MACRA and MIPS: A New Era for Medicare Providers

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From the Executive Director for Professional Practice

Welcome to a new year and the first issue of Good Practice magazine for 2017. As the year began, the Center for Medicare and Medicaid Services’ (CMS) final rule implementing new payment models under the Medicare Access and CHIP Reauthorization Act (MACRA) went into effect. In this issue, we break down the details of MACRA and the Merit-based Incentive Payment System (MIPS) and what psychologists need to know about reimbursement for services under this new payment program.

We look at a new opportunity to help train psychologists to work within integrated health care systems through a $2-million grant from the CMS Transforming Clinical Practice Initiative (TCPI). APA and Practice Organization President Antonio E. Puente, PhD, answers members' questions on reimbursement codes. We also highlight a psychologist who makes a living exclusively as a Medicare provider and feature advice from practitioners on how to work in the Medicare system.

The Practice Organization is here to support our members by providing you with tools and resources to help you sustain your current practice or prepare to be at the forefront of new and emerging models of practice.

I hope you enjoy Good Practice.

Sincerely,

Katherine C. Nordal, PhD

Executive Director for Professional Practice

Follow Katherine Nordal on Twitter, @drnordal.
MACRA & MIPS: A New Era for Medicare Providers

What the new rules for physicians in 2017 could mean for psychologists in 2019

Beginning this year, most physicians who are Medicare providers will be subject to the Medicare Access and CHIP Reauthorization Act, or MACRA. MACRA was signed into law in 2015, and makes comprehensive changes to how Medicare pays providers for services. MACRA is a shift toward a payment model that evaluates and rewards quality of care.

Physicians and some “physician extenders,” such as physician assistants and advanced practice nurses, must begin following MACRA’s rules in 2017. Psychologists, clinical social workers and other non-physician specialties will not be subject to MACRA until 2019.

But psychologists—even those who aren’t Medicare providers—should pay attention now for two important reasons:

• The two-year delay gives psychologists a unique opportunity to observe how the new payment models for physicians are implemented. Psychologists have plenty of time to prepare and to anticipate what may be asked of them in 2019.

• The decisions made by the Centers for Medicare and Medicaid Services (CMS) often influence the decisions that commercial insurers make. Even if you aren’t a Medicare provider and don’t plan to become one, it’s smart to keep an eye on CMS.

In this article, we’ll explain how MACRA works in 2017 for physicians to give you a sense of what to expect in 2019.

One important caveat: Since this is a new and complex law, we should assume that some of these rules will change between now and 2019. The Practice Organization will continue to follow MACRA’s implementation and keep you informed about how it plays out. Our Complete Guide to Medicare for Psychologists, located on the Practice Organization website, is also a valuable resource for learning about Medicare’s payment system.

The Quality Payment Program

MACRA repealed the Sustainable Growth Rate (SGR), a component of the Medicare payment formula that consistently threatened to reduce payments to providers.

It also abolished the Physician Quality Reporting System (PQRS), a reporting program that calculated payment adjustments based on the data submitted by providers.

In their place, MACRA establishes a new, combined reporting program called the Quality Payment Program. In this program, providers will choose to participate in the Merit-based Incentive Payment System track or the Advanced Alternative Payment Models track to report their performance data.

The MIPS Track

The Merit-based Incentive Payment System, or MIPS, is the model that we expect most psychologist Medicare providers will be subject to in 2019. MIPS combines three previous Medicare programs: PQRS, the Value-Based Modifier, and Meaningful Use (which measured a practitioner’s use of technology in their practice). Providers can submit data as individual clinicians or as part of a group practice.

MIPS participants will be asked to submit data in four separate categories, and then will receive a total composite score based on that data. The composite score for a given year will be used to determine the provider’s payments two years later. This could mean either a negative, neutral or positive payment adjustment. Psychologists were not included in the law’s definition of “eligible clinician” but are likely to be added by the U.S. Department of Health and Human Services by 2019, hence the two-year lag.

Many of the MIPS measures will be familiar to psychologists. All 12 of the PQRS measures applicable to psychologists in 2016 became part of MIPS in 2017, along with most of the 2016 Dementia measures group. We anticipate that this will still be the case in 2019.

If MIPS continues in this form through 2019, we can reasonably expect that the MIPS data psychologists report in 2019 will affect their Medicare payments in 2021. In 2019 and 2020, psychologists’ Medicare payments will not be adjusted because they will not participate in MIPS in 2017 or 2018.
However, it's important to note that although PQRS ended on Dec. 31, 2016, it will continue to impact payments through 2018. Psychologists will see a 2-percent loss in payment in 2017 and 2018 if they did not successfully report PQRS measures in 2015 and 2016, respectively.

The APM Track
The second reporting option is available to providers who participate in Advanced Alternative Payment Models. Alternative payment models, or APMs, are usually designed to provide patient-centered and coordinated primary care services. Under MACRA, a provider opting for the Advanced APM track will earn a 5 percent incentive payment each year from 2019 to 2024 for participating in a payment model that bears some financial risk (e.g., bundled payment).

Providers who choose this track must meet three requirements: use of certified electronic health record technology; performance in quality measures similar to those used in MIPS; and assumption of risk for financial expenditures that exceed the providers’ expectations.

In 2019, the APM track is unlikely to be a common one for psychologists. To exercise this option, a psychologist would have to be part of an Advanced APM established by a different specialty, such as primary care. We expect that most psychologists will continue as traditional Medicare providers and report under MIPS.

Declining to Report
In 2017, physicians and other eligible providers can decline to choose either of these options. However, this means that they will receive a significant negative adjustment to their payments in 2019, and that rate will increase by year. The negative adjustment rate for declining in 2017 is 4 percent, and it will rise to a 9 percent loss by 2019.

More on MIPS
Since we expect that many psychologists will begin reporting under MIPS in 2019, here is a more detailed description of what that will involve for physicians in 2017.

As you learned earlier, MIPS combines features from three previous Medicare programs (PQRS, the Value-Based Modifier, and Meaningful Use). Providers will be scored across four performance categories (Quality, Clinical Practice Improvement Activities, Advancing Care Information and Cost), and their composite score will determine future payments. Note that in the final rule on MACRA, CMS states that they anticipate that the weighting of these categories may change over time.

Clinical Practice Improvement Activities (CPIA) is one of four performance categories under Medicare’s new Merit-based Incentive Payment System (MIPS), which takes effect for some health care providers in 2017. (Psychologists will not participate in MIPS until 2019.)

In 2017, physicians, physician assistants and advanced practice nurses will have more than 90 improvement activities to include in their report. Their CPIA rating will comprise 15 percent of their MIPS composite score in 2017. Both individuals and group practices can report these activities.

Although psychologists will not be eligible for MIPS until 2019, it may be useful for you to know about these clinical improvement activities now so you can prepare for MIPS ahead of time.

Below is a list of CPIAs. Note that this list may change before 2019.

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety and Practice Assessment
- Achieving Health Equality
- Emergency Response and Preparedness
- Integrated Behavioral and Mental Health, for example:
  - Diabetes screening for patients with schizophrenia or bipolar disorder who are using psychotropic medication
  - Tobacco use: prevention and treatment
  - Unhealthy alcohol use: prevention and treatment
  - Depression screening and follow-up plan: prevention and treatment
  - Major depressive disorder: prevention and treatment
  - Colocation of mental health and substance use disorder services in clinical care settings
  - Behavioral health services for patients with behavioral health needs, dementia and poorly controlled chronic conditions

For more information on CPIA, visit qpp.cms.gov/measures/ia.
• **Quality:** The Quality category incorporates many PQRS measures. Individual providers will report on six quality measures, including an “outcome” measure, while group practices will report on 15 measures. In 2017, Quality makes up 60 percent of the composite score.

• **Clinical Practice Improvement Activities:** Under this new category, providers and small group practices must select a certain number of activities from a list of 90, each worth a certain number of points. “Medium-weighted” activities, such as providing regular depression screenings or substance abuse interventions, are worth 10 points; “high-weighted” activities, such as the integration of behavioral health services for patients with poorly controlled chronic conditions, are worth 20 points.

Individual providers must attest that they completed four of these activities (of any weight) over a minimum of 90 days. Small group practices, or those in rural or health professional shortage areas, must attest to completing two “medium-weighted” activities or one “high-weighted” activity for a minimum of 90 days. In 2017, this category counts for 15 percent of the composite score.

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**MIPS Quality Measures: The Mental/Behavioral Health Specialty Measure Set**

Although the Physician Quality Reporting System (PQRS) ended on Dec. 31, 2016, many of the quality measures in MIPS will be taken from PQRS. In the final rule on MACRA, CMS established a measure set for mental and behavioral health. This set is listed below and includes the PQRS numbers for each measure.

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Additional information on MIPS Quality Measures is available on the Quality Payment Program website, [qpp.cms.gov](http://qpp.cms.gov).
Michael Fresé, PhD, is an early career psychologist with a part-time schedule, no overhead costs and a six-figure salary. He says his work never really feels like a job, and he is excited to do it every day.

This might sound like a riddle, but it isn’t. Fresé, who lives in Los Angeles, has simply found a formula that works very well for him and for his clientele.

“It’s a real blessing,” he says. “Honestly, I think I get more out of my patients than they get out of me!”

Fresé is a geropsychologist who works exclusively with Medicare patients in skilled nursing and assisted living facilities. He travels to these facilities to meet with them, splitting his time between the Los Angeles Jewish Home and a high-end assisted living facility in Beverly Hills. He also provides on-site consultations and trainings for facility staff.

Fresé says there are very few psychologists who are exclusively Medicare providers, and even fewer who are facilities-based, like he is. “You don’t often hear about psychologists working with older adults in their living environment,” he says.

This arrangement has major advantages for Fresé. “I do all my own billing and I don’t have an office,” he says. “That means all of my payments from Medicare, or from Medicare supplements, go right in my pocket.”

The flexibility of his schedule also affords him the opportunity to be involved in professional activities, such as serving on the Board of Directors of the Los Angeles County Psychological Association and the Board of the Alumni Council at Palo Alto University.

“I realized that the most joy I got out of my clinical work was when I was working with older adults. There was always an older adult in the picture.”

– Michael Fresé, PhD

Fresé’s patients benefit from this arrangement, too. He says they are very motivated and look forward to their sessions, in part because he meets with them regularly and at a location convenient to them. In many facilities, the residents’ day-to-day lives are largely determined by the rhythms of the institution, and things happen at the convenience of their doctors and the staff. That’s not the case with Fresé.

“With me, the residents have regular appointments at a set time, and they really appreciate that,” he says. “It makes me a little different from their other doctors.”

A practice goldmine

Fresé began his career working with veterans and their families at Veterans Affairs (VA) facilities in Salt Lake City and Los Angeles, and he planned to continue with the VA after getting licensed. But while working on a research project with non-veterans as part of his post-doctoral training, he recognized a compelling pattern.

“I realized that the most joy I got out of my clinical work was when I was working with older adults,” he says. “There was always an older adult in the picture.”

After passing his licensing exams, he decided to give private practice a try. He researched skilled nursing and assisted living facilities in the Los Angeles area, cold-called them and offered his services. The response was overwhelmingly positive.

“I was honestly quite surprised by their lack of awareness of the kinds of services I was offering,” he says of his initial conversations with administrators. “They didn’t seem to be aware that psychologists could be a resource for their residents in this way.”
GETTING STARTED AS A MEDICARE PROVIDER

Psychologist Amy Rosett, PhD, provides advice on what psychologists need to know to become Medicare providers.

1. Know the basics. Medicare is a federal health insurance program for people aged 65 or older; those with permanent disabilities, including mental illnesses; and those with end-stage renal disease or Amyotrophic Lateral Sclerosis (ALS). Federal law requires all physicians and other healthcare providers who provide services to Medicare beneficiaries, including psychologists, to either enroll as a Medicare provider or formally opt out of the program.

2. Get familiar with www.cms.gov. There, you will find answers to most questions about Medicare. One important thing to know is that CMS contracts regional private insurers called Medicare Administrative Contractors, or MACs, to administer most Medicare claims. Providers enroll with a specific MAC based on location. Rules and forms vary, so you will need to identify your MAC and go to its website to access its enrollment or opt-out forms, information on reimbursement rates, or contact information for staff trained to help providers.

3. On your enrollment form, identify yourself as a Clinical Psychologist (CP), and not an Independently Practicing Psychologist (IPP), even though both categories might seem accurate. CPs furnish diagnostic and therapeutic services, while IPPs are limited to diagnostic testing only. These categories, and many other details, are explained in the CMS Mental Health Service, a booklet available on the CMS website. The enrollment paperwork may seem detailed and repetitive, but don’t overthink it—just answer the questions as asked, and contact CMS staff for help if you need it. Your enrollment will be processed much faster if you don’t make any errors.

4. As a Medicare provider, you will be required to accept Medicare’s allowed charge as the full fee for service, even if it’s below your usual rate. Collecting additional payment is illegal. It’s important to know if the reimbursement will be fully paid by insurance, or if the beneficiary will pay a portion out-of-pocket. Find out if your patient has traditional Medicare or a Medicare Advantage plan, and whether they have a Medigap supplement plan, as this may affect your reimbursement rate.

5. If you’re concerned about MACRA and MIPS, relax! Psychologists won’t be affected until 2019, and Medicare’s rules for quality control programs like these often change from one year to the next. Just stay informed for now.

The Practice Organization’s Complete Guide to Medicare for Psychologists provides information and resources to help psychologists with Medicare enrollment, billing and payments. The guide is available at apapracticecentral.org/medicare.

Amy Rosett, PhD, provides psychotherapy to adults, specializing in older adults, in Encino, California. She provides consultation and teaches classes about clinical geropsychology topics. Her website is dramyrosett.com.
Decoding the Insurance Billing Process

APA and the Practice Organization’s new president answers psychologists’ billing code questions

Antonio E. Puente, PhD, 2017 president of the APA Practice Organization and the American Psychological Association, is well-known in the clinical psychology community for his extensive work and knowledge on reimbursement codes related to the American Medical Association’s Current Procedural Terminology (CPT) and the International Classification of Diseases (ICD). He served two terms on the AMA CPT Editorial Panel and was APA’s advisor to the panel from 1992-2007.

Q Are ICD codes replacing DSM codes or should they be submitted in conjunction with ICD codes?

A Essentially ICD codes have replaced DSM codes for insurance reimbursement, but not for clinical understanding and research use. DSM codes are descriptive codes in that they describe in some detail the disorder in question. In contrast, ICD codes are diagnostic codes. As of Oct. 1, 2015, insurance companies only accept ICD codes for reimbursement. At present, we’re using ICD-10-CM.

Q How can I bill for scoring and report writing time?

A All testing codes allow for billing for face-to-face time as well as non-face-to-face time. In essence, this means that you can bill for pre-testing, intra-testing and post-testing. Pre-testing involves selection of tests and preparation for testing. Intra-testing is the actual direct contact with the client. Post-testing involves the scoring and interpretation of that test along with the integration of this information with observed behaviors, clinical interview and other information obtained from patient records, which might range from education records to hospital records.

Q How do you find out which ICD codes a particular insurance will cover?

A There are no clear-cut ways. Public payers, such as Medicare, publish the formulary matching CPT codes to diagnostic codes typically on their websites. They do not advertise this information, but it is available to the practitioner. Private payers (insurers) make such formularies proprietary and not available for public use by practitioners. The best solution is to track the insurer’s explanation of benefits (EOB) to see which diagnostic codes match CPT codes. Check the provider section of the insurance company website for this type of information. Also check to see whether the company’s benefits materials warn consumers that the company will be excluding certain diagnoses. When private insurers use internal billing/payment policies to limit coverage without properly warning consumers, providers can argue that it’s a “hidden limitation” on coverage and a misrepresentation to consumers. Sometimes this information can be gleaned from others who have submitted claims of a similar type. Talk to colleagues to learn about their experiences.

Q Are there keywords to use when searching for codes to use?

A If you’re asking about diagnostic codes, I suggest that you use words that you’re familiar with or nomenclature from the DSM. Also, you may want to look at a website, such as ICD10data.com, that would translate your DSM classification into ICD-10-CM nomenclature. If you’re talking about CPT codes, there are essentially two kinds of codes: interview-testing, which are diagnosing codes, and intervention codes, namely psychotherapy. You can find more information in the CPT code book published by the American Medical Association. Another useful resource with coding information includes the APA Practice Organization website www.apapracticecentral.org. I also provide information through my website www.psychologycoding.com.
Q Can you bill a diagnostic interview on the same day as when you bill a testing code?

A Each insurance company plan has its formularies and regulations that are not necessarily known to the practitioner. So the question can only be answered by understanding the insurance plan under which you’re billing. However, with Medicare, namely CPT codes, the system allows for interviewing and testing on the same day.

Q How should neurodevelopmental disorders be coded and covered?

A There are several ways to do this including using the developmental code found in the CPT system. However, the codes developed for psychologists are primarily psychological and neuropsychological testing. If the psychologist does the testing, then they should bill 96101 for psychological testing (DSM type disorders) or 96118 (for neurological and related disorders). If the technician administers the test, use 96102 for psychological disorders or use 96119 for neurologically related disorders. If you use a computerized test that involves no cognitive work on the part of the professional, use 96103 if it’s a psychological problem, 96120 if it’s a neurological related problem.

Q What is a good diagnostic code to use for Medicare to do testing to rule out dementia and mild cognitive impairment?

A There is no good code per se to rule out dementia or non-cognitive conditions as this depends on the patient’s insurance plan. For many cases, using the F codes might suffice. Examples include F90 and F54. However, you may want to consider an R code if you can use the medical side of the insurance plan, such as ICD-10-CM code R41.1. Essentially most psychologists are considered mental health providers and are limited to F codes in the ICD 10 system. If the opportunity arises to bill under the medical (rather than mental) side of an insurance plan then greater opportunities for provision of services arise.

Q What advice do you have for psychologists on navigating the complicated process of billing for services?

A Truthfully, psychologists need a reality check on how to work in the real world of insurance companies. It’s up to psychologists to know the ins and outs of insurance. Psychologists are trained to deliver psychological interventions and make treatment decisions. But they’re not prepared to navigate the real world of billing and reimbursement. As soon as you sign a contract with an insurer, you have to work within the confines of that insurance carrier and become knowledgeable about the insurance company’s coverage policies. So, it’s important to fully understand the fine print before signing a contract. However, it is similarly important to remember that if the policies are restrictive of professional practice and problematic for patient care, then advocacy and education are the next steps in insuring effective care.

Questions were submitted by psychologists who participated in an Aug. 31, 2016, webinar on reimbursement with Dr. Puente. A recording of the webinar is available at youtube.com/APAPOvideos. For additional information on billing, payment and codes, visit apapracticecentral.org/reimbursement.

Written by Luana Bossolo
$2-Million Grant Helps APA Train Psychologists for Integrated Health Care

**Psychologists’ role in producing better health outcomes**

Last year, the American Psychological Association’s Center for Psychology and Health received a three-year, $2-million grant from the Centers for Medicare and Medicaid Services (CMS) Transforming Clinical Practice Initiative (TCPI) to help train psychologists to work within an integrated health care system. Integrated care brings together physicians, psychologists, nurses and other clinicians working in tandem to diagnose physical and psychological health problems, plan and provide treatment, and evaluate its effectiveness.

During the three-year award period, APA will serve as a Support and Alignment Network (SAN), leading an education and workforce development project that will enroll and provide 6,000 psychologists with clinical and leadership skills needed to work in primary and specialty care practices that are implementing integrated care programs.

The TCPI is one of the largest federal investments designed to support clinician practices through collaborative peer-based learning networks. It works through its SAN awardees to achieve these goals:

- Improve the quality of care delivered
- Rapidly transform health care practices in preparation for participation in alternative payment models
- Reduce the total cost of care

The initiative is one part of a strategy advanced by the Affordable Care Act to strengthen the quality of patient care and spend health care dollars more wisely.

**Benefits of the training**

APA will offer interested members free online training to prepare them for working on an integrated health care team. Once training is completed, APA will help connect members with a practice transformation network – a clinic, hospital or health care practice – in their region for additional coaching, mentoring and assistance in moving into integrated care practice. Participating in this collaborative, peer-based learning ensures that these clinicians will be part of leading and creating positive change for the entire health care system.

Additional benefits include:

- Eight hours Continuing Education Credit
- High-quality training by an expert team
- Opportunity to connect with like-minded individuals
- Better positioned for change
- Opportunity to stay current
- Diversify the settings you practice in using your current skills
- Identify skill gaps and positions for success after completing the course
- Reinvigorate your work in an exciting area

**Why this grant is important to psychologists**

The U.S. health care system is shifting away from a model that pays physicians only to help those who are ill toward a system that emphasizes keeping people healthy and improving their health. This is demonstrated in the policies that are changing health care payments. With an increasing focus not only on the population of patients served but also for the system of professionals caring for these patients, this shift will also emphasize value and outcomes over volume. Health outcomes for people are determined more by individual behavior than most practitioners realize.

Because of the Medicare Access and CHIP Reauthorization Act, health care practices will be seeing a transition to payment for quality of care and patient outcomes, and there are several ways in which psychologists can have a positive effect on those outcomes.

Some psychologists may not recognize the impact that they have on their patients’ physical health. For example, many...
psychologists see clients who suffer from depression, but also have diabetes or some other chronic illness. Research from the National Institute of Mental Health shows that people living with a chronic illness are at a higher risk for depression.

In other cases, psychologists may see patients who are pregnant or first-time mothers, and counsel them on how to adapt to the major life change of raising a child for the first time, or raising multiple children.

A change in thinking about health care creates a great new opportunity for psychologists. Primary care sites are where most people go when they have mental health problems. Recognizing the role behavioral health plays in treating physical health conditions is just one way psychologists can participate in the changing health care landscape.

The Practice Organization knows that the most common mental health disorders – anxiety, depression and substance misuse – adversely affect health outcomes. The mind and body are inextricably intertwined, and the most effective way to reach people who need help can be as a member of an integrated health care team. Adapting to working on a health care team will create new learning opportunities for psychologists. It is a chance to be an ambassador for the profession, educate other health care clinicians on what psychologists do, and improve patients' experiences and health.

Written by Toni Vincent, MPH
The Value of Integration

Practitioner Profile: Allen R. Miller, PhD, MBA

“T

his is no secret, but behavioral health does not drive the health system. We don’t make the big money,” says Allen R. Miller, PhD, MBA. “But in the new integrated environment, we demonstrate our value not by how much we bring in, but how much we save.”

Allen R. Miller, PhD, MBA

Miller is the director of behavioral health at WellSpan Health, a large integrated health care system headquartered in York, Pennsylvania. In his 25 years there, Miller has had the opportunity to observe and influence the scope of behavioral health’s value in an integrated setting.

“In integrated care, health systems are incentivized by payers to provide good quality care, and earn better patient satisfaction,” he says. A greater emphasis on quality is not only cost-effective, but good for patients and providers, too.

Integrated care is not without its challenges, however. Training a new generation of psychologists to work in health care settings is one challenge. Designing a business model that works for everyone involved – patients, providers, health systems and payers – is another. Miller, who started his career as a private practitioner and forensic consultant, is helping to tackle both.

“I didn’t decide to go into integrated care. It found me!” Miller says.

Miller was the first psychologist hired by York Hospital, which later became the WellSpan system. He was assigned to work in the emergency department – something of an irony, given his childhood dread of hospitals. “I couldn’t go near them,” he jokes. “I honestly didn’t know how it was going to work out at first.”

It ended up working out very well. Miller quickly found that his training in cognitive behavioral therapy was useful in treating emergency patients, whether they were in temporary crisis or had longstanding medical problems. “In many cases, they had coexisting psychological issues — panic disorder, depression, anxiety,” he says. “At that point, my focus was helping to stabilize them and connect them with longer term care.”

This was in the early 1990s, when many hospitals were cutting behavioral health services, Miller says. York Hospital, however, recognized their value, and chose to invest in behavioral health rather than downsize. As York became WellSpan, and as the health system expanded, Miller moved from a strictly clinical position to one with administrative responsibilities.

“Over time, I frequently came into contact with different medical departments – geriatrics, pediatrics, OB/GYN, etc. – who were interested in psychological and behavioral services for their patients,” Miller says.

This led him to help establish the role of psychology in a program called Bridges to Health, an intense outpatient program for “super-utilizers” – patients, often with comorbid conditions, who rely heavily and frequently on hospital resources. Many of the participants in this program have mental health or substance abuse issues in addition to chronic medical problems, Miller says.

“What we learned in the early days of Bridges to Health is what we all now know: there is a strong interaction between people’s medical conditions and their psychological state,” he says. “As we started treating these patients more comprehensively, including psychological services, we had better outcomes.”

A “good outcome” is measured in different ways by different people, he says. “Patients want to feel better; we
want to help them reduce their overutilization of services; payers want to reduce their costs.” Bridges to Health continues to be a very successful program on all these fronts, he says.

Miller became the director of behavioral health 14 years ago. Since then, WellSpan has committed to developing and integrating behavioral health services with all its medical services. For example, the system is now affiliated with the comprehensive mental health clinic Philhaven in south-central Pennsylvania, and one of WellSpan’s goals is to establish on-site behavioral health services at all 49 of its primary care practices.

Miller notes that the WellSpan physicians in primary care practices where psychologists are already in place report higher job satisfaction, lower levels of stress, and a better-quality work environment than those without psychologists on-site. “In these practices, psychologists handle the problems primary care providers might not be equipped to deal with. It’s a win-win for everyone involved.”

In line with the system’s commitment to training future psychologists to work in health care settings, Miller is also the director of WellSpan’s flourishing doctoral internship program.

This year, there are 14 doctoral interns at WellSpan, and there are plans to bring in more next year. “We get very positive feedback from them – this seems to be a great training environment,” Miller says.

The interns (along with several post-docs) also help with WellSpan’s growing staffing needs. Still, Miller is careful to maintain the perspective that they are training students to become practicing psychologists, not to benefit the health system’s development plans. “Clearly, however, there is a mutual interest and need,” he says.

Similarly, WellSpan’s intense focus on growth and development benefits patients and the community first, but its expansion is also essential from a business standpoint, according to Miller.

“We need to be big in order to survive in the current health care climate,” he says.

Miller, who earned an MBA in Medical Services Management from Johns Hopkins University in 2002, still finds that the managerial and financial challenges of his job are far more difficult than the clinical challenges. “My orientation of using cognitive behavioral therapy to work with patients is a foregone conclusion,” he says. “It’s the business model that’s hard.”

Figuring out how to pay, and get paid, for integration is a large and dynamic problem that requires lots of negotiation with payers, creative contracting and a great deal of experimentation, he says. “That means we still have to do some fee-for-service, while continuing to develop and design different ways to get paid in the future.”

That future has been cast into some uncertainty following the recent presidential election, Miller acknowledges. But regardless of the outcome of the election, he believes that Americans still want the best possible care for the least amount of money – and his experience shows that psychologists can have a transformative role in shaping a new status quo.

Written by Hannah Calkins
Early career psychologist Maryam Jernigan-Noesi, PhD, had the first inkling that she might want to become a psychologist while watching her father lead a support group at a local Vet Center program office, a division of Veterans Affairs that offers counseling to veterans and their families.

She recalls going with her mother and siblings during her childhood to meet her dad, a veteran of the Vietnam War, after support group meetings for veterans, many of whom suffered from post-traumatic stress disorder.

“I obviously didn’t know anything about PTSD or trauma at that particular time, but I thought it was really cool that people came together to meet, and that my dad facilitated this group,” says Jernigan-Noesi. Even in his retirement, her father remains an activist, advocating for all veterans and particularly veterans of color.

Her parents’ devotion to advocacy and support for traditionally marginalized groups of people is what inspired Jernigan-Noesi to become a practitioner focused on addressing the needs of women, children, communities of color and other groups of people who may have limited access to mental health services. She achieves this by integrating an emphasis on diversity into her clinical-research, consulting work and her two-year-old private practice.

As a practitioner and a researcher, Jernigan-Noesi studies populations that are typically excluded from mental health practice research. “I hope to develop more culturally responsive treatment interventions because we know that not all recommended interventions work for all populations,” she says.

A clinical research track reveals a need.

Although she’s a solo practitioner and consultant, Jernigan-Noesi says her mind for scientific research influences every aspect of her work. She studied to become a clinical research psychologist at Boston College, where she received her doctorate. Her advanced clinical training began in a postdoctoral fellowship in the Division of Adolescent Medicine at Harvard Medical School and Children’s Hospital Boston. Based on a recommendation from one of her graduate school mentors, Jernigan-Noesi then transitioned to another fellowship at Yale Medical School that was sponsored by the National Institute of Mental Health. This fellowship in clinical research was geared specifically toward psychologists who were interested in developing mental health interventions.

“The primary investigator on this particular fellowship recognized the need for a bridge between research and practice, but also that the unique training required for psychologists to become licensed often puts trainees in the position of being removed from research for a few years. This can place them at a disadvantage when developing their careers as independent researchers,” she says.

Jernigan-Noesi was interested in developing evidence-based practices and thinking about interventions that would reach larger populations of adolescents outside of direct one-on-one work. Still, she often met parents of adolescents, specifically people of color, who wanted to see her in a private practice setting.

“There was this need for one-on-one direct care. And I identify as a person of color. There were many people of color who approached me with the desire to have a clinician of color with the assumption or hope that a clinician of color might be more culturally competent. That is a recognized need, and I think that is what finally drove me into private practice,” she says.

The need is more apparent in the city where she is based, East Hartford, Connecticut, where there is a shortage of clinicians of color in private practice and practitioners who accept private and federal insurance, says Jernigan-Noesi.
Inclusive practice leads to inclusive research.

In 2015, Jernigan-Noesi started her private practice, seeing mostly women and older children, many who identify as people of color, and many patients who identify as lesbian, gay, bisexual or transgender. From the start, she says everything she needed to launch her practice quickly fell into place. She attributes this primarily to networking and seeking advice from colleagues who had private practices of their own.

“I don’t think that our psychology graduate programs, particularly those that may have an emphasis on practice and have graduates that go on to do practice, emphasize or offer enough resources around the business of practice,” she says. “It’s important to learn all of the psychological theories with regard to working with clients, but there also needs to be conversations around thinking about private practice and how to turn it into a viable, financial career.”

It was important for her to establish a practice that accepts insurance, including Medicare and Medicaid. In addition to taking out-of-pocket payments and insurance, she offers patients a sliding fee scale. Jernigan-Noesi says many of the communities she wants to help are often excluded from access to mental health services, either due to their ability to pay or a lack of available clinicians. She advises early career practitioners to consider whether their payment models reflect the clients they want to serve.

During her research training, she also learned that people of color, as well as LGBT populations also tend to be left out of mental health research.

“There’s this emphasis on evidence-based practice. As a person interested in multicultural issues, what I often found striking is that the research that I was reading didn’t necessarily include the populations of individuals that I served or was interested in serving across a variety of social identities. You think about traditionally marginalized populations like women, like people of color, like LGBT populations. Psychologists really historically haven’t included them in the research that we’re saying informs practice.”

Seeing these communities in private practice allows Jernigan-Noesi to see and report on the success rate for interventions and treatments that research psychologists are recommending.

Her practice has allowed her to be actively involved in adding to the research that she reads about and teaches to clinical psychology students at the University of Saint Joseph and Yale.

Recognizing the differences that people from all walks of life bring to the table, and understanding them, is essential to working with and treating diverse groups in a therapeutic capacity.

Building bridges between communities

When she’s not seeing patients, Jernigan-Noesi takes what she learns from her patients’ experiences in their workplaces or schools and applies it to her consulting work. For many, the intersections of their racial and gender identities have unfortunately led to experiences of racism and sexism. She says the goal for her consulting group, Jernigan & Associates LLC, is to help organizations understand how inclusive and non-inclusive environments may impact their employees or students. She points to how some negative attitudes toward diverse communities have led to more hostile learning environments at U.S. schools since the end of the 2016 presidential election.

“I think people are really fearful of how to respond, and focusing too much on individual political beliefs as opposed to seeing the election as symbolic of larger issues that have always been present in our society and have resurfaced in an explicit manner that many younger generations have not personally witnessed in recent years,” she says. “Schools would absolutely benefit from having an outside perspective and learning some strategies on how to build or rebuild a sense of community amongst their students and also among faculty and staff.”

Coming from a family that taught her and siblings to think about issues of social justice, Jernigan-Noesi says it’s only natural that she devotes most of her research, practice and consulting work to issues surrounding multiculturalism and diversity. She says recognizing the differences that people from all walks of life bring to the table, and understanding them, is essential to working with and treating diverse groups in a therapeutic capacity.

Written by Jewel Edwards-Ashman
The Committee for the Advancement of Professional Practice (CAPP) is the governance committee dedicated to APA Practice Organization and reports to the APA Practice Organization Board of Directors. CAPP works with the APA Practice Organization board to identify, plan and implement projects important to the protection, defense and enhancement of professional practice.

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Nominations to CAPP for 2018 are being accepted through March 2017. To learn how to submit a nomination, visit apapracticecentral.org. Elections will be held between Aug. 1 and Sept. 30, 2017, and new members will be announced in the fall.
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Advancing Care Information: This category replaces the previous Meaningful Use requirements, and will be of particular concern to psychologists who were not included in Medicare’s previous electronic health record incentives. For 2017, CMS will not require reporting in this category by clinicians who did not report under Meaningful Use in the previous year. In 2017, these measures count for 25 percent of the composite score.

Cost: No data submission is required in this category, as CMS will take the relevant information directly from claims. CMS will not count cost data as part of the composite score until 2018.

The Low-Volume Threshold
Some providers will be exempt from MIPS if they treat too-few Medicare beneficiaries. CMS is calling this exemption the “low-volume threshold.”

In 2017, individual providers or group practices will be exempt from MIPS under this rule if they treat 100 or fewer Medicare beneficiaries, or if they have $30,000 or less in Medicare charges. (Originally, CMS proposed that providers fulfill both requirements to be exempt, but agreed to separate them after the Practice Organization and other groups objected.)

CMS estimates that over 30 percent of eligible providers will be exempt under the low-volume threshold rule in 2017. It’s difficult to know how this will affect psychologists, because we don’t know if or how the rule will change before 2019. CMS does state that they expect the rule to evolve over time.

Written by Diane Pedulla, JD
Psychology Careers

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Soon, Fresé’s schedule was so full he had more patients than he could see. From a business standpoint, he had hit “a goldmine” – especially considering that he knew many colleagues in private practice who were struggling to fill their schedules.

Six and a half years later, he still has a constant flow of referrals from the staff at the facilities, which gives him the flexibility to be selective about the patients he sees.

“Part of the reason I get so much joy out of my work is that I’m very particular about the referrals I accept,” Fresé explains. “I’m there to identify a problem, make a plan and work toward a goal. If the patient doesn’t have the cognitive capabilities to do that, I refer them back to the staff at their facility.”

Understanding Medicare is the path to success.

Fresé estimates that he spends about 80 percent of his workweek doing clinical work. For the remaining 20 percent, he provides supervision, staff trainings and consultation. It adds up to approximately 20 clinical hours and five non-clinical hours per week, he says.

“There’s a myth that Medicare pays horribly, but that’s not true. At least, it doesn’t have to be true,” says Fresé.

To that end, Fresé views himself as a government contractor. “Medicare providers are basically working for the federal government,” he says. “I do what’s expected of me. And as long as I’ve been a Medicare provider, I’ve never received a rate reduction or other penalty.”

Still, he sympathizes with colleagues who don’t appreciate or understand Medicare’s focus on data and measures. “I know that can make them feel unappreciated as clinicians, but I also don’t think Medicare makes unreasonable demands of us. At the end of the day, we are contractors.”

Furthermore, he notes that Medicare is more flexible than other insurance providers on certain things, such as not putting limits on the number of visits a patient is allowed each year.

“The bottom line is that if you learn and follow the rules, you shouldn’t have a problem as a Medicare provider,” he says.

His thinking also applies to the looming onset of the Medicare and CHIP Reauthorization Act (MACRA). Its new reporting structure, the Merit-based Incentive Payment System (MIPS), has some psychologists feeling stressed and unprepared, although they won’t be subject to the new system until 2019.

“People are anxious. It can be overwhelming. But I'd tell them to just take a deep breath and look at what MIPS involves. It’s not worth this stress and panic!”

– Michael Fresé, PhD

Fresé, however, is not one of them. “People are anxious. It can be overwhelming. But I’d tell them to just take a deep breath and look at what MIPS involves. It’s not worth this stress and panic!”

To dispel MIPS anxiety, Fresé encourages his colleagues to take advantage of the informational materials provided by their professional organizations, such as the APA Practice Organization. He also recommends that they look into workshops or consultation services like those offered by his mentor and colleague, the geropsychologist Amy Rosett, PhD, (see sidebar on page 7).

Fresé’s resourcefulness has certainly paid off. “Career-wise, I’m in a place where people who have worked for 30 or 40 years are trying to get, and I’m six and a half years post-licensure.”

The only drawback to Fresé’s setup is more of a frustration than an obstacle, he says. Medicare requires that providers list an address, which leads some people to call or show up at the Jewish Home hoping to make an appointment with him. “It’s always unfortunate to have to explain that’s not how it works and turn people away.”

Based on this example, high demand may be the only disadvantage to mobile geropsychology practice. More psychologists might consider following Fresé’s lead.

Written by Hannah Calkins
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