

APA SERVICES, INC. RESOLUTION

on Psychologists in Integrated Primary Care and Specialty Health Care Settings

ADOPTED BY THE APA SERVICES, INC. BOARD OF DIRECTORS
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**AMERICAN
PSYCHOLOGICAL
ASSOCIATION**
SERVICES, INC.



This policy was originally developed under the APA Practice Organization and is now under APA Services, Inc. as of January 1, 2019.

INTRODUCTION

This policy was established as a companion to the 2016 APA Council Resolution, *Psychologists in Integrated Primary Care and Specialty Health Settings*. The goals of this companion policy are to support and expand the aforementioned Council resolution, specifically addressing practice issues related to the promotion of psychologists in integrated care settings through initiatives related to employment, workforce development, reimbursement through commercial and public insurance, billing, legal corporate partnerships between psychologists and physicians, education and training psychologists in integrated care, patient and health systems outcomes research, organizational collaborations supporting evidence-based, interdisciplinary approaches to health-care across the lifespan (older adults, adults, children and youth) and across general and specialty care, as well as products supporting psychology practice in integrated care. For the purposes of this document, the term “integrated care” will be used to refer to various models or approaches of incorporating behavioral health services with adult and pediatric medical care ranging from co-location to fully integrated inter-professional team-based services.

Psychologists across the United States increasingly serve in leadership roles in academic health systems, community hospitals, and health systems in the public and private sectors¹. Examples of administrative roles include: Deans of Medical Schools or Allied Health Schools, Vice or Associate Chairs of Family Medicine, Section Chiefs in Pediatrics, Directors of Integrated Behavioral Health, Chief Psychologists or Chiefs of Psychology Services, Directors of Behavioral Medicine, and Directors of Research Centers. In these leadership positions, a psychologist demonstrates the value of psychological services and advocates for appropriate scope of services and reimbursement, increased psychology workforce, and staff privileges at departmental and organizational levels. Nonetheless, psychologists working at academic health centers, hospitals, and health systems continue to face barriers to hospital staff appointments and clinical privileges (Coons, 2015).

Psychologists are currently functioning well in various levels of integrated care models in fact, 29% of behavioral health providers co-located in primary care are psychologists. (Miller, Petterson, Burke, Phillips, & Green, 2014). These models are supported by the science of psychology, which has shown integrated care to be valuable in terms of both health outcomes and costs. For example, research has shown that integrating mental health care into primary care helps to lower costs, decrease emergency department visits and increase quality of care (Nielsen, Langner, Zema, Hacker, & Grundy, 2012). In addition to primary care, psychologists are also essential multidisciplinary team members in

specialty areas such as pain management, weight management/ bariatric surgery, oncology, cardiology, sleep medicine, neurological disorders, and rehabilitation medicine.

Nonetheless, reimbursement of psychological services in health and other practice settings by Medicare and commercial insurance companies has steadily declined over the last three decades. Routine health behavior interventions such as effective obesity treatment, specified by the USPTF includes: “Behavioral-based clinical interventions optimally will combine information on safe physical activity and healthy eating for weight loss with cognitive and behavioral management techniques to help participants make and maintain lifestyle changes,” which are not reimbursed by Medicare when provided by a psychologist. (LeBlanc, O’Connor, Whitlock, Patnode, & Kapka, 2011). In addition, health care finance reform in the Federal, State, and private sectors is expanding the use of bundled and global payments, although it is unclear if psychological consultation, psychological and neurocognitive assessment, as well as prevention and treatment interventions, will be included in these payment models.

Current regulations in many states prevent billing for psychological assessment and treatment services on the same day that psychiatric services are delivered, thus compromising inter-professional approaches to mental health and substance abuse conditions and contributing to fragmented care and disparities in care. In addition, psychological services billed with the Health and Behavior CPT codes are not uniformly reimbursed by CMS or commercial insurance companies in each state. Moreover, even when reimbursed, these services are paid at significantly lower rates than those of comparable mental health services.

State Corporate Doctrine of Medicine Laws which govern inter-professional contractual relationships among health care professionals prevent psychologists from partnering with physicians to create business entities in almost half of the states. These laws compromise psychologists’ ability to partner in Accountable Care Organizations and other professional groups who contract with insurance payers for medical services. Additional barriers to integrated care include accreditation requirements that are difficult to accomplish in brief and population based integrated care treatment models.

Psychologists across the career trajectory are requesting information and training on competencies, models, and contractual options for individual and group practice in and outside of primary care and specialty health care settings (Coons, 2014).

The health system market place is increasingly hiring behavioral health professionals who may be doctoral level psychologists, social workers, licensed counselors, health coaches, and other masters prepared professionals. Unlicensed interns and post-doctoral fellows, and early career psychologists are not

¹ APA gratefully acknowledges the work of the APA Council of Representatives Integrated Policy Workgroup/Helen L. Coons, PhD, ABPP, in their contribution of this background on practice issues included here.

always eligible to bill insurance companies for psychological or neuropsychological testing or treatment or prevention services, and consequently are less employable in the health care market place.

The APASI supports the following actions to promote psychologists in integrated care through professional identity development, marketplace tools, legislative advocacy, and legal/regulatory advocacy:

Professional Identity

- Implement specific strategies using social media, targeted publications and briefing papers to disseminate research on the value of psychosocial and health behavior interventions in integrated health care settings to improve patient, clinician, health system and population health outcomes. Differential messages need to target key and influential Federal and State policy makers, individual and group practices to provide integrated or collaborative care in and outside of health settings.
- Encourage the adoption of comprehensive competencies for psychologists working in primary care and specialty health settings such as those developed by the 2013 Interorganizational Work Group on Primary Care Psychology Competencies.
- Communicate with commercial health insurance companies, health professional organizations, health systems and foundations, health and science writers in varied media outlets, key thought leaders in health care, and consumer groups concerned about health and mental health issues.
- Disseminate information to the current psychology workforce on competencies, models, and contractual issues affecting the practice of integrated care through social media, targeted publications and continuing education workshops.
- Provide members with information and updates on the emerging role of value based payment models and the impact of quality improvement programs on practicing psychologist incomes and practice standards.
- Support reliable, valid, and sensitive use of outcome measures for psychologists practicing in integrated care.
- Educate members about the barriers to psychologists' practice of integrated care and how to navigate them in health systems and with payers and regulatory bodies.
- Educate members about additional roles in integrated care such as team facilitation and communications skills training.
- Encourage psychologists to educate health systems, legal/regulatory bodies, and government agencies about the unique training of psychologists as doctoral-level experts in behavior change, psychological health, and behavioral intervention.

Marketplace

- Support the development of quality data registries (such as the Qualified Clinical Data Registry Initiative [QCDRI]) for integrated healthcare, with input from psychologists and behavioral health consumers, and using reliable, valid, appropriate and meaningful measures of evidence based quality indicators.
- Support future research evaluating specific components of integrated care models in an attempt to determine which elements are most necessary for successful outcomes such as patient satisfaction, improvement in patient physical and psychological health, reduced costs, and population health indices.
- Support integration of psychologists in value-based, bundled and global reimbursement models and the role of psychologists in improving population health.
- Promote the inclusion of practice, research, and health policy by psychologists in integrated primary and specialty health care settings to improve patient, family, and population health. Formal collaborations should be considered with other influential health care organizations such as organizations representing physicians in primary and specialty care, health policy organizations, commercial insurers, federal agencies such as Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Medicare and Medicaid Services (CMS), as well as consumer groups such as AARP.
- Promote the recommendations and products from the 2014 APA Presidential Taskforce on Patient Centered Medical Homes through evidence-based articles, social media and briefing papers on the value of including psychologists in Patient Centered Medical Homes for children and adults across the life span.
- Work to educate primary and specialty care physicians and hospital systems on the value of psychologists in integrated care, as well as how to best incorporate psychologists into their work setting and environment through workforce training and development.
- Identify workforce training and development resources for psychologists and organizational leaders in primary and

specialty integrated care and provide education on their availability with a particular emphasis on mid-career psychologists and psychologists involved in training settings.

- Educate APA members on how to locate and apply for available grant-funded and other opportunities for psychologists working in integrated care settings.
- Develop a strategy for ongoing data collection reflecting a variety of integrated care settings and practice areas and sizes, across as broad a geographic area as possible.
- Advocate for the creation of new codes that will enable psychologist providers to provide preventative and treatment adherence, support services to patients, communication and consultation to the integrated healthcare team members, settings.
- Educate members about barriers to integrated care and how to navigate them in health systems and with health systems and with payers and regulatory bodies including where and how to access information on salaries and how to promote the appropriate valuation of psychological services RVU expectations.

Legislative Advocacy

- Support efforts to include psychologists in the CMS definition of “physician” to provide access to tools necessary for integration such as electronic health records (EHR) incentives and current procedural terminology (CPT) codes for integrated services.
- Continue to advocate for the reimbursement of psychological and substance abuse evaluation, psychological and neuropsychological testing, and prevention and treatment interventions for child, adult and geriatric patients across the life span in Federal and State programs and with third party payers.
- Identify services that psychologists can provide in integrated care settings that are not currently reimbursed under the CPT codes for psychologists, and advocate for the enabling of psychologists to use existing codes to provide Evaluation and Management Services.
- Advocate for payment methodologies to fairly account for behavioral health services at levels that reflect the training, skills and resources of psychologists, and the impact these services will have in reducing future healthcare expenditures.
- Advocate for inclusion and appropriate reimbursement under state plans, such as Medicaid.

- Support psychologists in being able to access affordable and effective EHR as a broad aspect of integrated care that is essential for collaborative work involving psychologists who are not embedded in larger health organizations.

Legal/Regulatory Advocacy

- Track and support changes in State Corporate Doctrine of Medicine laws that compromise psychologists’ ability to enter into contractual partnerships with physicians and other health care providers to provide integrated care in health settings.
- Provide technical assistance to states working to eliminate contractual barriers to physician and psychologist partnerships.
- Advocate for state laws, federal rules and regulations and payer rules that promote the inclusion of behavioral health services in integrated settings.
- Advocate for removal of restrictions on patients participating in multiple procedures on the same day.
- Advocate for removal of restrictions on the number of co-pays or total copays, deductibles or coinsurance a patient or their family must pay in a time period.
- Advocate for psychologists providing continuity of care for patients changing insurance plans given the ever-changing payer market.
- Engage with members and other entities to develop appropriate payment models for psychologists and in integrated care settings that are funded by bundled, value based and global payment models.
- Advocate for state governments to investigate allegations that insurance companies are failing to implement The Mental Health Parity and Addiction Equity Act (MHPAEA) when evidence warrants such investigations.
- Support new payment models that are not based on encounters or volume, which would allow for primary care and behavioral health to better integrate in one practice setting and have the opportunity to achieve financial viability.
- Advocate with organizations that evaluate and accredit healthcare organizations (e.g., Joint Commission on Accreditation of Healthcare Organizations, Commission on Accreditation of Rehabilitation Facilities) to educate these organizations on the role of psychology in health-care settings

WORKFORCE DEVELOPMENT AND TRAINING

Psychologists play a significant role in integrated care models, not only in primary care, but also specialty care. Psychologists' highly developed rapid assessment and diagnostic skills, as well as the use of evidence-based screening tools and assessments, make psychology an important and efficient part of primary and specialty care teams. Interventions are useless if they are not targeted to the correct diagnosis or the individual needs of the patient. Research suggests anywhere from 60-80% of primary care visits are related to stress (Avey, 2003). A skilled clinician who can quickly detect and address the underlying mental health issue will lead to fewer office visits and less unnecessary and expensive diagnostic testing.

Although the term "integrated care" may be new to the public and payers, psychologists have been involved in integrated care for decades. (Hunter, Hunter, & Kessler, 2015) These roles have included working collaboratively with physicians in independent practice, as well as a part of teams in community mental health settings and in integrated hospital settings. Research and clinical experience support the physical and mental health benefits of integrated care and the fiscal benefits of decreased healthcare costs, both of which increase interest in expanding the number of psychologists in medical settings. To this end, APASI seeks to promote opportunities for psychologists in integrated care settings. An important aspect of this involves promotion of workforce training and development.

Targeted Workforce Development and Training. Despite increased interest in integrated care by health systems and consumers, barriers exist to the routine inclusion of psychologists on primary and specialty care teams including: 1) challenges in recruitment, retention and training of skilled providers and leaders who value behavioral health services in health settings; 2) reluctance of psychologists and health care providers to change practice patterns and routines, 3) need for additional funding for the inclusion of behavioral health providers within health settings by health systems and payers, and 4) stigma related to mental health issues in and outside health settings.

Increasingly, graduate school training recognizes the importance of integrated care, and many programs offer training opportunities in health psychology, inter-professional practice, and working in healthcare settings. Three primary areas of workforce development need to be addressed to ensure that practicing psychologists develop the competencies to work in or collaborate with primary and specialty health professionals: 1) training for mid-career psychologists without prior integrated care experience; 2) trainers and supervisors of psychology trainees and other disciplines; and, 3) healthcare and payer system-level education on the value and benefits of integrated care.

Competency-Based Workforce Development and Training. Competency in integrated care encompasses proficiencies across many domains, including science, systems, professionalism, relationships, application and education (McDaniel, et al., 2014). Existing training programs and resources for graduate students includes the APA Society for Health Psychology Committee on Integrated Primary Care's course, "Integrated Primary Care Psychology: An Introductory Curriculum" (Gunn et al., 2016). For professional psychologists, the APA CMMI funded Integrated Health Care Alliance program provides an introduction to the field, while the UMASS Medical School integrated care training provides skills training of recommended competencies illustrated by APA past-president Susan McDaniel, PhD (2014); and competencies outlined by SAMHSA, among many others.

Funding Workforce Development and Training. Limited financial resources exist to motivate many institutions, organizations, practices and providers to move towards integrated care. Currently grant funding may enable psychologists, organizations, and institutions to gather data establishing value of an integrated care service delivery model.

REIMBURSEMENT CHALLENGES FOR PSYCHOLOGISTS IN INTEGRATED HEALTH SETTINGS

Behavioral health interventions impact physical health outcomes. While much thought and effort has been given to including behavioral health clinicians in integrated settings, little consideration has been given to how the services they provide are valued as a component of patient care or to how they should be paid. The goals of healthcare reform at the federal level under the Patient Protection and Affordable Care Act (2010) and under many state regulations are to improve the patient access and experience of care, improve the health of populations, and reduce the per capita cost of health care (Berwick, Nolan & Whittington, 2008). Health behaviors have a vital impact on health and adherence for acute, chronic and life-threatening physical conditions. (US Burden of Disease Collaborators, 2013). Forty percent of all illness is accounted for by behavioral factors (Mokdad, Marks, Stroup, & Gerberding, 2004). In addition, mental illness has an adverse impact on physical health, work place productivity, and quality of life. Nonetheless, behavioral health prevention and treatment have been grossly under resourced in the United States. Efforts to describe how stigma impacts the view of the mentally ill and mental health treatment (Satcher, 1999) have helped to improve recognition of the importance of behavioral healthcare in medical settings and nationally. Despite the Mental Health Parity Act of 1996 and the Mental Health Parity and Addiction Equity Act of 2008, behavioral health is still not fully recognized as important to the future of health care and to achieve the goals of the Triple Aim (Berwick, 2008).

Current procedure codes are a barrier to psychologists participating in integrated care. The current system of identifying medical procedures by using Current Procedural Terminology (CPT) codes, and reimbursement based on those procedures, is delegated to the American Medical Association's Specialty Society Relative Value Scale Update Committee (RUC) by the Center for Medicare and Medicaid Services. Although integrated health-care models have been developed and implemented over many years, the CPT codes have never been adapted to enable behavioral health clinicians to provide the wide range of services that are within their scope of practice (APAPO, 2016). The current CPT system includes explicit codes for Evaluation and Management services restricted to physicians as well as codes in a Psychiatric Collaborative Care Model (CoCM) that are restricted to mental health prescribers such as nurse practitioners, physician assistants and psychiatrists. (Archer et al, 2012). CMS's long-standing prohibition against psychologists billing for E/M services continues to thwart psychologists' efforts to fully participate in behavioral health integration (APAPO, 2016). Psychologists are excluded from use of primary care billing codes for providing treatment for obesity and smoking cessation, despite the fact that many of the evidence-based interventions for these conditions were developed by interdisciplinary teams led by psychologists, which indicated behavioral variables as essential for successful treatment. Psychologists and other non-physician providers are also excluded from utilizing reimbursement codes for work which involves supporting communications among integrated care team members. Psychologists are well-trained to provide psychoeducational services to prevent illnesses, as well as overseeing and implementing quality improvement and assessment initiatives.

Insurance practices that do not or poorly reimburse psychologists' services can be a barrier to integrated care. State health insurance exchanges that cover health services under Medicaid have historically not reimbursed psychological and substance abuse services or done so at disproportionately low rates for psychologists. This barrier contributes to health disparities for underserved children and adults across the life span.

CO-LOCATION/COORDINATION OF CARE

Coordinated care necessitates addressing reimbursement barriers. Health care policy has not changed to accommodate the new coordinated care delivery model (Kathol, Butler, McAlpine, & Kane, 2010). Various external factors continue to influence the ultimate effectiveness of integrated and collaborative care. These factors include: 1) current payment systems and financial reimbursement; 2) lack of reimbursement for multiple services on same day; 3) multiple copays and deductibles on same day; 4) the need for CPT codes in addition to Health & Behavior (H&B) codes which accurately reflect team-based work and 5) integration of electronic health records. Mental health remains largely "carved out" of physical health reimbursement practices.

This payment schism is not only a significant policy barrier for integration efforts, but it also affects care coordination and team-based training which leads to organizational and cultural barriers (Kathol et al., 2010; Miller, Phillips, Petterson, & Teevan, 2011). Although the new Medicare Physician Fee Schedule released by the Centers for Medicare and Medicaid Services (CMS) allows primary care providers to receive additional payments for chronic care coordination and telehealth services, it does not include payment for psychologists and other non-physician providers who deliver such services, which limits integrated care teams effectively funding the valuable care they provide.

Highly integrated care requires a shift in structure. Collaborative teams vary from rudimentary, such as developing a preferred referral relationship with a physician group, to complete integration which requires an operational, structural, and financial transformation of a clinic. Doherty, McDaniel, and Baird (1996) have offered a five-level continuum, describing levels of collaboration that can occur alongside varying degrees of integration. While this continuum does imply a certain hierarchy of values, it is one of the few models proposed which outline the different degrees of integration. Common characteristics of highly integrated clinics are those which have on-site full-time mental health staff, combined medical record and billing services, universal screening for depression and substance abuse, enhanced assessment of mental health issues, and focus on treatment approaches that encourage shared patient care. Thus there is a continuum of collaboration from none, referral relationships, co-location to highly integrated (SAHMSA).

Psychologists are key behavioral health providers in colocation with primary care. There is significant geographic variation in distribution in the behavioral health workforce including psychologists (Miller et al., 2014). Approximately 29% of primary care physicians have psychologists co-located in their practices while 43% have any behavioral health provider in their setting. (Miller et al., 2014). As rurality increases, the percentage of primary care physicians co-located with a behavioral health provider decreases, with a sharper decline for psychologists. However, proximity is not always indicative of collaboration, and the fact that providers are within close proximity to each other does not necessarily mean they are interacting clinically or sharing patients. There is currently no data which shows a true count of integrated, collaborating practices.

Regulations prohibiting contractual relationships are a barrier to integrated care. State Corporate Practice of Medicine Laws, which govern interprofessional contractual relationships among health care professionals, prevent psychologists from partnering with physicians to create business entities in almost half the States. These laws compromise psychologists' ability to partner in Accountable Care Organizations and other professional groups who contract with insurance payers for medical services. As of 2017, seventeen states have corporate practice laws that prevent contractual partnerships between physicians and psy-

chologists, with an additional 4 states with limitations. Although a few states have changed their laws to allow contractual partnerships between physicians and psychologists, it will be important for all states to work to achieve this goal.

INTEGRATED CARE, QUALITY IMPROVEMENT, AND OUTCOME MEASUREMENT

Impact of healthcare reform on payment systems. Even with changes in the political climate, healthcare reform efforts in the United States will continue to significantly impact psychologists practicing in integrated care settings. Integrated care psychologists, like their counterparts in independent practice, have been dependent on fee for service payment. The Patient Protection and Affordable Care Act (PPACA) (2010) created service delivery, financing and reimbursement models which move away from fee for service payment to a model that utilizes bundled payments to incentivize improved health outcomes and quality of care at lower costs (Nordal, 2012). Private insurers and healthcare systems also have been moving toward value based payment, and are likely to continue to do so even in a changed political climate (Morse, 2017). This change toward value-based reimbursement is likely to impact psychologists in integrated care settings, (Nordal, 2012). Psychologists in integrated care settings are at risk for being excluded from reimbursement through bundled payments because existing reimbursement mechanisms do not typically include ability to reimburse integrated behavioral health or neuropsychological assessment, treatment, consultation. Without CPT codes reflecting psychologists' role integrated care, it is impossible to place value on their work, and thus to allocate a portion of the bundled payment for psychological services.

Relationship of outcome data to quality improvement. The Patient Protection and Affordable Care Act (2010) emphasized outcome data on patient care and patient satisfaction as well as health system benchmarks. Significant research supports the benefits of integrating behavioral health services into primary care. Findings highlight lower costs, decreased emergency department visits, increased quality of care, and patient satisfaction (Nielsen, et al., 2012). Psychologists will need to be prepared to use their skills in outcome measurement to demonstrate the value added by behavioral health services through financial and quality enhancement, as this data is likely to be linked to reimbursement with ongoing healthcare reform (Rozensky, 2014).

Value based payment. Payers of behavioral healthcare have an interest in incentivizing behavioral health providers to improve the quality of their care. Pay for performance links clinical performance (including patient satisfaction and clinical outcome measures) to monetary incentives designed to motivate and reward quality of care. There are over 100 pay for performance efforts underway in the U.S., including from the Centers for Medicare & Medicaid Services (Bachman, 2006). These value based

payment models typically use clinical outcomes as at least one benchmark. In 2006, Bachman's outline of pay for performance behavioral health models included the importance of a clinical information system for tracking cases and data, such as clinical outcomes measures and other quality benchmarks (i.e., patient satisfaction and adherence to clinical practice guidelines) that could be associated with bonus payments or a differential payment of a base fee.

Integrated care psychologists and value based payment. In the emerging integrated care models, it will be important for psychologists to be able to demonstrate that their services are effective and of high quality through outcomes research, patient satisfaction measures, and practice guideline adherence. In addition, integrated care psychologists who can demonstrate that behavioral health services reduce other healthcare costs (i.e., reduction in hospital and emergency department utilization, etc.), will be well positioned to integrate into healthcare systems, accountable care organizations (ACO's) and patient centered medical homes (PCMHs). Psychologists will need skills in outcome measurement and technology to be successful in a healthcare reform environment (Nordal, 2012). Psychologists are well equipped to help organizations be successful with integration redesign using their knowledge of measurement. Outcome measurements such as PHQ-9 and GAD-7 are already being used across settings to look at effectiveness of programs. Successful integration will require using data to make continuous improvements. Research suggests that behavioral health integration into medical clinics provides costs savings or "cost offsets" that reduce overall healthcare costs (Blount et al., 2007). Systematic outcomes research for integrated psychology practice could help to further this knowledge and potentially both improve practice and provide the data needed for psychologists to receive value based payment.

Psychologists' voice in quality improvement programs and data collection. The APA has provided criteria for evaluating quality improvement plans and use of quality improvement data (2009). Recognizing that both public and private third party payers are interested in "pay for performance" programs, APA provided recommendations, including but not limited to: 1) psychologists and recipients of psychological services must be involved in program design; 2) programs must be evidenced/research-based; 3) data should take into account patient characteristics and be designed to reduce health disparities; and, 4) measure used should be reliable, valid, and sensitive to change. "Psychologists must have a voice in determining appropriate quality and outcomes measures" according to Dr. Katherine Nordal, Executive Director of Professional Practice APA (2012).

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