A New Way to Pay for Psychological Services

Financial incentives are increasingly rewarding quality of care instead of volume.

The rising cost of health care and other factors are causing payers to explore new models of payment, says Elena Eisman, EdD, director of the Center for Psychology and Health at APA. One key trend? Shifting from fee-for-service payment models that reward volume to payments that reward positive outcomes for patients.

For psychologists, says Eisman, that means moving from “hold a session, get a payment” to getting paid for their role in keeping people healthy. The emphasis shifts from individual patients and episodes of care to populations of patients. And providers’ roles also change, with a move away from individual practitioners working alone, to team-based services designed to keep shared patients healthy. These trends are being reflected at the state and federal level as well as at the commercial insurance level. Although health care policy is unsettled at the moment, says Eisman, the U.S. Department of Health and Human Services “is expecting and hoping for a sharp decline in fee-for-service reimbursement and a sharp increase in value-based services.” Where and how mental and behavioral health services get valued in new models is evolving but still somewhat unclear.

There are several steps along the way toward changing the culture of health care providers and accustoming them to the idea that seeing more patients or providing additional services isn’t the right approach, says Delaware-based health policy consultant Alan Greenglass, MD.

The first step is pay-for-performance or pay-for-value models, which offer financial rewards or penalties to providers according to how well they meet quality measures. “Does ‘pay-for-value’ improve the quality of care? The jury’s still out on that,” says Greenglass, pointing to a 2017 meta-analysis in the *Annals of Internal Medicine*.

The next step up is a total-cost-of-care model, says Greenglass. That can mean gains-sharing, such as the Centers for Medicare and Medicaid Services’ bundled payment program that lets providers share savings for coming in below budget for particular procedures. Medicare’s accountable care organization model is similar, allowing organizations to share in savings if they beat the budget for treating a population of Medicare beneficiaries in a geographic region.

The final step is capitation, in which an organization is paid a set price to care for each covered patient. “While other models have made incremental change, this is the only model that has been demonstrated to actually succeed at controlling the cost of care, improving patients’ experience and improving health care outcomes,” says Greenglass.

What does this mean for psychologists?

Psychologists are already moving along this continuum. Kevin D. Arnold, PhD, who directs the Center for Cognitive and Behavioral Therapy (CCBT) in Columbus, Ohio, for example, is co-locating psychologists within primary-care practices to jointly care for patients. “We aggressively pursue integration,” says Arnold of his large group practice.

Arnold now sees patients at Central Ohio Primary Care, a physician-owned medical group. “It was supposed to be four hours one day a week, but after two months, it became three days a week for 12 hours,” says Arnold, adding that CCBT has an expedited referral process for patients.
who need more ongoing care. “I hardly see patients in my own office anymore.” Arnold hopes to place one of his clinicians in each of the primary-care practice’s many clinics across Ohio.

Having more CCBT psychologists work across disciplines to keep patients healthy could eventually give Arnold’s practice access to per-member-per-month payment models. Medicaid, for example, offers a flat payment rate for each patient to networks that are integrating behavioral health and primary care. “We know we’re going to give value,” says Arnold. “We reduce the primary-care practitioner’s time in an encounter, because behavioral health issues are rolled over [to behavioral health providers].”

Arnold is already initiating value-based contracting with two large insurers. “We see payers as partners,” he says. “We want to help them save health care costs.”

Insurers know psychologists’ value, says Robin Henderson, PsyD, chief executive for behavioral health at Providence Medical Group, which has a health plan covering a quarter of Oregon’s Medicaid, Medicare and commercial populations.

The American Psychiatric Association’s Milliman report, for example, found that asthma costs 244 percent more with concurrent behavioral health conditions, cancer 172 percent and diabetes from 150 to 170 percent more, she points out. The elevated costs for comorbid conditions emphasizes the importance of treating both conditions for optimal care and likely cost savings.

Kevin D. Arnold, PhD, who directs the Center for Cognitive and Behavioral Therapy (CCBT) in Columbus, Ohio, is co-locating psychologists within primary-care practices to jointly care for patients.
But when it comes to contracting with hospitals, there are things holding psychologists back, says Henderson.

Privacy concerns may make psychologists in private practice reluctant to share information with medical providers, for instance. That’s out of step with today’s collaborative health care, says Henderson. “You don’t need to spill all the beans when talking with primary care, but you need to spill the beans that are pertinent,” she says.

New ways to deliver psychological services
Psychologists also need to be open to new ways of working, whether that means five-minute consultations about shared patients with multidisciplinary care teams or replacing traditional 50-minute sessions with new tech tools for engaging Millennials. APA is helping psychologists transition to working in integrated care teams, thanks to a Support and Alignment Network 2.0 cooperative agreement from the U.S. Centers for Medicare and Medicaid Services.

Psychologists should also reach out to physician practices to offer help on meeting their outcome measures.

Henderson encourages private practitioners to make collaborations with hospitals part of their practices. “If you’re in private practice, figure out how to engage with someone as large as Providence,” she says. “Make it easy for us.”

Written by Rebecca A. Clay

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APA TRAINING PSYCHOLOGISTS IN INTEGRATED CARE

The American Psychological Association’s Center for Psychology and Health has received a three-year, $2-million grant from the Center for Medicare and Medicaid Services (CMS) to help train psychologists to work within an integrated health care system.

The award comes from the CMS Transforming Clinical Practice Initiative (TCPI) Support and Alignment Network (SAN). 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.

During the three-year award period, APA will serve as a SAN, leading an education and workforce development project that will provide 6,000 psychologists with clinical and leadership skills needed to participate as part of primary and specialty care practices that are implementing integrated care programs and alternative payment models.

For more information, contact APA’s Center for Psychology and Health at PsychologyandHealth@apa.org.

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