill for Medicaid reimbursement for services provided by interns, whether or not they have an employment relationship with the CMHC. CMHCs owned or affiliated with a hospital may not separately bill for intern services, because reimbursement for intern services is included in the hospital’s medical education add-on payment to inpatient claims.

To qualify for reimbursement, the intern must be a graduate or post-graduate student currently enrolled in an accredited college or university program in one of the following fields of study:

- Medical (including physician assistant)
- Nursing
- Mental health
- BH
- Addiction Treatment

<sup>16</sup> Indiana Health Coverage Programs, *IHCP Bulletin*, [http://provider.indianamedicaid.com/ihcp/Bulletins/BT201859\\_PF.pdf](http://provider.indianamedicaid.com/ihcp/Bulletins/BT201859_PF.pdf)

The student must also be approved by the college or university to work as an intern or practicum student at a CMHC. The student must be supervised by a Medicaid enrolled practitioner employed by or contracted with the billing CMHC. The services rendered by the intern must be within the scope of practice of the supervising practitioner.

The supervising practitioner must be listed on the CMS-1500 claim or electronic equivalent as the rendering provider. The modifier HL (intern) is used to indicate that the service was performed by an intern. The reimbursement is at 50% of the base Medicaid physician fee schedule amount. MCOs also published billing guidance for the covered services for their members.

Washington could utilize this approach to track and to reimburse services provided by interns. The use of the modifier gives the State information to ensure that services rendered by interns are properly supervised and that managed care organizations reimburse for those services properly.

## Georgia<sup>17</sup>

On July 1, 2019, CMS approved a State Plan Amendment for Georgia to make add-on payments directly to Community Service Boards (CSBs) for graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). The methodology allows the Medicaid agency to make per claim Graduate Medical Education (GME) add-on payments for ambulatory services directly to the CSBs for the costs attributed to GME to Medicaid.

CSBs are service providers of BH and intellectual/developmental disability services to one or more counties in their designated areas. There are 25 CSBs throughout Georgia that make up the Public Safety Net that provide mental health and substance use disorder services to Medicaid eligibles, uninsured and underinsured.

## Potential Approaches for Washington

### Regulation Clarification Permitting Interns to Have Non-Employment Arrangements

Many of these approaches will require a change to FFS billing policy to permit interns to bill even if they have no independent contracts, leasing or other non-monetary employment arrangements with the provider entity. Current Washington regulations for FFS require that provider entities employ (i.e., have a "W-2" employment agreement) with the practitioner.

Washington billing guidance in Service Encounter Reporting Instructions (SERI) permits trainees and interns to bill under their existing qualifications in managed care. Under this guidance, the intern/trainee would be under the direct supervision of the licensed practitioner and providing services as part of the patient's normal course of treatment and would be permitted to bill consistent with SERI guidance. Because SERI does not apply to FFS, HCA has no policy that interns and trainees may bill under the FFS program. HCA has clarified that any core provider agreement with HCA to provide services via FFS to American Indian/Alaskan Native individuals, providers would follow the HCA provider billing guides (not the SERI). As stated in the provider billing guides, the Department of Health credential is required to bill

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<sup>17</sup> Georgia 19-0006 State Plan Amendment



FFS. Providers and stakeholders directed Mercer to focus on interns as Master's degree seeking individuals rather than Bachelor's degree seeking individuals.

Other Medicaid state agencies require a combination of direct/indirect supervision and employment or contract relationship with the provider entity in order for the provider entity to bill for the encounter generated.

Some of these approaches may also require additional billing guidance for providers or updates to the SERI.

The approaches described below include expense illustrations based on publicly available information and Mercer's experience in other state programs; this information is included in order to provide numeric comparisons of various approaches. The analyses illustrated here *do not* reflect an actuarial analysis of equitable fee reimbursement levels specific to Washington and Mercer disclaims any use beyond the intended purpose.

The proposed approaches below follow federal Medicaid reimbursement principles that Medicaid may only reimburse for the portion of care provided to Medical eligibles. Agencies serving a mix of Medicaid and non-Medicaid enrollees, will only receive reimbursement for the Medicaid portion of their caseload. Services provided to non-Medicaid enrollees may not be funded through the Medicaid rates. The proposed approaches reflect aggregate fiscal estimates without consideration for Federal Medical Assistance Percentages (FMAP).

### **Approach #1: Implement a Capitation Rate Increase**

Under this option, there would be an increase in the capitation rates proportionate to the amount of funding that the State would like to see devoted to additional supervision for workforce development initiatives when the entity has a program for interns and trainees. This increase could be informed by direct investments or through adjustments to clinical supervision assumptions included in historic BHO capitation rate calculations. While this option is fairly straightforward, unless Washington also amends its contractual requirements and receives CMS approval for directed payment (See Approach #2) to the providers, there is no guarantee that the MCOs would forward this funding to the community-based providers through enhanced reimbursement for workforce development costs. Further, requirements should be established at the provider level to ensure these activities continue to expand workforce development initiatives. This approach could increase the State expenditures without directly requiring the MCOs to give the funding to the providers. A lack of accountability could lead to budget increases without affecting workforce development.

### Potential Fiscal Impact

Assuming that there are 2,700 trainees<sup>18</sup> seeking licensure each year and 2,700 interns seeking degrees, if each trainee seeking licensure requires 800–1,000 face-to-face hours of direct patient care<sup>19</sup> and each intern seeking a degree requires 600 hours<sup>20</sup>, the actuary could build in an additional amount of costs for enhanced supervision (between 15%–20% of direct care wages for the supervisor) for particular CPT and Healthcare Common Procedure Coding System (HCPCS) codes. The additional supervision costs of 15%–20% of direct care supervisor wages would be roughly \$5.00 an hour.

**Table 2. Approach #1 Potential Fiscal Impact**

	<b>Trainees with degrees seeking licensure</b>	<b>Interns seeking MA degrees</b>
Number of individuals	2,700	2,700
Number of hours estimated per individual per year	1,000	600
Total number of hours	2,700,000	1,620,000
Assumed cost for additional supervision per hour <sup>21</sup>	\$5.00	\$5.00
Total cost built into the MCO capitation rate	\$13,500,000	\$8,100,000
Amount passed along to the community-based entity providing the internship	No guaranteed pass along	No guaranteed pass along

<sup>18</sup> According to [projectionscentral.com/Projections/Shortterm](https://projectionscentral.com/Projections/Shortterm), there are:

- Approximately 380 new clinical, counseling and school psychologists positions annually in Washington
- Approximately 1300 new counselors, all other (not including educational, guidance, school and vocational counselors) annually in Washington
- Approximately 480 new health care social worker positions annually in Washington
- Approximately 40 marriage and family therapist positions annually in Washington
- Approximately 330 new Mental Health and Substance Abuse Social Worker positions annually in Washington
- Approximately 40 psychologists, all other positions annually in Washington
- Approximately 120 new social worker positions annually in Washington
- 10 new therapists, all other positions annually in Washington

<sup>19</sup> [Social Work Guide, Washington Social Work Licensing Requirements, Socialworkguide.org/licensure/Washington](https://socialworkguide.org/licensure/Washington) — nine schools offer Bachelor of Social Work (BSW) and five offer Master of Social Work (MSW). For example, Eastern Washington University BSW need between 15 credit hours over three quarters in work related practicum. MSW need 13 credit hours over three quarter’s practicum.

<sup>20</sup> Based on expected intern hours for students seeking Master’s degrees shared during the Proviso 57 stakeholder workgroup meeting on November 18, 2020.

<sup>21</sup> \$5.00 is based on Mercer’s experience on working with other states on supervision costs and is intended to reflect a roughly 15%-20% of the hourly cost for a supervising practitioner.

## Approach #2: Increase Unit Reimbursement for Supervision When an Intern Is Present Through a Directed Payment

Another option would be to permit entities providing internship opportunities to bill for additional supervision costs when an intern is present using a modifier (HL-Intern modifier). This teaching enhancement or add-on bonus would be directed to community-based entities with workforce development programs including interns and trainees. The actuary could build an additional amount into the capitation rates and, at the same time, the State could direct the MCOs to increase unit reimbursement for supervision where an intern was present for that encounter.

Under this directed payment approach, the State would set parameters for MCOs to pay this additional amount to the entity supervising the intern. This would allow the State to direct how expenditures under MCO contracts would achieve its overall objectives for workforce development. These State directed payments must be approved by CMS in advance and tied to delivery and utilization of services to Medicaid beneficiaries covered under the contract. In this case, there is clear CMS guidance on how to apply for and receive approval from CMS on parameters for directed payments to providers of a particular service under the contract including a minimum fee schedule or minimum rate increase pass along.

No regulatory change would be needed for this approach because the practitioner generates the encounter and receives increased reimbursement for having intern present. The increased reimbursement is intended to reimburse for the increased costs to the provider without the provider being permitted to generate additional encounters. The intern would not need to have an employment relationship with the entity.

This approach would require an update to the SERI.

### Potential Fiscal Impact

Assuming that there are 2,700 trainees<sup>22</sup> seeking licensure each year and 2,700 interns seeking degrees, if each trainee seeking licensure requires 800–1,000 face-to-face hours of direct patient care<sup>23</sup> and each intern seeking a degree requires 600 hours<sup>24</sup>, the actuary could build in an additional amount of costs for

<sup>22</sup> According to [projectionscentral.com/Projections/Shortterm](https://projectionscentral.com/Projections/Shortterm), there are:

- Approximately 380 new clinical, counseling and school psychologists positions annually in Washington
- Approximately 1300 new counselors, all other (not including educational, guidance, school and vocational counselors) annually in Washington
- Approximately 480 new health care social worker positions annually in Washington
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- Approximately 40 psychologists, all other positions annually in Washington
- Approximately 120 new social worker positions annually in Washington
- 10 new therapists, all other positions annually in Washington

<sup>23</sup> Social Work Guide, *Washington Social Work Licensing Requirements*, [socialworkguide.org/licensure/Washington](https://socialworkguide.org/licensure/Washington) – nine schools offer BSW and five offer MSW. For example, Eastern Washington University BSW need between 15 credit hours over three quarters in work related practicum. MSW need 13 credit hours over three quarter's practicum.

<sup>24</sup> Based on expected intern hours for students seeking Master's degrees shared during the Proviso 57 stakeholder workgroup meeting on November 18, 2020.

supervision for particular CPT and HCPCS codes billed using the HL modifier. The practitioners would receive an enhanced rate for these codes billed using the HL modifier to indicate that an intern was present.

**Table 3. Approach #2 Potential Fiscal Impact**

	<b>Trainees with degrees seeking licensure</b>	<b>Interns seeking MA degrees</b>
Number of individuals	2,700	2,700
Number of hours estimated per individual per year	1,000	600
Total number of hours	2,700,000	1,620,000
Assumed cost for additional supervision for units with HL modifier per hour	\$5.00	\$5.00
Total cost built into the MCO capitation rate	\$13,500,000	\$8,100,000
Amount passed along to the community-based entity providing the internship	\$13,500,000 passed along to entities billing using HL modifier to indicate presence of an intern	\$8,100,000 passed along to entities billing using HL modifier to indicate presence of an intern

**Approach #3: Clarify billing for trainees and interns**

Washington may want to clarify billing guidance in SERI that permits trainees and interns to bill under their existing qualifications in managed care. Under this guidance, the intern/trainee would be under the direct supervision of the licensed practitioner and providing services as part of the patient’s normal course of treatment and would be permitted to bill consistent with SERI guidance. Because SERI does not apply to FFS, HCA has no policy that interns and trainees may bill under the FFS program. HCA has clarified that any core provider agreement with HCA to provide services via FFS to American Indian/Alaskan Native individuals, providers would follow the HCA provider billing guides (not the SERI). As stated in the provider billing guides, the Department of Health credential is required to bill FFS.

Unlike Approach #1 and Approach #2, this approach would require that HCA clarify how entities with workforce development programs for interns and trainees bill for services provided using the current qualifications of the unlicensed practitioner if they are under the supervision of the entity. Washington could clarify how trainees and interns as well as other non-licensed practitioners may generate billable encounter using the fees set for unlicensed practitioners, similar to the billing practices in Ohio described above. The fees set for unlicensed practitioners already include an allowance for the extensive supervision of the unlicensed staff at a Bachelor’s or Master’s education.

**Potential Fiscal Impact**

The cost of this approach depends upon two factors: the extent to which entities are not billing for the current intern and trainee workforce today and the magnitude of the lack of access within the Medicaid BH industry in Washington. We present a range of cost impacts that assume that most entities bill for

interns and trainee services today (e.g., 75% of entities already bill for the interns and trainees’ services) up to an assumption that many entities could affect their workforce today by billing for interns and trainees (e.g., only 50% of entities already bill for intern and trainees’ services).

The high and low estimates are intended to illustrate the fiscal impact tied to the increase of new utilization in Medicaid (managed care and FFS) as a result of additional practitioners, such as interns and trainees, providing behavioral health services assuming that there is commensurate demand or need for the services in the Medicaid population.

Assuming that there are 2,700 trainees<sup>25</sup> seeking licensure each year and 2,700 interns seeking degrees each year, if each trainee requires 1,000 face-to-face hours of direct patient care annually<sup>26</sup> and each intern seeking a MA degree requires 600 hours<sup>27</sup>, the actuary could increase the availability of BH services provided through increased utilization of interns and trainee services.

The low estimate assumes that with additional clarification and guidance, some community-based entities would bill for some additional services provided by trainees and interns. This estimate would cost approximately \$88 million for the new utilization.

**Table 4. Approach #3 Low Estimate**

	<b>Trainees with degrees seeking licensure</b>	<b>Interns seeking MA degrees</b>
Number of Trainee/Interns	2,700	2,700
Number of estimated hours per individual per year	1,000	600
Total number of hours	2,700,000	1,620,000
Assumed additional cost for supervision	N/A — built into existing unlicensed practitioner unit cost	N/A — built into existing unlicensed practitioner unit cost

<sup>25</sup> According to [projectionscentral.com/Projections/Shortterm](https://projectionscentral.com/Projections/Shortterm), there are:

- Approximately 380 new clinical, counseling and school psychologists positions annually in Washington
- Approximately 1300 new counselors, all other (not including educational, guidance, school and vocational counselors) annually in Washington
- Approximately 480 new health care social worker positions annually in Washington
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- Approximately 40 psychologists, all other positions annually in Washington
- Approximately 120 new social worker positions annually in Washington
- 10 new therapists, all other positions annually in Washington

<sup>26</sup> Social Work Guide, *Washington Social Work Licensing Requirements*, [socialworkguide.org/licensure/Washington](https://socialworkguide.org/licensure/Washington) — nine schools offer BSW and five offer MSW. For example, Eastern Washington University BSW need between 15 credit hours over three quarters in work related practicum. MSW need 13 credit hours over three quarter’s practicum.

<sup>27</sup> Based on expected intern hours for students seeking Master’s degrees shared during the Proviso 57 stakeholder workgroup meeting on November 18, 2020.

	<b>Trainees with degrees seeking licensure</b>	<b>Interns seeking MA degrees</b>
75% of entities already bill for the interns and trainees' services	25% new utilization	25% new utilization
Assumed hourly unit cost for a trainee or intern	\$100	\$50
Total cost	\$67,500,000	\$20,250,000

The high estimate assumes that with additional clarification and guidance, many community-based entities would bill for a much higher proportion of services provided by trainees and interns. This estimate would cost approximately \$176 million for the new utilization.

**Table 5. Approach #3 High Estimate**

	<b>Trainees with degrees seeking licensure</b>	<b>Interns seeking MA degrees</b>
Number of Trainee/Interns	2,700	2,700
Number of estimated hours per individual per year	1,000	600
Total number of hours	2,700,000	1,620,000
Assumed additional cost for supervision	N/A — built into existing unlicensed practitioner unit cost	N/A — built into existing unlicensed practitioner unit cost
50% of entities already bill for the interns and trainees' services	50% new utilization	50% new utilization
Assumed cost for an intern	\$100	\$50
Amount passed along to the community-based entity providing the internship	\$135,000,000	\$40,500,000

## Other suggestions

Regardless of the approach(es) selected, providers and MCOs could benefit from additional training regarding the current allowable coding and modifiers under which interns, trainees and other unlicensed practitioners are permitted to bill under existing HCA policy.

## 4

### Disclosures and Limitations

This report is intended to support HCA efforts to respond to Proviso 57 developed by Washington State Legislature as part of ongoing budget planning. This report is intended to be relied upon solely by HCA and other State stakeholders and is not intended to be distributed broadly. The illustrations presented in this report are based on publicly available information and Mercer's experience in other state programs; the information in this report is compiled to provide numeric comparisons of various approaches. The analyses illustrated here *do not* reflect an actuarial analysis of equitable fee reimbursement levels specific to Washington and Mercer disclaims any use beyond the intended purpose.

This report relies on data provided by the HCA as part of separate engagements. Mercer acknowledges that the suppliers of data are solely responsible for its validity and completeness. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it.

All estimates are based upon the information and data available as of the date of this report and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely and potentially wide range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. To the extent additional information becomes available that may impact the anticipated structure of the programs, the recommendations and accompanying fiscal analyses may need to be revised accordingly.

The State understands that Mercer is not engaged in the practice of law or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that the State secure the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work. Mercer expressly disclaims responsibility, liability or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

## Appendix A

# Incident to Requirements

Medicare defines "incident to" services as those services that are furnished incident to the professional services of a physician or other non-physician licensed practitioner such as physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives or clinical psychologists in the practitioner's office (whether located in a separate office suite or within an institution) or in a patient's home. Many states permit "incident to" billing consistent with Medicare requirements. These services are subject to the same requirements as physician-supervised services. "Incident to services" supervised by non-physician practitioners are reimbursed at 85% of the physician fee schedule.

To qualify as "incident to," services must be part of the patient's normal course of treatment, during which a qualified practitioner personally performed an initial service and remains actively involved in the course of treatment. The licensed practitioner does not have to be physically present in the patient's treatment room while these services are provided, but the practitioner must provide direct supervision, that is, the licensed practitioner must be present in the office suite to render assistance, if necessary. Direct supervision means that the licensed practitioner supervisor does not have to be physically present in the treatment room while the service is being provided, but the licensed practitioner must be present in the immediate office suite to render assistance if needed. If the licensed practitioner is a solo practitioner, the practitioner must directly supervise the care. If the licensed practitioner is in a group, any physician member of the group may be present in the office to supervise.

The patient record should document the essential requirements for "incident to" services.

The service must be an integral, although an incidental part of the physician's professional services.

- Physician/licensed practitioner must have provided a previous evaluation and management or office visit service, determined a diagnosis and documented a Plan-of-Care (POC).
- Physician/licensed practitioner must be present in the office suite (direct supervision) and immediately available.
- Physician/licensed practitioner does not need to see the patient each time but must see the patient subsequently for services of a frequency that reflects active participation in the course of treatment for the specific problem. There is no set period of time from CMS; however, some conditions would require more frequent visits (e.g., allergy verses congestive heart failure). The documentation should support the frequency.
- Availability by phone does not meet the definition of direct supervision.
- Must be billed under the supervising physician/licensed practitioner's NPI.
- When there is a change in the POC, it is no longer considered incident to.



- Services are furnished by ancillary personnel under the direct supervision of the physician/licensed practitioner.
- Services are in a non-institutional setting.
- There are no incident to services in a hospital inpatient or outpatient or skilled nursing facility.

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