



AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION  
PRACTICE ORGANIZATION

May 29, 2013

The Honorable Max Baucus  
Chairman  
Finance Committee  
United States Senate  
Washington, DC 20510-6200

The Honorable Orrin G. Hatch  
Ranking Member  
Finance Committee  
United States Senate  
Washington, DC 20510-6200

Dear Chairman Baucus and Ranking Member Hatch:

The American Psychological Association Practice Organization (APAPO) appreciates the opportunity to submit suggestions for Medicare payment reform per your May 10<sup>th</sup> request. We thank you for reaching out to non-physician providers in this effort. In repealing the flawed sustainable growth rate (SGR) formula and in addressing payment reform generally it is vitally important that the committee consider recommendations and seek active involvement from all Medicare providers, including non-physician providers. Clinical psychologists, for example, are a major provider of Medicare mental and behavioral health services, providing 40% of outpatient and 70% of inpatient psychotherapy services and most of the diagnostic services to beneficiaries. As requested, we provide suggestions in the three areas of your inquiry:

1. What specific reform should be made to the physician fee schedule to ensure that physician and provider services are valued appropriately?

The Medicare physician fee schedule, as determined by the payment formula, is not working to ensure appropriate and fair reimbursement for clinical psychologists. In fact, psychologist reimbursement has plummeted, particularly in recent years. In 2000 Medicare paid \$98 for a 45 minute psychotherapy session (the most common mental health service). Today, the program pays just \$81 for the same service, a 39% drop adjusted for inflation. Medicare payment has fallen as much as 15% below private indemnity rates.

As result of plummeting Medicare payment rates for their services, clinical psychologists are leaving the program. A 2008 APAPO member survey determined that 3,000 psychologists had dropped out of Medicare, primarily due to low reimbursement rates.

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We have additional anecdotal evidence that the dropout rate has continued in the five years since. While our members are dedicated to their Medicare patients, they simply cannot continue to treat these patients if they cannot make a living doing so.

Of course, this means that Medicare beneficiaries are finding it increasingly more difficult to access the mental, substance use and behavioral services that they need. There are very few mental health providers in rural and frontier areas in our country. While psychologists are far more numerous and geographically dispersed than psychiatrists, there are wide geographic areas where only one or a few psychologists practice. When psychologists in these areas drop out of Medicare or reduce their Medicare patient loads, no doctoral level mental and behavioral health services may be available to the beneficiaries. Therefore, payment reform must provide for fair and appropriate payment for psychologists to ensure beneficiary access to their services in the future.

Under the payment formula, the Medicare program increasingly pays more for higher-cost, technology-driven services. These services have high overhead and therefore high practice expense under the formula. Clinical psychologists' services, by contrast, are highly cognitive and work intensive with low overhead. As a result, various changes in practice expense over the last few years have impacted psychologists much more harshly than most other specialties.

In 2006 Medicare revised its methodology for developing practice expense values and elected to phase in the impacts from that change over a four year period. This change in methodology resulted in practice expense payments for psychological services being reduced by about 2% each year from 2007 to 2010.

Then in 2009, CMS made new changes to the payment formula including reallocating the weighting of the work, practice expense, and malpractice expense relative values. More weighting was given to practice expense and malpractice expense to reflect data showing that these costs had grown relative to the professional work. As a work intensive, cognitive specialty with low technology and malpractice expense costs, psychology lost an additional 2% in practice expense each year over a second four-year period due to this adjustment by CMS.

Psychology was hit yet again in 2011 after CMS decided to rebase and revise the Medical Economic Index (MEI) by linking it to more recent practice data and making changes to the practice expense categories. While this did lead to some increases in practice expense, the agency's decision to maintain budget neutrality by reducing payments for the work value component placed the greatest burden on mental health professionals, with psychologists and social workers suffering on average a 4% reduction in their overall Medicare payments (not just the practice expense portion) due to the MEI changes.

We are aware of other providers who are in a similar situation under the formula, but we are unaware of any other provider groups who have faced such dramatic declines in payment as those delivering mental and behavioral health services to beneficiaries.

With the help of Medicare payment experts, APAPO is currently exploring how the formula could be very slightly modified to ensure better, fairer and more appropriate reimbursement for clinical psychologists. Our research should be completed in the coming weeks, and with completion we would appreciate the opportunity of talking with you and your staff about specific and very narrow changes that could be made to accomplish this payment objective.

2. What specific policies should be implemented that could coexist with the current fee for service payment system to ensure that healthcare providers' services are valued appropriately?

We briefly focus on two policies that could be implemented to help ensure appropriate Medicare valuation for clinical psychologists' services. Of course, these policies would be in addition to payment formula reform, as discussed in question one. These are: providing clinical psychologist eligibility for evaluation and management (E&M) services reimbursement and enabling appropriate policies for evidence-based practice.

Like physicians, psychologists deal with a range of complex patients, many of whom have mental and physical co-morbidities. But under current CMS internal policy, psychologists are not allowed to use the E&M codes to reflect levels of complexity. By contrast, psychiatrists and advanced practice mental health nurses furnishing psychotherapy can use an E&M code along with a psychotherapy code to indicate the severity of the patient's condition and the intensity of treating the patient. Psychologists are limited to using the psychotherapy codes, which reflect the time and nature of the service but fail to distinguish between patients and the intensity of the work involved. For psychologists, having access to the E&M codes would be a major step forward in appropriately valuing their services because they could more accurately report the services they provide.

Since 1996, CMS has maintained that psychologists do not provide the services unique to the medical management of psychiatric patients, such as medical diagnostic evaluation, drug management when indicated, physician orders, interpretation of laboratory or other medical diagnostic studies and observations. CMS has also cited activities such as the review of activity therapy reports, supervision of nursing and ancillary personnel, programming of hospital resources for diagnosis and treatment, and activity in leadership of a treatment team in its discussion of E&M services.

In fact, psychologists are authorized by state law to provide many of these very services. Psychologists frequently provide psychotherapy to patients who are being treated with, or may require, medication. In these cases psychologists monitor patients for the behavioral effects of the medication to provide ongoing clinical information to the prescribing physician. In Louisiana and New Mexico psychologists with advanced training may be

licensed to prescribe psychotropic medications. Psychologists counsel patients and their families regarding diagnosis, prognosis, treatment options, treatment protocols, and compliance with such protocols.

In hospitals and other inpatient settings, psychologists provide consultations, coordinate care with other providers, lead treatment teams, and supervise nursing and ancillary personnel. Complex chronic care coordination services are now captured by new CPT codes for services to patients who may have both medical and psychiatric behavioral comorbidities that complicate their care, along with social support weaknesses and psychosocial problems. Despite all their work with chronically ill, co-morbid patients, psychologists are not eligible to provide complex chronic care coordination services in Medicare because they are listed as E&M codes. If coordination of care for Medicare beneficiaries is going to improve, Congress and CMS should recognize psychologists' provision of E&M services.

Additionally, policies to support evidence-based practice could be beneficial to ensuring appropriate services are delivered. The American Psychological Association describes evidence-based practice in psychology (EBPP) as the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention. Psychologists' clinical expertise encompasses a number of competencies that promote positive therapeutic outcomes. Monitoring patient progress, in a fashion that is appropriate to the care of the individual patient, is critical to determining if interventions are successful and when interventions may need to be modified. Additionally, evidence-based practice demands a rationale for the clinical strategies, and such rationales are based on the professional literature that describes the research and interventions.

3. Within the context of the current fee for service system, how specifically can Medicare most effectively incentivize healthcare providers to undertake the structural, behavioral, and other changes needed to participate in alternative payment models?

Alternative payment models under consideration look to supplement or replace current Medicare fee for service payment with that for coordinated or team-based care. The provision of services by the appropriate provider will continue to be key to ensuring quality care. Unfortunately, sometimes beneficial yet affordable services, such as mental and behavioral health services, are not readily available to beneficiaries. Increasing coordinated or team-based care may help ensure that the appropriate type of provider is seeing the patient and addressing the patient's specific needs, including those related to mental and behavioral health. For instance, when a patient has pain, a psychologist can introduce new strategies to help that individual cope with pain, beyond the interventions routinely offered by physicians.

The APAPO is pleased that Medicare policies are in place to encourage clinical psychologists to practice in accountable care organizations (ACOs). Engaging psychologists in ACO and other coordinated care models being formed and tested by the Center for Medicare and Medicaid Innovation should help ensure beneficiary access to mental and behavioral health services that they provide. Physical and mental health are linked, and we urge the committee to continually consider the importance of mental and behavioral health as part of the health of the whole patient as it considers alternative payment models to the fee for service system.

To be given serious consideration by providers alternate payment models will have to demonstrate that they accurately value the provider's skill, time, and clinical decision making. They must also be consistent so that providers have some idea what they will be paid from one year to the next. The models' requirements cannot be overly burdensome and must be fair to both physicians and non-physicians.

We believe that reducing administrative burdens in Medicare will incentivize providers to explore alternative payment models. As discussed in question two, psychologists are not allowed to use the E&M codes to reflect levels of complexity in Medicare. Because of this prohibition on E&M, psychologists are not recognized for their work in care coordination and transitional care management (TCM), vital services necessary to ensure patients' health and well-being.

For example, when a patient has been hospitalized for a psychiatric condition, post-discharge is a high risk period and it is critical to establish care as soon as possible. A psychologist providing care to a patient following a psychiatric admission must collaborate with hospital staff to facilitate the transition and contact the patient about moving forward with treatment. During the first appointment, the psychologist would assess the patient by documenting symptoms, psychiatric diagnoses, medical needs, functional status, pain control, and psychosocial needs following the discharge. The psychologist would engage family members in the care planning process, contact local support agencies if necessary, and communicate with the patient's primary care provider regarding the patient's mental health needs.

Psychologists routinely provide such TCM services for patients who are transitioning from a facility stay to the community but because Medicare only reimburses for TCM services when linked to an E&M visit psychologists are systematically excluded from payment for their work. Reducing such administrative burdens is essential for psychologists to be part of integrated health care that addresses patients' physical and behavioral health needs.

For psychologists to provide quality care to Medicare beneficiaries there must be changes in current law and policy allowing them to exercise their full scope of practice. We discussed the need to amend the Medicare payment formula to avoid penalizing low-cost providers under question one and the importance of psychologists having access to the E&M codes in question two. Other changes that would allow psychologists to better serve Medicare beneficiaries are:

adding psychologists to the physician definition in Medicare to remove unnecessary physician supervision in programs such as partial hospitals and making psychologists eligible for the same incentives as other providers to adopt electronic health records into their practices.

a. Adding psychologists to the Medicare physician definition.

Psychologists are the only doctoral level provider not included in the Medicare “physician” definition. This definition currently includes both physician and non-physician providers—dentists, podiatrists, optometrists and chiropractors. Psychologists are licensed for independent practice to provide services in all 50 states and the District of Columbia. Unfortunately, Medicare law, which has remained essentially unchanged since the 1960s, does not recognize this independent practice stature and imposes unnecessary and inappropriate physician supervision of psychologists’ services to beneficiaries. These physician supervision requirements are hampering clinical psychologists from providing their full range of services to Medicare beneficiaries within state licensure. As a result, Medicare beneficiaries have limited access to the mental and behavioral services that clinical psychologists, a major provider of these services in the program, could provide them.

Senator Sherrod Brown and Representative Jan Schakowsky have introduced companion bills, S. 1064 and H.R. 794, which would include clinical psychologists in the Medicare physician definition, thereby ending unnecessary physician supervision. We urge Congress to pass this legislation to improve beneficiary access to the mental and behavioral health services they need by allowing psychologists to provide these services to the full extent of their state licensure.

In inpatient hospital and psychiatric hospital settings, for example, passage of this bill would enhance psychologists’ ability to direct appropriate care for their patients. Psychologists are licensed to assess, diagnose and treat mental and substance use disorders and are already key providers in these settings, but they are often hindered by inappropriate physician supervision of services provided within their licensure. This overdue change would help clarify clinical oversight for hospital patients under the care of psychologists and reduce the administrative burden on and cost to hospitals.

In outpatient hospital and community mental health center settings, for example, Medicare patients who would otherwise need inpatient psychiatric care are provided partial hospital services. Psychologists can and do run partial hospital programs in the private health system today—overseeing, supervising and providing treatment—yet Medicare requires that such services must be prescribed by a physician, provided under a written treatment plan established and periodically reviewed by a physician, and furnished while under the care of a physician. If these physician barriers were removed, beneficiaries would have better access to partial hospital services they need.

b. Making psychologists eligible for the same incentives as other providers to adopt electronic health records into their practices

The Behavioral Health Information Technology Act, sponsored by Sen. Sheldon Whitehouse and Rep. Tim Murphy in the last Congress, would support mental and behavioral health by enabling psychologists and social workers to qualify for Medicare and Medicaid incentive payments for integrating electronic health records into their practices. Including mental and behavioral health providers, as well as treatment facilities, will increase the likelihood that Medicare and Medicaid patients will receive effective, high-quality care in settings designed to meet their needs. In addition, the inclusion of psychology will generate savings for Medicare and Medicaid. Recognizing mental health professionals as eligible “meaningful users” under the law will promote integration of psychology and mental health in primary care settings, reduce duplicative tests, and provide necessary information to the emergency department at hospitals to triage patients more effectively.

We look forward to working with you and members of the Finance Committee as you explore ways to repeal the SGR and reform the current Medicare payment model. The APAPO is pleased to assist you in any way in this effort. If you have any questions or would like further assistance, please contact Doug Walter, J.D., Managing Director and Legislative and Regulatory Counsel, Government Relations, at [dwalter@apa.org](mailto:dwalter@apa.org) or (202) 336-5874

Sincerely,

A handwritten signature in cursive script that reads "Katherine C. Nordal".

Katherine C. Nordal, Ph.D.  
Executive Director