The Background and Current Status of Education and Funding for Music Therapy Services in the United States

Geschichtlicher Hintergrund und gegenwärtiger Status der Ausbildung sowie die Finanzierung musiktherapeutischer Dienste in den USA

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In Memory of Dr. Rosalie Rebollo Pratt

Music therapy in the United States has existed as a profession since 1950. "The American Music Therapy Association" currently reports a membership of over 3500 members. This paper will examine a short background of the profession, education and entrance level requirements for music therapists and current means of financial reimbursement. Future trends for the music therapy profession will also be discussed.

In den USA existiert die Musiktherapie seit 1950 als ein akademischer Beruf. Die „American Music Therapy Association" umfasst gegenwärtig mehr als 3500 Mitglieder. Dieser Beitrag gibt einen kurzen Einblick in den Beruf, die Ausbildung und die Zugangsvoraussetzungen für Musiktherapeutin, sowie in die gegenwärtigen Finanzierungsformen. Ebenso werden Zukunftsperspektiven für den musiktherapeutischen Beruf diskutiert.

Professional History

After many starts and stops in the first half of the twentieth century (Schmidt Peters 1987), the first curriculum was developed in 1944 to train music therapists at what is now Michigan State University. The first didactic and laboratory course was taught at the university of Kansas in 1946 (Schneider, Unkefer, & Gaston, 1968). In 1950, the National Association for Music Therapy was formed, bringing the profession into the modern era (Solomon 1982). In 1971, a second national organization was established soon taking the name, American Association for Music Therapy (www.musictherapy.org). Both groups helped to establish curriculum for degree programs, published journals giving voice to research, and in general helped elevate music therapy to a more professional level and develop employment opportunities.

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In the early 1980's, the need for objective and credible certification was recognized, which was hoped would "have a positive effect on employment practices and reimbursement possibilities" (Certification Board for Music Therapists 1983, 6). The Certification Board for Music Therapists (CBMT) was established for this purpose and the first certification examination was administered in 1985. The purpose of CBMT board certification is to provide an objective national standard that could serve as a measure of professionalism by interested agencies, groups, and individuals.

In 1998, The National Association for Music Therapy and the American Association for Music Therapy merged into one organization, the American Music Therapy Association (AMTA). AMTA is committed to the advancement of education, training, professional standards, credentials, and research in support of the music therapy profession (www.musictherapy.org). In addition, AMTA publishes two professional journals, The Journal of Music Therapy and Music Therapy Perspectives.

Educational Requirements

Professional requirements include a bachelor's degree or higher in music therapy from an AMTA-affiliated university program. AMTA has developed Professional Competencies that are organized into three main areas: musical foundations, clinical foundations, and music therapy (AMTA Member Source Book 2005). In addition, 1200 hours of clinical training are required, including a supervised internship of at least 900 hours. Graduate degrees focus on advanced clinical practice and research. Some universities are now offering doctoral degrees in music therapy including, Florida State University, New York University, Lesley University, Temple University, University of Kansas, and the University of Iowa.

In order to qualify for professional practice, graduates must pass the CBMT exam and receive national board certification, obtaining the credential Music Therapist – Board Certified (MT-BC) (www.musictherapy.org).

History of Reimbursement

In the 1950s, most music therapists were employed by adult psychiatric institutions. As the value of music in the treatment of handicapped children was recognized, more and more music therapists began to work with the mentally challenged. (Lathom 1980). The therapists were reimbursed by the institution hiring them.

Music therapy gradually became recognized as a viable adjunct in other types of settings such as hospitals, broad-based special education, geriatric centers, nursing

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homes, prisons and substance abuse centers. In the 1970s, music therapists began to go into private practice and contract their services to agencies and individuals (Michel 1976).

During the 1980s, music therapists also began to be involved in the MusicMedicine movement, using music during medical interventions in the hospital setting (Spintge & Droh 1992). Many of these projects were financed through grant funding.

The 1990s showed a steady increase in the number of music therapists who were self-employed. Third party reimbursement became available to music therapists on a case-by-case basis and reimbursement under Medicare Partial Hospitalization Programs was implemented in 1995. Another area of rapid growth in the 1990s was in the provision of music therapy services within a special education context, where state and federal education funds provided payment.

Current Status of Reimbursement

Although there is a national system for education and credentials, reimbursement is much more varied from state to state. The following areas address topics that are more consistent across states.

Each year the AMTA does a survey of their professional membership that includes a report of work settings. The 2005 AMTA Sourcebook indicates that 12% of the current membership categorizes their work as self-employment or private practice. With regard to fees, the 2005 respondents had a mean rate for individual sessions of $56.86 and a mean rate for group sessions of $58.57. Respondents also indicated that about 28% of their fees came through some kind of third party reimbursement or payment. Some of these current reimbursement possibilities are as follows (AMTA Sourcebook 2005).

Grant Funding

This has long been a source of funding for facilities employing a music therapist. Funding from grants can offer an institution the necessary finances to employ a music therapist. This money is usually allowed as a dollar amount given for specific programs (such as music therapy in a hospital oncology department) and does not involve a sum for each individual client served. The trend in grants currently is to fund start-up programs that did not exist prior to the grant rather than providing funds for long-standing programs (www.musictherapy.org).

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Individual Education Plan (IEP)

Another successful area is payment for music therapy for school-based special education services, included in a child's Individual Education Plan (IEP). Federal law requires all children receiving special education services to have an IEP each year. When a music therapy assessment indicates that music therapy services are necessary for a child to benefit from his special education program, music therapy services must be included in his IEP and paid for by the school district. This is a case where the money is received from both state and federal governments (Coleman and Brunk 1999).

Medicare

Medicare is a federal health insurance program for people age 65 and older and for individuals with disabilities (www.alz.org.Resources/Glossary.asp). Since 1995, music therapy has been identified as a reimbursable service under benefits for Partial Hospitalization Programs (PHP). Successful reimbursement requires listing the therapy under Activity Therapy. Interventions cannot be purely recreational or diversionary in nature and must be individualized, based on goals specified in the treatment plan. Thus, the music therapy must be considered an *active* treatment and meet the following criteria:

- be prescribed by a physician
- be reasonable and necessary for the treatment of the individual's illness or injury
- be goal directed and based on a documented treatment plan
- the goal of treatment cannot be to merely maintain current level of functioning; the individual must exhibit some level of improvement (www.musictherapy.org)

All services and bills submitted to Medicare must include an established code, describing the intervention. In this system, a typical music therapy intervention could be defined as: "Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems" (HCPCS Level II Expert 2002).

Medicaid

Medicaid is a program jointly funded by the states and federal government, reimbursing hospitals and physicians for providing care to qualifying patients who cannot finance their own medical expenses (www.thefreedictionary.com/Medicaid).

There is no national Medicaid program for music therapy. Coverage and avenues for music therapy services vary from state-to-state. Some private practice music

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therapists have successfully applied for Medicaid provider numbers within their states. Other states offer waiver programs, covering music therapy.

For example, in the State of Minnesota, individual music therapists received provider numbers to service clients with mental illness and developmental disabilities. A waiver program for children with developmental disabilities provides coverage for music therapy. The Pennsylvania Department of Aging Waiver program allows Medicaid payment for music therapy provided in a community based setting. Music therapy is listed under health and mental health related counseling services.

Although music therapy is not specifically listed as a covered service, when functional outcomes are achieved, these interventions may fall under an existing treatment category such as community support, rehabilitation, or habilitation (Simpson & Burns 2004).

Private Insurance

Over the past 12 years, in response to the increasing demand for music therapy, the music therapy profession has worked to facilitate the reimbursement process through third party reimbursement and it continues to grow. At least 28% of music therapists are paid this way (AMTA Sourcebook 2005). This number is expected to increase exponentially as music therapy increases its presence in the health care industry.

There is currently an increasing demand for greater patient choice of health care services. Insurance companies are recognizing the advantages of music therapy as a benefit as they respond to this market demand; and are beginning to reimburse for music therapy services on a case-by-case basis, based on medical necessity. The term medical necessity is defined as "the reasonable and necessary medical treatment and services needed for an individual diagnosed with a specific medical condition." (Simpson & Burns 2004, 26)

Comparable to other health professions, music therapists must provide an individual assessment for each client. The music therapy service must be reasonable and necessary for the individual's illness or injury and include a goal-directed, documented treatment plan.

Finally, music therapy is typically pre-approved for coverage or reimbursement, when deemed medically necessary to reach the treatment goals of the individual patient. Reimbursement is determined on a case-by-case basis and available in a large variety of health care settings (www.musictherapy.org).

Other sources include: many state departments of mental health, state departments of mental retardation/developmental disabilities, private auto insurance, employee

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worker's compensation, county boards of mental retardation/developmental disabilities, special education schools, foundations, grants, and private pay (Simpson & Burns 2004), (www.musictherapy.org).

Professional Trends

Since the 1980's, the health care system in the United States has been and is in flux with increased managed care. Managed care is intended to be a system of health care where the goal of the system is to deliver quality, cost effective health care through monitoring and recommending utilization of services, and cost of services (www.insweb.com/learningcenter/glossary/health-m.htm). In order to increase job opportunities and the number of music therapists needed to meet the predicted explosion in heath care needs, it is imperative that music therapists are informed of current trends within this system and knowledgeable about predicted demographics for specific populations who will need our services in the future. Some of these foreseeable populations and trends follow.

Neonatal Intensive Care Units (NICU)

The use of music therapy in neonatal intensive care units has been on the radar since the early 1990's. This use of music therapy continues to make slow but steady growth in the United States. Dr. Jayne Standley, MT-BC and Florida State University have provided steady leadership in the USA toward building research data to support this work. While the research indicates that music therapy can be a valuable resource, music therapists must be well-informed and well-prepared to convince the physicians and other professionals of the value of music therapy in NICU settings (Standley 2003).

Autism

Autism currently ranks as the 3rd highest handicap in the US with over one-half million individuals carrying the diagnosis (Palmer 2001). When related areas such as pervasive developmental disorder (PDD) are included, the estimate is close 1 in 200 persons. This is obviously a growing area for music therapists in special education and private practice. The increased need for more special educators is predicted at 21–35% by 2008 (USDE 2001).

Neurological Music Therapy (NMT)

By 2010, over 15% of the US population will be over 65 (US Census Bureau 2000). This population will be prone to strokes, Parkinson's Disease, and other

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neurological disorders. The positive therapeutic applications of NMT have been demonstrated by Michael Thaut and his colleagues at the Center for Biomedical Research in Music at Colorado State University. This evidence based research and the resulting techniques are proving highly effective in dealing with rehabilitation issues in cognitive and sensorimotor domains to facilitate and train gait, arm movement, memory, attention, speech and language skills and gait performance (Thaut, Kenyon, Hurt et al 2002, Thaut 2003). It is opening present and future opportunities for music therapists to work with speech, physical and occupational therapists in rehabilitation.

Palliative Care

Another rapidly growing area is palliative care, which is proving to be extremely cost effective. Medicare identified 2,444 hospices in 2004, with continued growth expected. Mainly offered by hospices, palliative care emphasizes compassionate therapies focused on physical, psychological, social and spiritual needs of the patient, family and caregiver (NAHC Publications 2004). Music therapy is becoming increasingly recognized as a valuable tool in pain management and in working with the dying (Krout 2000).

Group Practice

The wheel need not be reinvented. Many professionals work as a team to help the same client (Groene 2003). More and more day programs and numerous out-patient medical settings are being set up to cut the high cost of hospitalization (Kruse 2003). Professional liaisons can help music therapists gather more truth about human health, education and well-being (Rebollo-Pratt, 1996). It would seem feasible and profitable for music therapists to actively work to become a part of group practices, such as

- cancer out patient treatment centers
- pain management clinics
- stress management, relaxation
- health promotion and disease prevention (Quinn & Traub 2002).

Since the 1980's, there has been an ongoing movement to humanize American hospitals, making them more attractive and inviting to patients. Inter-disciplinary, creative therapy programs are also growing to meet this marketing demand (Rebollo Pratt 1997). This would also seem an obvious venue for music therapists to create opportunities in health promotion and disease prevention (Quinn & Traub 2002).

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Healthy People 2010

The 1979 United States Surgeon General's Report, Healthy People, and later, Healthy People 2000: National Health Promotion and Disease Prevention Objectives established national health objectives that serve as a basis for the development of State and community plans. Healthy People 2010, the most current report, established two overarching goals: Increase Quality and Years of Healthy Life and Eliminate Health Disparities. This report is intended to guide health initiatives and grants and to enable diverse groups to combine their efforts in initiatives intended to improve health (Healthy People at www.healthypeople.gov).

Private Practice

Although the number of music therapists in private practice is growing in the United States, the vast majority of these practitioners are receiving payment through contracts with agencies or through private payment from the individual receiving services. The AMTA has made reimbursement for music therapy services a Priority Goal as part of the AMTA strategic plan. While reimbursement from third-party payers is a priority issue for the AMTA, the percentage receiving this type of reimbursement is still small at this time (Simpson & Burns 2004).

Wilhelm (2004) surveyed 465 music therapists who were members of AMTA and had identified themselves as self-employed or in private practice (2002 AMTA Sourcebook). Two hundred eight-eight music therapists responded indicating they worked with 29 different clinical populations. Overall, the top four methods of payment were: private pay, agency or school district payment, third-party payment, and grants. The other category only accounted for 1% of payment. Third party payment accounted for approximately 30% of payments.

American WholeHealth Networks, Inc.

The American WholeHealth Networks, Inc. (AWHN) provides integrative medicine services through a network on Complementary and Alternative Medicine practitioners for managed care organizations and health plans. In July 2004 AWHN announced, in conjunction with AMTA, its Music Therapy Network Program. This program would credential music therapists to be providers for AWHN for referral within some of the AWHN client health plans. Payment for services would occur if a health plan approved music therapy services for one of their clients from an AWHN credentialed music therapist. No information was available on the extent to which this has occurred since the 2004 launch (www.american-wholehealth.com).

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New York State Practitioner's Law

The State of New York has created a Mental Health Practitioner's Law to license the providers of Mental Health Counseling, Marriage and Family Therapy, Creative Arts Therapies, and Psychoanalysis. Effective January 1, 2006, the law requires that mental health practitioners be licensed to practice in the State of New York.

For the creative arts therapists, the education standard for New York's new law requires a master's degree or higher in one of the creative arts therapies from a program that is accredited by an acceptable accrediting agency or is determined to be substantially equivalent. The program must include a minimum of 48 semester credit hours and include supervised clinical experiences in the creative art therapy with a minimum of 500 clock hours. The law also requires training in identifying and reporting child abuse. Post-masters, a candidate for licensure must complete 1500 supervised clock hours.

The examination requirements are the Board Certification examinations that are already in existence for music therapy and art therapy or another examination determined comparable for other disciplines (www.op.mysed.gov/catselect.htm).

Marketing

There is also a significant need to get the profession of music therapy in front of the public through more public relations, media spots, and in-service training (Wilhelm 2004). AMTA is currently making an effort to increase the visibility of music therapists in its relationship with the U.S. Federal government to hopefully increase reimbursement possibilities (www.musictherapy.org).

Many therapists also have a combined degree in music therapy and psychology/counseling in order to have multiple opportunities for reimbursement. This provides a broader therapy basis and has also helped to open doors to more reimbursement venues.

Many of the trends discussed above suggest that it would be advisable to raise the entry level of education to a Master's degree as found in other therapies (ex: Art Therapy, Dance Therapy, Occupational Therapy, Speech and Language Therapy, Clinical and Rehabilitation Counseling). When other therapies demand a graduate level degree for entry into the profession and licensure, this would seem a logical way to improve training and be on more equal footing as colleagues.

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Conclusions

The profession of music therapy in the United States has come a long way in the past 55 years. There is now a single professional organization (AMTA), standardized professional competencies for education, professional certification, and two refereed journals. The authors feel there are two essential areas that will need to be addressed in the near future. Firstly, the entry level of education requirements needs to be raised to a Master's degree level commensurate with other therapies (art, dance, speech physical and occupational). A master's degree is also the entry credential for licensure, which is clearly on the horizon for other states now that the State of New York has passed a licensure law that includes creative arts therapists. The second essential area relates to AMTA's reimbursement initiative. The area of reimbursement for services must continue to be a priority for AMTA and AMTA regional organizations with the goal of reimbursement becoming broader and more consistent across the United States.

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