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OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

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AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY  
Committee on Health Care Access and Economics TASK FORCE ON MENTAL  
HEALTH

*Pediatrics* 2009;123:1248-1251

DOI: 10.1542/peds.2009-0048

The online version of this article, along with updated information and services, is located on the World Wide Web at:

<http://www.pediatrics.org/cgi/content/full/123/4/1248>

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American Academy of Pediatrics

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# Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration

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TASK FORCE ON MENTAL HEALTH

## INTRODUCTION

“Mental Health: A Report of the Surgeon General”<sup>1</sup> documents the high prevalence of mental health needs of America’s youth. Although almost 1 in 5 children in the United States suffers from a diagnosable mental disorder, only 20% to 25% of affected children receive treatment. This is a troubling statistic, especially when considering that treatment of many mental disorders has been deemed highly effective. The Surgeon General’s report highlights the challenges of gaining access to mental health services in a complex and often fragmented system of health care. Without intervention, child and adolescent psychiatric disorders frequently continue into adulthood. For example, research shows that when children with coexisting depression and conduct disorders become adults, they tend to use more health care services and have higher health care costs than other adults. If the system does not appropriately screen and treat them early, these childhood disorders may persist and lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood. No other illnesses damage so many children so seriously.<sup>2</sup> On the other hand, early identification and treatment of children with mental health problems has the potential to reduce the burden of mental illness and its many consequences. Furthermore, data from a number of sources have demonstrated that enhanced access to outpatient mental health services is cost-effective.<sup>3</sup>

The American Academy of Pediatrics (AAP) and the American Academy of Child and Adolescent Psychiatry (AACAP) have created this joint position paper to ensure the mental health and wellness of our children and adolescents. With the implementation of the federal mental health parity law, many more children may be seeking mental health treatment.\* Shortages of children’s mental health professionals will make the coordination of care between pediatricians and child and adolescent psychiatrists even more necessary. By addressing the administrative and financial barriers that primary care clinicians and children’s mental health professionals face in providing behavioral and mental health services to children and adolescents, we hope to improve access, collaboration, and coordination for pediatric mental health care. The National Business Group on Health has endorsed this document.

## IMPORTANCE OF THE PRIMARY CARE SETTING

With the appropriate training and collaborative relationships, primary care clinicians can and should deliver mental health services to children and adolescents in the primary care setting. This setting is ideal for initiating services to children with emerging developmental and behavioral problems and common mental health disorders such as attention-deficit/hyperactivity disorder (ADHD), depression, anxiety disorders, and substance use. The primary care setting provides opportunities for early identification and intervention, counseling, guidance, care coordination, and chronic illness management. Primary pediatric mental health care is friendly to families and fully coordinated with the child’s other health care. Colocation of a child and adolescent psychiatrist and/or other mental health professionals in the primary care setting can further expand the range of provided services. Furthermore, enhancing access to outpatient mental health services reduces psychiatric hospitalizations and does not significantly increase the overall cost of mental health care.<sup>3,4</sup>

Children whose problems do not improve with initial intervention<sup>†</sup> and/or children with more severe degrees of impairment or complex coexisting conditions require mental health specialty consultation and, often, specialty treatment. The AACAP publication “When to Seek Referral or Consultation With a Child and Adolescent Psychiatrist”<sup>5</sup> details the parameters related to this referral process. A matrix of child and adolescent psychosocial interventions summarizes the evidence in support of evidence-based psychosocial interventions for common mental health disorders of children and adolescents.<sup>6</sup> Even after specialty referral or consultation, the primary care clinician plays

[www.pediatrics.org/cgi/doi/10.1542/peds.2009-0048](http://www.pediatrics.org/cgi/doi/10.1542/peds.2009-0048)

doi:10.1542/peds.2009-0048

### Abbreviations

AAP—American Academy of Pediatrics  
AACAP—American Academy of Child and Adolescent Psychiatry  
CPT—Current Procedural Terminology  
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\*The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 applies to group health plans providing mental health or substance abuse benefits and insuring 50 or more employees, whether the plans are self-funded (regulated under ERISA) or fully-insured (regulated under state law). However, the new law does not apply to individual health plans offered by businesses with 50 or fewer employees.

†The term “mental” throughout this position paper is intended to encompass behavioral, neurodevelopmental, psychiatric, psychological, emotional, and substance use issues. It also encompasses somatic manifestations of mental health issues, such as eating disorders and functional gastrointestinal symptoms. This is not to suggest that the full range or severity of all mental health problems falls within the scope of pediatric primary care practice but, rather, that children and adolescents may suffer from the full range and severity of mental health conditions.

a critical role in ongoing communication and comanagement to monitor the child's progress, support the child and family, and ensure coordination of care. The medical home can provide family-centered, coordinated, collaborative care that is multidirectional and addresses the child holistically, which is particularly critical for children with a complex constellation of needs.<sup>6</sup>

In some circumstances, such as a disaster or terrorist event, or residence in communities with high rates of posttraumatic stress disorder or high-risk inner city or rural areas, the need for mental health services may be far greater and the resources even less adequate than in other areas. For many, if not most, children affected by a critical event or those who reside in these communities, primary care clinicians will be the first and often only responders to children's mental health needs.

### UNDERLYING PRINCIPLES

The AAP and the AACAP endorse the following principles:

- Families and children need access to mental health screening and assessment and a full array of evidence-based therapeutic services to appropriately address mental health conditions.
  - The identification, initial assessment, and care of mental health problems ideally take place in the child's "medical home," where he or she will benefit from the strengths and skills of the primary care clinician in establishing rapport with the child and family, using the primary care clinician's unique opportunities to engage children and families in mental health care without stigma.
  - Primary care clinicians can be trained and equipped to recognize mental health problems, to manage common mental health problems, and/or to determine when mental health specialty care or referral is indicated.
  - To support primary care clinician involvement in mental health care, payment for assessment and treatment of mental health problems must be adequate and comparable with payment for services addressing other medical illnesses. Furthermore, payment must be proportionate to the complexity of the situation and the additional time and work required in managing mental health conditions.
  - Primary care clinicians and families must have continuous access to consultation and collaboration with child and adolescent psychiatrists and with other members of the mental health services system who are equipped to provide support to family members of all ages.
  - The consultation and collaboration process must be supported adequately through economically viable models recognizing the shortage of mental health professionals with pediatric expertise in many regions of the country and, specifically, of child and adolescent psychiatrists nationwide.
- Primary care clinicians must be recognized as a portal of entry to the specialty mental health system and an ongoing source of care and coordination for children and adolescents in the mental health specialty system.

### ISSUES AND SOLUTIONS

A number of barriers impede primary care clinicians' delivery of mental health services. These barriers include:

- insufficient payment for the range of mental health services provided by primary care clinicians to address the range of mental health problems encountered, including the identification and management of emerging problems or symptoms not rising to the level of a diagnosis;
- lack of payment to primary care clinicians and mental health professionals for visits with parents only (ie, when the patient is not physically present);
- lack of payment to primary care clinicians and mental health professionals for other non-face-to-face components of care and consultation (eg, contact between primary care clinician and psychiatrist, counselors, therapists, schools, and other involved agencies);
- lack of incentives for the establishment of multidisciplinary mental health treatment teams based in pediatric and psychiatric group practices, such as the application of "incident to"<sup>‡</sup> payment methodology to collocation of mental health professionals;
- inadequate communication and comanagement mechanisms among primary care clinicians, mental health professionals, school personnel, and others providing mental health services, family support, and/or case management;
- insurance plan policies that preclude payment to primary care clinicians when mental health diagnostic codes are reported or that limit access to mental health care in other ways (eg, lack of coverage for recommended assessment and treatment services, limited or no coverage for out-of-network providers [even when in-network providers are not able to see new clients], and high out-of-pocket expenses for certain medications);
- mental health intake procedures that bypass the primary care clinician, without requirements for communication between mental health professionals and primary care clinicians, without care coordination mechanisms, and, too often, without pediatric expertise among mental health providers<sup>§</sup>;
- administrative and financial barriers that limit access to effective psychosocial interventions; and

<sup>‡</sup>"Incident to" services are described as those services furnished by an allied health professional, employed under the same tax identification number as the supervising physician, to an established patient incident to the physician's professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home (see [www.cms.hhs.gov](http://www.cms.hhs.gov)).

<sup>§</sup>These issues may create barriers in both mental health "carve-outs" (separate panels of mental health care providers, accessed through a toll free number or other separate process outside the primary care system) and "carve-ins" (medical and mental health benefits combined in a single plan with a single entry point).

- lack of procedural and diagnostic parity in mental health and physical health benefits.

In addition, there are barriers to colocating child and adolescent psychiatrists and other mental health professionals in primary care settings. Physicians have a long-established pattern of extending access to their medical services through the employment of nurse practitioners and physician assistants in their offices to treat patients under a physician's supervision. Medicare pays for these services as if they are provided directly by the physician as long as they are provided according to Medicare "incident to" regulations. Private insurance companies and Medicaid agencies typically follow the same billing conventions for medical services but do not provide similar economic incentives for psychiatric services provided by psychiatric advanced-practice nurses, psychologists, and social workers employed in medical and psychiatric group-practice settings, even though they meet the same "incident to" standards. Without this incentive, there is no recognition that a psychologist or social worker employed by a child and adolescent psychiatrist or primary care clinician and working in the same office suite delivers team-based care that improves access to care and increases the complexity of service.

## RECOMMENDATIONS

The following are recommendations to insurance purchasers, payers, and managed behavioral health organizations. They address a set of key impediments that primary care and specialty clinicians encounter when providing mental health services to children and adolescents in the primary care setting. We believe these recommendations support the underlying principles listed above and call for specific corrective actions.

1. Allow primary care clinicians to provide and authorize services for common mental health conditions of childhood and adolescence.
2. Compensate primary care clinicians for the mental health services they provide, including steps in the assessment and engagement process preceding a definitive diagnosis.
3. Promptly implement procedures to fully support parity in benefits packages, eliminating separate deductibles, high copays, and annual spending limits lower than those established for medical services.
4. Support the principle of diagnostic parity. Mental health disorders result in distress and functional impairment just as medical illnesses do.
5. Support the principle of procedural parity, paying similar rates for similar services. For example, children's mental health professionals as well as primary care clinicians should be paid appropriately when reporting evaluation and management Current Procedural Terminology<sup>7</sup> (CPT) codes.
6. Remove disincentives for appropriate and accurate diagnostic coding by allowing primary care clinicians to be paid for services on reported mental health diagnostic codes.
7. Support the emerging use of standardized tools by paying for mental health screening at routine medical visits and paying for the administration, scoring, and interpretation of standardized mental health-assessment instruments.
8. Recognize circumstances such as treatment-planning and treatment-team meetings, in which the most appropriate service delivery does not include the patient or, at times, even family members. In these situations, there should be payment for primary care clinicians, child and adolescent psychiatrists, and other mental health professionals for time spent in consultation. These would be recorded with medical team conference codes (99366–99368).
9. Support payment for primary care clinicians, child and adolescent psychiatrists, and mental health professionals for sessions with parents without the patient present. This is best accomplished by paying for evaluation and management CPT codes, including those for non-face-to-face services.
10. Restructure mental health plans to include primary care clinicians in mental health networks and ensure coordination of mental health specialty care with the primary care clinician through ongoing communication, exchange of information, and co-management.
11. Support colocation models of mental health professionals working within medical settings by applying Medicare "incident to" payment regulations to mental health services rendered in pediatric primary care and child and adolescent psychiatry practices.
12. Support payment for evidence-based psychosocial interventions as well as psychopharmacologic therapy.
13. Support payment for non-face-to-face aspects of care, such as communication with community providers including early education and child care professionals, teachers, social workers, therapists, and case managers, and other nonclinical aspects of caring for children with mental health problems (eg, care-plan oversight, health-risk assessment). There should also be financial support for coordination (CPT codes 99339–99340).
14. Enhance coordination between the primary care clinician and other treating providers by encouraging the development and use of systems such as inter-professional electronic communications, including telemedicine, that are an integral part of emerging care processes.
15. Develop a risk-adjustment system that takes into account the complexity of the child's needs.

## CONCLUSIONS

Primary care clinicians have unique strengths, skills, and opportunities to identify and address the unmet mental health needs of children and adolescents; however, many administrative and financial barriers currently prevent them from fulfilling their potential. By collabora-

rating with primary care clinicians, child and adolescent psychiatrists, and other mental health professionals, as well as professionals associated with schools, public agencies, and community organizations, to implement the recommendations put forward in this paper, insurance purchasers, payers, and managed behavioral health organizations can increase access to behavioral and mental health services for children and adolescents in a cost-effective and clinically significant manner.

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#### **ACKNOWLEDGMENTS**

This paper was developed with guidance from members of the AAP Task Force on Mental Health and the AACAP Committee on Health Care Access and Economics. This paper was supported by Improving Mental Health in Primary Care Through Access, Collaboration, and Training (IMPACT) grant G95MC05434, which was awarded to the AAP in 2005 from the US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.

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DOI: 10.1542/peds.2009-0048

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