



## FAQs on Medicaid Financing for LGBTQ+-Affirming Behavioral Health Services

Medicaid covers a variety of LGBTQ+-affirming services, but it is not always clear which services are eligible or how providers should bill for them. This document provides answers to frequently asked questions about financing LGBTQ+-affirming behavioral health services through Medicaid. The types of care addressed include group therapy, family therapy, gender-affirming care, and culturally adapted programs. Links to additional resources and further reading are also provided. Visit [lgbtqequity.org](http://lgbtqequity.org) for more resources and tools.

### **Some of the interventions the Center of Excellence promotes to support LGBTQ+ individuals are delivered in a group therapy format, but I was told that Medicaid in my state won't pay for group therapy. Is that true?**

Medicaid is a joint federal and state program. Within federal parameters, each state sets its own eligibility and service guidelines, and the program varies by state. States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services to offer based on the broad federal guidelines. Federal law requires states to provide certain [mandatory benefits and allows states the choice of covering other optional benefits](#).

You will need to determine what the barrier is in your state to using Medicaid to pay for group therapy for Medicaid-eligible individuals. Is it truly a lack of coverage, or is it due to other factors, such as youth are not meeting medical necessity criteria for the service or your providers are not meeting criteria for providing group therapy? Determining the specific barriers will inform what strategies can be employed to change Medicaid policy and practice.

Federal requirements stipulate that services must be provided by a Medicaid provider, must be covered by Medicaid, and must be provided to Medicaid-eligible individuals who meet medical necessity criteria for the services. Many states cover group therapy in their Medicaid programs and have defined criteria for the provision of group therapy, such as who can provide group therapy and under what conditions.

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under the age of 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. Based on certain federal guidelines, states are required to provide comprehensive services and furnish all Medicaid services that are coverable, appropriate, and medically necessary to correct and ameliorate health conditions, regardless of whether the service is covered in a state's Medicaid plan. EPSDT is made up of the following screening, diagnostic, and treatment services:

#### **Screening Services**

- Comprehensive health and developmental history
  - Comprehensive unclothed physical exam
  - Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
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- Laboratory tests (including lead toxicity screening)
- Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

### **Vision, Dental, and Hearing Services**

At a minimum, vision, dental, and hearing services must include diagnosis and treatment such as hearing aids, eyeglasses, and maintenance of dental health.

### **Other Necessary Health Care Services**

States are required to provide any additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered regardless of whether the service is covered in a state's Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis.

### **Diagnostic Services**

When a screening examination indicates the need for further evaluation of an individual's health, diagnostic services must be provided. Necessary referrals should be made without delay and there should be follow-up to ensure the enrollee receives a complete diagnostic evaluation. States should develop quality assurance procedures to assure that comprehensive care is provided.

### **Treatment**

Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

**When I am working with parents who are not affirming of their child's LGBTQ+ identity, I find it's best to meet with them alone so the child does not have to listen as the parents process their feelings. However, I was told that Medicaid does not pay for family therapy without the child present. Because the parents are not my patients, I can't bill their Medicaid. How can I bill for this clinically important service?**

Many states allow for the provision of family therapy without the youth being present if the service is related to the health and well-being of the youth as the identified Medicaid recipient. There are Current Procedural Terminology Codes (CPT Codes) for family therapy when the patient is not present: Code 90846. CPT codes are used by all providers and payers. However, as discussed in the answer to question #1 above, states have a great deal of flexibility in deciding what services to cover, who can provide the services, and under what circumstances the services are to be provided. You will have to examine what the barriers are in your state to using Medicaid to pay for family therapy when the youth is not present. Is it a coverage issue, a narrow definition of the circumstances in which it can be provided, a restriction on the providers who may provide this service, or some other factor?



## **Can I bill for therapeutic and clinical programs that were created or adapted specifically for LGBTQ+ youth or their families?**

Therapeutic and clinical programs developed for LGBTQ+ youth and their families could be billed as outpatient services or as part of the Rehabilitation Services Option, which often include in-home, rather than clinic-based, services. The ability to bill Medicaid will depend on your state's Medicaid program, including what services they cover, service and medical necessity criteria, provider credential requirements, and the like.

Most youth in Medicaid are enrolled in Medicaid Managed Care Organizations (MCOs). Within state contractual requirements, MCOs have a degree of flexibility in the services they will reimburse. For example, MCOs may pay for what are referred to as “in lieu of services”—defined as alternative services or settings that are not included in the state plan but are medically appropriate, cost-effective substitutes for covered services or settings. In addition, MCOs are required to engage in quality improvement initiatives. While your state may not have data on cost or quality outcomes specific to the LGBTQ+ Medicaid population, national data indicate that this population is at high risk for mental health and substance use disorders and is less likely to access needed and appropriate services. As a result, this population is at risk for the use of more costly care, such as emergency rooms and hospitalization. (See, for example, [Access in Brief: Experiences of Lesbian, Gay, Bisexual, and Transgender Medicaid Beneficiaries with Accessing Medical and Behavioral Health Care](#), June 2022. MACPAC.). One strategy is to engage Medicaid MCOs in your state about the outcomes experienced by LGBTQ+ youth in managed care and evidence-informed interventions, specific to this population, that have been shown to improve cost and quality outcomes.

Most state Medicaid agencies have a medical or clinical director, in addition to the Medicaid director. They also have key personnel overseeing behavioral health, managed care, and EPSDT. More recently, some state Medicaid agencies have designated staff to oversee issues related to health equity and social determinants of health. Many Medicaid MCOs have similarly designated directors and staff. If you do not have personal contacts within the state Medicaid agency or within Medicaid MCOs, you can contact any personnel in the key positions described above to raise awareness of LGBTQ+ issues. You can share with them the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC) report cited above, which presents disparities in access to quality care for the LGBTQ+ population in Medicaid. MACPAC is widely respected as a nonpartisan legislative agency charged by Congress with making recommendations related to Medicaid and CHIP. You can also share data on the higher risks faced by LGBTQ+ youth for using expensive and restrictive services, such as emergency rooms, inpatient psychiatric hospitalization, and residential treatment. You can also let Medicaid and MCO key personnel know that your agency has developed evidence-based practices that can improve the quality and cost of care for this population. Let them know that these are services that can be covered under the Clinic or Rehabilitation Services Option or within various waivers. Begin or strengthen dialogue that can lead to inclusion of best practices for LGBTQ+ youth within the Medicaid delivery system.



**I am a therapist working in a state where my governor has said it is child abuse to provide gender-affirming care such as hormones to youth. Does this mean that Medicaid won't pay for hormones even if we find a doctor to prescribe them? Does the doctor have to be in my state?**

While states have wide discretion to establish their own Medicaid policies within broad federal guidelines, the EPSDT mandate entitles youth to any medically necessary service that is federally allowable even if it is not covered by the state Medicaid plan. There have been many successful lawsuits that have evoked the EPSDT mandate to ensure that states cover particular services—for example, home and community-based behavioral health services. Many of the issues related to gender-affirming care within Medicaid will be decided in the courts. The EPSDT mandate in Medicaid may provide one avenue for legal redress on gender-affirming care.

On a related note, the [Biden Administration has reaffirmed its support for gender-affirming care](#), and the [Centers for Medicare & Medicaid Services approved a request to provide gender-affirming care](#) in the individual and small group health insurance markets as part of Colorado's Essential Health Benefit benchmark. This was a landmark step aligned with the Biden-Harris Administration's efforts to address health care disparities by removing longstanding barriers and expanding access to care for transgender persons, including within the Medicaid program.

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