



AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

May 11, 2009

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

The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510-6200

Re: Senate Finance Committee Health Care Reform Policy Options (#1)—“Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs”

Dear Chairman Baucus and Ranking Member Grassley:

I submit these comments on behalf of the American Psychological Association (the “APA” or “we”) regarding the first healthcare reform policy options paper released by the committee on April 28, 2009. As the professional organization representing more than 150,000 members and affiliates engaged in the practice, research, and teaching of psychology, the APA greatly appreciates the opportunity to provide input to the committee on reform of the health system.

We recognize that this first options paper is primarily focused on Medicare reform. Many of our members are devoted to serving Medicare beneficiaries and care deeply about the program and the people that it serves. However, the Medicare program, as it was constituted in the 1960’s, has not been modernized to allow psychologists to fully serve Medicare beneficiaries within the scope of their licensure. As a result, Medicare beneficiaries now face significant barriers to the care that psychologists could provide if permitted in a modernized program. These barriers are particularly acute in rural and frontier areas across the United States, where psychologists are available to provide the services that beneficiaries need and where no other similarly trained mental health professionals are available. For this reason we are particularly grateful to offer comments that focus on the mental health needs of Medicare beneficiaries and how the committee could reform the Medicare program to break down these barriers to care.

We focus our comments on three areas of Medicare reform offered by the committee in this initial policy options paper:

- ✓ *Payment Reform:* the APA seeks extension of section 138 of the Medicare Improvements for Patients and Providers Act of 2008 (“MIPPA”) that partially restored psychotherapy payments which were sharply reduced as a result of the “Five Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology,” published in the June 29, 2006 Federal Register (“5-year

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review rule”). This MIPPA provision, critically important for Medicare mental health services, will expire at the end of this year. We also note that the committee seeks to incentivize Medicare primary care services through bonus payments for the provision of evaluation and management (“E&M”) services in specified ambulatory settings. We agree with this goal, but urge that psychologists be recognized for the E&M services that they already provide to beneficiaries within the scope of their licensure. We also briefly discuss the need to address the sustainable growth rate (“SGR”) payment formula and the committee’s options regarding the Physician Quality Reporting Initiative (“PQRI”).

- ✓ *Lowering Barriers to Psychologists’ Services:* Psychologists and their services should be fully integrated into the Medicare primary care initiatives envisioned by the committee. More fundamentally, psychologists should be included in the Medicare “physician” definition to eliminate unnecessary and inappropriate physician supervision requirements which impede beneficiary access to needed mental health care. Psychologists also should be eligible for payment bonuses provided for adoption of health information technology (“HIT”) into their practices.
- ✓ *Psychology Training and Workforce:* Congress has given clear direction to the Centers for Medicare and Medicaid Services (“CMS”) to reimburse hospitals for psychology internship training, but CMS has not permitted this reimbursement. We urge that Congress include a statutory provision to make this overdue recognition a reality. In addition, the APA strongly supports two training bills before Congress, the “Graduate Psychology Education Act” (S. 811, Senator Inouye) and the “Health Access and Health Professions Supply Act of 2009” (S. 790, Senator Bingaman), and urges that the committee include these bills in its consideration of health care reform both for the Medicare program and in the broader health system.

Payment Reform

MIPPA Mental Health Payment Extender. The APA greatly appreciates the committee’s leadership last year in including in MIPPA a provision (section 138) to partially restore outpatient psychotherapy reimbursement that was cut as a result of the CMS 2006 5-year review rule. In that rule, CMS increased payments for E&M codes and reduced payments for other Medicare part B services to balance the additional costs associated with higher E&M payments. Unfortunately, psychologists’ services were reduced more than any other providers’ services as a result of this rulemaking. The MIPPA partial restoration greatly helped psychologists in the Medicare program to continue to provide needed mental health services to beneficiaries.

This MIPPA mental health restoration provision will expire at the end of this year. It is critically important to psychologists and the Medicare patients they serve that this provision be extended for two years until the next 5-year review. The cost of protecting Medicare outpatient mental health services is very low, and based on the estimated cost of the MIPPA provision, extending the provision for two years would increase costs by \$60 million.

Psychologist Eligibility for E&M Payments. We agree with the committee’s proposal to provide a bonus payment incentive for the provision of primary care services in ambulatory settings for

the provision of E&M services (p. 10 of the committee options paper). This provision should be of some assistance to Medicare beneficiaries who live in rural and underserved areas.

However, the committee should also address another fundamental problem in Medicare for primary care providers who treat beneficiaries who have mental or behavioral issues. This fundamental problem is that CMS does not but should reimburse psychologists for the E&M services they provide within the scope of their licensure. Psychologists do work with physicians, for example, to address the mental and behavioral aspects of a patient's care. This work includes consultations, establishing diagnosis and treatment options, analyzing tests and records, and counseling and coordinating care. Psychologists also work with physician specialists in hospitals, for example, to evaluate and help address the needs of patients with multiple chronic care conditions. Psychologists also, for example, provide ongoing intervention services to address behavioral management issues for nursing home residents who suffer from Alzheimer's disease or dementia.

The E&M services that psychologists already provide are at the heart of helping to coordinate care among providers in an integrated fashion, helping to facilitate primary care as a basis for our healthcare delivery system and addressing the chronic care needs of patients. Importantly, psychologists provide these services in rural and underserved areas, where psychiatrists are not as available to work with primary care physicians. The fact that psychologists are available and able to provide evaluation and management services but denied Medicare E&M payment recognition is a real barrier to access to patient care. In Montana, for example, there are twice as many psychologists as there are psychiatrists available to provide these services. In Iowa there are more than twice as many psychologists than there are psychiatrists in non-metropolitan statistical areas to provide these services.

CMS prohibits psychologists from billing for E&M services under a vaguely described rationale that these are "medical" services, and therefore cannot be provided by psychologists. However, since psychologists can and do provide these services now, they should be permitted to provide them to Medicare beneficiaries in accordance with their scope of practice as defined by state licensure. The cost of allowing psychology Medicare E&M reimbursement is extremely low. Healthcare Visions, Inc. estimates that the cost of making psychologists eligible for such reimbursement would increase Medicare costs by approximately \$12 million a year, certainly a very low sum considering the real need that exists in the Medicare program to address the chronic illness needs and behavioral and mental health needs of beneficiaries, which psychologists are able to address.

With this underlying need for psychology Medicare E&M reimbursement in mind, we address other aspects of primary care in specified ambulatory settings in the committee's options paper. First, if psychologists were Medicare E&M eligible, then the committee should recognize their services as eligible for the bonus payment associated with these ambulatory settings along with the other services specified in this options paper, provided they met the other requirements of the provision. Second, we note that psychologists should also be eligible for the current HPSA bonus payment now available to physicians as referenced in the options paper. Inclusion of psychologists in this payment, much like E&M reimbursement eligibility, would help to fundamentally address Medicare beneficiary mental and behavioral health needs in underserved

areas. And finally, we note that the committee is considering offsetting the primary care bonus in this option through an across-the-board reduction in payments for services under all other Medicare codes. Absent psychologist eligibility to provide E&M services, it is inequitable to reduce psychologists' services further to provide higher payments for this primary care bonus. Considering our experience with a similar cut provided by the 5-year review rule (see discussion immediately above), we urge Congress and CMS to carefully weigh how this cut would adversely impact the delivery of much needed mental and behavioral health services to Medicare beneficiaries.

Sustainable Growth Rate Formula. The APA agrees with the committee chairman's assessment in his "Call to Action" health reform outline from last November that "the current SGR formula is fatally flawed and must be replaced." Therefore, we were disappointed to see that the options paper (pp. 16-17) provides options concerning how to extend the SGR formula into the coming years without its replacement. While we recognize that replacing the formula will be extremely difficult as a policy matter, we are hopeful that at some point Congress will find a way to address Medicare provider payment that both addresses program costs while ensuring that providers are fairly paid for their services. Of course, we greatly appreciate that either of the two SGR options that the committee is considering will divert the scheduled 21% payment decrease scheduled to take place next year, and find the first option more favorable in terms of payment in the coming years.

PQRI. The APA supports the committee proposals (pp. 5-7) requiring CMS to establish an appeals process for healthcare professionals who participate but do not qualify for incentive payments and to provide more timely feedback during the course of the performance period. We do not, however, agree with the concept of imposing a non-compliance penalty on eligible professionals who fail to successfully participate in the PQRI. Rather, the program should be voluntary and incentive payments should be used to reward successful participation. Payment reductions applied as punishment may discourage eligible professionals from becoming Medicare providers. Additionally, we are not in full agreement with either of the two options for extending PQRI incentives beyond 2010, because both include non-compliance penalties. Absent this objection, if the committee will consider only these options, we recommend Option 1 as it appears to provide the highest incentive payments to those who successfully participate.

Lowering Barriers to Psychologists' Services

Inclusion of Psychologists in Medicare Primary Care: The APA commends the Finance Committee for including depression among the major chronic diseases in need of integrated, transitional care management (pp. 10-11). Importantly, psychologists are vital in treating and preventing a range of chronic illnesses, including all of those recognized by the committee in this options paper—congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, asthma, diabetes and depression—and have a well-established history of working with physicians and other health care professionals in integrated care settings to address these problems. Psychologists are qualified to serve as care managers if they choose, but we wish to note that the transitional care management option should continue to allow Medicare beneficiaries to have unrestricted access to the services of psychologists in independent practice.

The committee should ensure that psychologists are eligible for the supplemental fee that will be offered to primary care practices for follow-up care after a hospital discharge. Under this provision however, the committee has tied this fee to the provision of E&M services. Again, we urge that the committee address the more fundamental issue of psychologists' eligibility for E&M payments (see discussion above), since under this provision psychologists could provide E&M services for patients suffering from depression and other chronic illnesses to reduce the chance of a hospital readmission. Accordingly, psychologists should have access to the E&M codes in order to accurately bill Medicare for their services. Alternatively, under this provision psychologists should be able to receive the supplemental fee for providing psychotherapy or health and behavior services to a patient within 30 days of discharge.

Regarding the CMS Chronic Care Management Innovation Center ("CMIC") (pp. 11-12), psychologists should be involved in the development of the CMIC to address both mental health disorders and the behavioral health aspects of physical conditions. Psychologists' particular expertise in the assessment of cognitive impairment will be especially valuable to CMS in the development and testing of models involving patients with dementia.

Regarding the extension and expansion of the Medicare Health Care Quality Demonstration Program ("MHCQDP") (p. 19), studies have shown that integrating behavioral health into primary care settings improves the quality of patient care and produces cost savings. The MHCQDP should be expanded to include integrated care models that incorporate the services of psychologists to address both mental and physical health conditions. Future demonstration programs should include models where psychologists are embedded in primary care settings and serve as members of a treatment team as well as models where psychologists consult with physicians and other health care professionals but treat patients in their own offices.

Inclusion of Psychologists in the Medicare "Physician" Definition: The APA urges the committee to amend the Medicare "physician" definition (section 1861(r) of the Social Security Act) to include psychologists. Such inclusion would remove unnecessary and inappropriate physician supervision requirements of psychologists' services, which impede Medicare beneficiary access to needed mental health care. As the committee knows, this definition already includes both physician and non-physician providers (chiropractors, optometrists, dentists and podiatrists). Already included non-physician providers perform these services within their state licensure without inappropriate physician supervision. Psychologists, licensed to practice independently in all 50 states and the District of Columbia, should be included in this definition as well.

The current exclusion of psychologists from the "physician" definition has real adverse consequences for Medicare beneficiaries now, since many of the physician supervision requirements imbedded in Medicare law currently slow down or even hinder patient care. For example, Medicare imposes physician supervision requirements on psychologists in hospitals, partial hospital settings, and comprehensive outpatient rehabilitation facilities (to name a few settings) where psychologists are qualified to provide their services with no or less physician supervision than the law currently requires. These supervision requirements hamper patient care, particularly in rural and underserved areas, where physicians may not be as available to provide

the supervisory role. The committee should address this fundamental problem by amending the definition to include psychologists.

HIT Incentive Payments: The APA is encouraged to see that the committee intends to include nurse practitioners and physician assistants as eligible providers under the Medicare incentive payments to be made available under the Health Information Technology for Economic and Clinical Health Act. However, it is fundamentally bad policy to exclude psychologists and social workers from these incentive payments. Psychologists and social workers deliver the great majority of Medicare psychotherapy and testing services to Medicare beneficiaries. Excluding these professionals from the incentive payments essentially excludes most mental health records from the interoperable, electronic patient records systems that these payments are meant to incentivize.

If the committee were to consider the situation in rural and underserved areas—where physicians providing mental health services are relatively scarce—exclusion of psychologists and social workers from these bonus payments essentially encourages the establishment of a two-tiered system, where mental health records are excluded from the interoperable electronic networks, while all other records are included. However, we know that for these networks to properly function in their communities and regions, all records need to be included. Therefore, we urge the committee to include psychologists and social workers for eligibility for these incentive payments.

Psychology Training and Workforce

Psychology Internship Training: We are pleased that the committee is considering graduate medical education and workforce issues in this first options paper. However there is a fundamental training issue that the committee should take up as part of its reform efforts. While physicians and at least 19 other allied health professionals, including nurses, physical therapists, and clinical pastoral counselors, are eligible for Medicare training dollars, psychologists are not. Hospitals pay for and run psychology internship training programs with no Medicare reimbursement. This lack of reimbursement places these programs at a distinct disadvantage, particularly in this difficult fiscal time where many hospitals must consider reducing financial support for psychology training.

CMS proposed a rule in January 2001 (66 Fed. Reg. 3377) to provide for hospital reimbursement for psychology internship training but will not implement the rule absent Congressional statutory intervention. Congress has clearly directed CMS to reimburse hospitals for psychology internship training for more than a decade through report language. For example, in report language accompanying the Medicare Prescription Drug and Modernization Act of 2003, conference committee *directed implementation of the proposed internship training rule within six months of the enactment of the law to which the report was attached* (see Conference Report on H.R. 1, Medicare Prescription Drug and Modernization Act of 2003, at 149 Cong. Rec. H12068 (2003)). Now more than six years after enactment, CMS still has not implemented the proposed rule.

We suggest that there would be a policy “disconnect” were Congress to address larger issues of Medicare training reimbursement, GME for physicians for example, without addressing a relatively inexpensive and fundamental training provision for psychology, as a primary provider of care to Medicare beneficiaries. Psychology interns provide a range of key therapeutic, primary care, and diagnostic services to Medicare beneficiaries, often in hospitals in rural and underserved areas where physicians are not available to provide similar services. Medicare reimbursement for psychology interns would help protect patient access to quality care and at a modest cost. CBO estimates that the cost of providing Medicare reimbursement for psychology internship training would be about \$40 million a year (CBO, Cost Estimate: H.R. 1 and S. 1, at p. 65 (July 22, 2003)).

Senator Jeff Bingaman, as a member of the Finance Committee, has introduced a psychology internship training provision that is ready for committee consideration. Section 106 of the “Health Access and Health Professions Supply Act” (“HAHPSA,” S. 790) would direct CMS to implement the 2001 psychology internship training proposed rule. We urge the committee to adopt this provision as part of the legislation that is crafted from this first options paper.

Workforce: The APA greatly appreciates that the committee is considering broader issues associated with workforce needs (pp. 36-37). We strongly support Senator Bingaman’s HAHPSA legislation, not only because it addresses Medicare reimbursement for psychology internship training, but also because it establishes a new but targeted strategy to address workforce needs broadly into the next decade. We urge the committee to include HAHPSA in its healthcare reform legislation.


We would also ask that the committee include Senator Daniel K. Inouye’s legislation, the “Graduate Psychology Education Act” (S. 811) in its reform legislation. This bill helps to directly address mental and behavioral workforce shortages in our country by authorizing a competitive grant program to fund accredited doctoral, postdoctoral, and internship psychology programs for interdisciplinary training with a focus on assisting underserved populations in rural and urban communities. At a very modest cost—authorization of \$10 million for 2010 and additional modest authorization through 2014—Senator Inouye’s bill would greatly enhance training for underserved populations, including for older adults and chronically ill persons.

Closing

Beyond the payment, access, and training and workforce issues we have discussed above, we believe that imposing application fees as part of the provider screening requirements (p. 42) in public program integrity efforts would discourage healthcare professional participation in the Medicare program and suggest that these should not be imposed. In addition, the level of screening and enhanced oversight that will be required for new providers is unclear under the proposed option as currently written, and we look forward to specifics on these provisions as they are developed. Regarding data base creation and data matching (pp. 43-45), we offer that any comprehensive databases, such as the proposed “One PI”, should be designed with stringent safeguards to protect against the unauthorized use of any new or existing data.

The APA thanks the chairman, ranking member and committee for allowing us to offer these comments. We realize that reforming Medicare and the healthcare system are enormous tasks and are deeply grateful to you for taking up the challenge. We look forward to working with you to accomplish both this year. Please let us know how we may be of assistance to the committee in the coming weeks, and if you have any questions regarding our comments, please contact Doug Walter, at dwalter@apa.org or at (202) 336-5889.

Sincerely,

A handwritten signature in black ink that reads "Katherine C. Nordal, Ph.D." The signature is written in a cursive, slightly slanted style.

Katherine C. Nordal, Ph.D.
Executive Director