Sustaining Integrated Behavioral Health Practice Without Sacrificing the Continuum of Care

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This article describes how an innovative model of practice transformation, used by 4 integrated pediatric primary care practices over a 2 year grant period, promoted the practice of integrated primary care (IPC) behavioral health services. Practice transformation was possible through the implementation of an alternative billing strategy to enhance sustainability, effective utilization of clinical productivity to provide meaningful patient services, and the identification of strategies to further the practice of IPC. Specifically, we provide: (a) a description of the diversity of billing strategies typically used by pediatric practices utilizing integrated care and how those strategies are impacted by state health care policies; (b) a description of the grant, including the service delivery model, implementation phase, and data collection procedures; (c) results of implementation and billing/reimbursement data that were collected across the 4 practices; (d) an analysis of how billing strategies are critical in defining implementation strategies within pediatric integrated care; and (e) lessons learned about how billing strategies must be flexible and amenable to change over time to stay current with ever-changing health care policies and reimbursement models.

Implications for Impact Statement
This article describes how an innovative model of practice transformation, used by 4 integrated pediatric primary care practices over a 2 year grant period, promoted the practice of integrated behavioral health services in primary care. We provide lessons learned about financing primary care using innovative billing strategies beyond the use mental health diagnoses and billing codes, which enable psychologists to focus more on preventative and health behavior change services.

Keywords: integrated primary care, pediatric primary care, billing reimbursement

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The World Health Organization ranks the United States 37th in the world in health care quality, although health care costs are between $2.8 and $2.9 trillion annually, accounting for approximately 18% of the Gross Domestic Product (Moses et al., 2013). Various initiatives...
have sought to address this disparity between the level of spending and quality outcomes. Central to these efforts is the Patient-Centered Medical Home (PCMH), which endeavors to control health care costs and ensure quality through a variety of attributes (Agency for Health Care Research and Quality, n.d.).

Integrating psychologists into primary care settings helps to fulfill the goals of the PCMH by addressing the behavioral aspects of health (Kazak, Nash, Hiroto, & Kaslow, 2017). Integrated primary care (IPC) psychologists are positioned to play a vital role in advancing the Quadruple Aim (i.e., enhancing patient experiences, promoting population health, improving provider satisfaction, and reducing the per capita cost of care), which guides the objectives of the PCMH (Berwick, Nolan, & Whittington, 2008). Psychologists in IPC can reduce costs by addressing behavioral health problems, engaging in program development and evaluation, and using validated tools to assess the impact of these efforts on cost (Miller et al., 2017). Although pediatric patients comprise a relatively small percentage of total health care costs relative to adult patients, effective health care for children can result in substantial cost savings over a lifetime (Stancin & Perrin, 2014). Furthermore, meta-analyses within pediatric PCMHs provide evidence for the role of IPC psychologists to effectively intervene around a myriad of developmental and behavioral concerns, which enhance family centered care and reduce future costs of managing untreated behavioral health concerns (Asarnow, Rozenman, Wiblin, & Zeltzer, 2015).

**Challenges to Reimbursement**

While a biopsychosocial approach underlies the PCMH model, the traditional biomedical model has contributed to a mind-body dualism represented in separate medical and mental health care systems, with “carve outs” for mental health care (McDaniel & deGruy, 2014). The mental health carve out system has been essential to ensuring individuals with severe and chronic mental health conditions have access to services, yet this structural divide creates barriers for reimbursement of services for mild to moderate mental health concerns in IPC. The fundamental lack of fit between models for coding and reimbursement for the delivery of behavioral versus physical health care creates challenges for the reimbursement of health and behavior codes (Kessler, 2008). Furthermore, fee-for-service (FFS) models provide no tangible value for the ways that psychologists enhance the PCMH; no support is provided for reimbursable activities that improve care and control costs, such as team-based consultation, program development, and program evaluation (Kessler, Stafford, & Messier, 2009).

Fragmentation of clinical services and payment threaten the sustainability of psychologists working in PCMHs (Miller et al., 2017). Siloing medical and behavioral health providers throughout training, education, and practice reinforces health care fragmentation. The contrast between traditional scheduling patterns of primary care providers (i.e., 15 min encounters) and behavioral health providers (i.e., 45–50 min encounters) create differences in how care is structured and can create barriers for clinic flow and cycle times. The aforementioned system of payment fragmentation, coupled with the traditional FFS model, have curtailed opportunities for integrating psychologists in PCMHs and focusing on comprehensive, coordinated, outcomes-based efforts to improve health care quality and cost. Some state-level policies create additional barriers, such as limiting same-day billing for medical and behavioral health services, tasking one behavioral health agency with providing all Medicaid mental health services, and creating complicated independent claims adjudication processes (Miller, Talen, & Patel, 2013). Similarly, commercial insurers have separate companies that manage behavioral health benefits, posing challenges for integrated PCMHs (Kathol, Butler, McAlpine, & Kane, 2010).

**Navigating Reimbursement Challenges**

As the broader health care landscape and alternative payment models are re-examined, exploring fiscal solubility of IPC within the current FFS payment model is necessary. Many IPC programs start with grant funding and struggle to determine how to finance themselves at the end of the grant period (Kathol et al., 2010). This threatens not only service provision but also the ability to create a training pipeline for future IPC psychologists (Beacham et al., 2017).
Research focused on the value added by integrating psychologists in PCMHs can aid in the navigation of these reimbursement challenges (see Miller et al., 2017). Although this research has demonstrated increased primary care utilization, reduced emergency care utilization, reduced hospitalizations, and reduced health care costs, most of this research focuses on addressing the complex mental health needs of adult patients (e.g., Kathol et al., 2010). Limited research explores the impact of providing financial resources for these types of activities and pay-for-performance methods to support traditionally nonbillable activities and other initiatives such as practice redesign, capacity building, and ongoing consultation activities to ensure sustainability (Miller et al., 2013, 2017), particularly for pediatric populations.

Financing pediatric IPC presents unique challenges. The scope of pediatric primary care is generally broader than adult primary care, with a greater emphasis on the prevention, early identification, and early intervention of developmental and behavioral concerns (Stancin & Perrin, 2014). Because pediatric primary care is a central port of entry to discuss parents’ concerns about their children’s development and behavior, IPC psychologists play a crucial role in elevating the skillset of pediatric primary care providers, although these training efforts constitute nonbillable services (Stancin & Perrin, 2014). Behavioral health visits conducted by pediatricians typically last 2.5 times as long as medical only visits and are typically reimbursed at lower rates than medical visits (Meadows, Valleley, Haack, Thorson, & Evans, 2011). To identify economic costs and benefits of IPC, an increased focus on the cost offset of integrating a psychologist in pediatric primary care is recommended (e.g., Hoffses et al., 2016).

Of the few studies to examine this cost offset, most of the focus on cost savings is related to the triage and/or treatment of mental health concerns in primary care (e.g., Rozensky & Janicke, 2012). Preliminary information regarding behavioral health productivity and billing in pediatric IPC reflect the nature of service provision within these models. Using a retrospective chart review, Cederna-Meko, Ellens, Burrell, Perry, and Rafiq (2016) reported that their integrated psychologists spent approximately 35% of their time in direct patient care and billed an average rate of $80.48 per hour. Most services focused on diagnosable mental health concerns and were billed using traditional behavioral health codes. However, no reimbursement data were available and underutilization of integrated services was a concern cited by the authors. Furthermore, they emphasize the integrated psychologists’ role in value-added, non-billable services but lacked data to characterize these activities.

Limited information is available regarding economic evaluations of pediatric IPC for settings that provide a continuum of services and that were not billed to the carved-out, specialty mental health system. In a descriptive analysis of a pediatric IPC model that emphasizes health promotion, prevention, and early intervention, the majority of consultations occurred in the context of routine well visits and were not eligible for billing under FFS or mental health carve outs, as the level of concern did not meet the diagnostic threshold (Talmi, Buchholz, & Muther, 2016a).

Present Study

This article describes one component of a project that explored IPC in nonacademic settings, wherein a model of IPC was disseminated and implemented in four community-based, private, pediatric primary care practices with careful program development and tailoring to the unique needs of each practice and their service populations. We explore the economic viability and financial sustainability of this model within community-based settings by analyzing how the implementation of an alternative billing strategy using physician extender and counseling codes impacted the practice of IPC behavioral health services. These codes were utilized for the following reasons: many of the services were preventative in nature or delivered to children with subdiagnostic thresholds of clinical impairment, services were provided based upon the recommendation of the medical provider and were, thus, rendered under the direction of that provider, and fellows were providing the services and were not eligible for empanelment with the mental health carve out. Specifically, this study explores: (a) the types of IPC services provided; (b) psychology fellows’ (herein, “fellows”) productivity; and (c) behavioral health billing and reimbursement data.
Method

Integrated Primary Care Settings

Setting and location: CLIMB overview. Project CLIMB (Consultation Liaison In Mental Health and Behavior), is an integrated mental health services program located in a residency training clinic at an urban, pediatric children’s hospital affiliated with an academic medical center (Talmi et al., 2016b). The clinic serves a predominantly publicly insured, ethnically diverse population that includes a large population of monolingual Spanish-speaking families and families with refugee status (Becker Herbst, Margolis, Herndon, McClellan, & Talmi, 2015; Herbst et al., 2016). CLIMB provides behavioral, developmental, and mental health consultations to children and families seen in the clinic and trains and educates pediatric primary care professionals in addressing child and adolescent behavioral health concerns during routine and acute care visits. The team comprises IPC psychologists, child and adolescent psychiatrists, master’s level clinicians, and psychology trainees at the extern, predoctoral intern, and postdoctoral fellowship levels.

CLIMB to Community overview. Drawing from core principles of the CLIMB model, grant funding was used to implement a pilot program of integrated behavioral health services in four community-based, private pediatric practices serving a substantial population of publicly insured children. The goals of this pilot project were to: (a) examine pediatric IPC needs in community-based practices, and (b) study financial sustainability as it relates to billable services and reimbursement rates. Over the course of the pilot study, four postdoctoral level psychology fellows provided IPC psychology services. Each fellow provided services in one pediatric primary care clinic, serving as a behavioral health clinician three half days per week (0.30 FTE) for 1 year. The pilot was conducted over the course of 2 years (September 2013 through August, 2015), with two fellows providing integrated services to separate pediatric practices each year. The practices represented a diverse payor mix with similar rates of Medicaid patients (at least 50%; refer to Becker Herbst et al., 2015 for practice descriptions). Each fellow developed, implemented, and evaluated the dissemination of fully integrated services into each clinic, tailoring IPC services to meet clinic-specific needs.

Participants

Data were collected regarding demographics, services provided, and billing reimbursement for all patients who received IPC services. This study was approved by the Organizational Research Risk and QI Review Panel. Table 1 provides the demographic information for study participants.

Data Collection and Analysis

An integral component of this work included collecting program development and evaluation data through clinical informatics and medical record abstraction. Each practice had a different electronic medical record system and grant resources did not include technological support for building data collection templates and data abstraction. The fellows manually entered de-identified data for each visit into an encrypted Survey Monkey database over secure servers. Information collected and entered at each visit included patient demographics, diagnoses, consultation types, presenting problems, recommendations, screening measure outcomes, and billing codes. Data were then exported into encrypted Excel and SPSS databases for analysis.

Data were analyzed using SPSS Version 23. Data were presented quarterly to the four practices to provide formative feedback regarding program development and evaluation. Aggregated data were shared with stakeholders to inform advocacy and policy efforts.

Outcome Variables

In addition to demographic, presenting problem, diagnosis, and recommendation data, we collected data on productivity, billing practices, and reimbursement. We calculated productivity outcomes by recording the amount of time spent in each visit then classifying consultation time as billable or nonbillable. Billing practice outcomes were examined by reviewing billing codes utilized. CPT Evaluation and Management codes for new and established patient visits were used as physician extender codes for specific concerns addressed during well visits and depend upon the amount of time spent with the patient and intensity of concerns addressed.
Evaluation and Management codes differ based on the classification of patient history and examination (detailed, comprehensive, problem-focused, or expanded), the complexity of medical decision making required (low, moderate, or straightforward), and the severity of presenting problems (self-limited/minor, low, moderate, or high; American Medical Association, 2008).

Physician extender codes were utilized for these visits for a number of reasons, including the following: (a) the primary reasons for these visits were related to concerns that were raised in addition to what is typical for a well visit and therefore extended the visit based upon concerns identified by the medical provider, (b) many of the concerns raised did not meet the threshold to be considered solely a mental health visit, and (c) fellows were not eligible for empanelment with payor sources and needed to document visits under the supervision of another provider. Physician extender codes require that a medical visit be completed by the medical provider and that the issues addressed by the fellow be related to concerns raised during the medical exam. This billing strategy allowed the practices to provide more preventive services than what could be offered under traditional mental health codes or health and behavior codes. Counseling codes were used during acute and follow-up visits to address specific concerns with greater than 50% of the time spent directly on counseling the patient or family. Counseling codes are typically used to provide preventative counseling for a concern that is raised during or as part of a medical visit and are coded by time spent with the patient (American Medical Association, 2008). Using this billing strategy allowed the service provider to bill for the visit time spent above and beyond the typical time allotted for the service provided. It is important to note that policy related to billing and coding changes frequently and differs from state to state.

Reimbursement outcomes were studied by examining gross reimbursement amounts for each billed code for visits with an IPC service, adjusted claims, and encounters that were not

### Table 1

<table>
<thead>
<tr>
<th>Demographics</th>
<th>All practices (n = 1031)</th>
<th>Practice A (n = 274)</th>
<th>Practice B (n = 237)</th>
<th>Practice C (n = 273)</th>
<th>Practice D (n = 246)</th>
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<td>Mean age in years (SD)</td>
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<td>White 455 (44.2%) 104 (38%) 82 (34.6%) 130 (47.6%) 139 (56.5%)</td>
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<td>Unrecorded 53 (5.1%) 10 (3.6%) 23 (9.7%) 19 (7%) 1 (4.4%)</td>
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<td>Not Hispanic 596 (57.9%) 173 (63.1%) 54 (22.8%) 214 (78.4%) 155 (63%)</td>
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<td>Unrecorded 49 (4.8%) 9 (3.3%) 21 (8.9%) 16 (5.9%) 3 (1.2%)</td>
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<td>Spanish 107 (10.4%) 30 (10.9%) 73 (31.1%) 0 (0%) 4 (1.6%)</td>
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<td>Private 296 (28.9%) 86 (31.6%) 26 (11%) 104 (38.2%) 80 (32.8%)</td>
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<td>Dual 5 (.5%) 0 (0%) 1 (.4%) 0 (0%) 4 (1.6%)</td>
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**Note.** CLIMB = Consultation Liaison In Mental Health and Behavior; IPAT = Integrated Practice Assessment Tool.
billed. Because the majority of patients were publicly insured and, therefore, had no patient responsibility for a portion of the visits, amounts for patient responsibility, such as copays and deductibles, were not factored into reimbursement totals. Consistency of reimbursement refers to the frequency with which billed claims were paid by insurers. Reimbursement rates refer to the 2015 dollar amount paid by insurers.

Finally, information regarding practice level of integration in the middle of the pilot, after substantial program development and establishment of preliminary practice, was gathered using the Integrated Practice Assessment Tool (IPAT; Waxmonskey, Auxier, Wise Romero, & Heath, 2014). The IPAT is a self-administered questionnaire completed by staff to identify the level of integration on a 6-point scale ranging from minimal collaboration (1), basic collaboration (2), basic onsite collaboration (3), close onsite collaboration with some systems integration (4), collaboration approaching integration (5), and to full collaboration within an integrated practice (6).

Results

Demographics

Across the four practices, the majority of patients were publicly insured (69%), male (55%), non-Hispanic (58%), White (44%), and primarily English-speaking (83%). The mean patient age was 8.81 years (SD = 5.22).

Characterizing IPC Services

Table 1 provides information regarding midyear IPAT scores. The services provided at Practices A, B, and C were at Level 5, indicating close collaboration approaching an integrated practice. Practice D (Level 4) indicated close collaboration onsite with some systems integration.

The most common primary presenting problems were mental health (70.0%), developmental (12.2%), and medical concerns (7.4%). The most prevalent primary diagnoses were family circumstances (19.3%; family circumstances refers to psychosocial concerns experienced among the family that impact the patient’s behavioral health, such as divorce or recent immigration), behavior problems (17.7%), and well visit enhanced anticipatory guidance (11.6%). The most common primary recommendations were discussion of developmental or behavioral concerns (42.9%), outside mental health referral (30.9%), and providing developmental or behavioral health resources (4.0%).

Billing and Reimbursement

A total of 629 claims were billed for fellows’ services across the four practices. Of these claims, reimbursement data were unavailable for 122 (19%) because their reimbursement status was still pending with insurance carriers when data were extracted. The total available revenue generated by the four fellows (at .3 FTE for 1 year each) over the 2 year grant period for the remaining 507 visits was 2015 USD $29,157.26. The average reimbursement rate was 2015 USD $46.35 per visit. One billing code was used by the fellow per visit and corresponded to the amount of time spent with the patient and/or their family. Reimbursement for claims from insurers was consistent; of the 507 visits assessed, only 38 claims (6%) were denied by the insurance carriers. No data regarding reason for denial were available at the time of this study.

Table 2 presents detailed information about the frequency of claims billed, and the total and average reimbursement per CPT code. The top three most frequently billed codes were Counseling codes, which differ based on the amount of time spent with the patient. Preventive medicine counseling (30 min, billing code 99,402) was used most frequently, accounting for 203 claims (32%), code 99,403 (45 min) was the next most frequent, accounting for 119 claims (19%) of billing claims, and 99,404 (60 min) was used the third most frequent at 86 claims (14%). The three least frequently billed codes were Evaluation and Management codes for new patients and were used for less than 1% of claims. The Supplemental Table online provides examples of the variety of codes that were billed with corresponding presenting problems, visit type and length, intervention and recommendations provided, ICD-9 diagnostic code, and reimbursement amount.

In addition to billed IPC services, the fellows provided a number of services that were not billable. These included case management (i.e., phone calls, care coordination, and documenta-
tion), provider consultations (e.g., fellows helped to inform patient care without directly seeing the patient), and a small proportion of well visits (e.g., fellows provided a service that the practice did not feel comfortable billing because the service fell within the scope of standard anticipatory guidance). For example, telephone consultations accounted for 14.6% of the non-billable clinical contact. Additionally, while 70 of direct patient visits (10%) were not billed, the majority of services (629; 90%) provided during well visits were billed.

Understanding Productivity

The average proportion of fellow time spent in billable activities was 28%. At 0.30 FTE, we estimated that each fellow worked 12 hr per week for approximately 44 weeks over the course of a year, totaling approximately 2,112 hr of service across the entire project period. Of these hours, 591 (28%) were direct service hours. Based on the total amount collected over the project (2015 USD $29,157.26), fellows recovered approximately $49.34 per hour in reimbursement for billable
services rendered. This hourly estimated rate of reimbursement differs from the calculated average reimbursement rate per billable visit ($29,157.26 total revenue/507 billable claims = $46.35) because billable visits varied in time duration and did not typically last a full hour. This figure includes some claims that were not paid.

Discussion

As discourse regarding the value added of IPC services has evolved, the literature has begun to focus on the sustainability of pediatric IPC models (Cederna-Meko et al., 2016; Stan cin & Perrin, 2014). This article extends our understanding of IPC solubility by characterizing the wide range of integrated behavioral health services provided in pediatric primary care, detailing IPC activities and productivity, and analyzing billing and reimbursement data. During initial implementation of an integrated care model within four community-based pediatric primary care practices serving diverse and majority publicly insured patients, the most frequent services provided were to patients with established mental health concerns followed by patients with developmental concerns. The most frequent diagnoses associated with IPC visits (family circumstances, behavioral concerns, and well visits) represent issues often unique to pediatric primary care that do not likely rise to the threshold of diagnosis-driven FFS mental health care, leaving behavioral health providers without billing options for these visits—especially from within the traditional mental health carve out system. A significant portion of IPC time was spent engaging in nonbillable patient care efforts including case management, provider consultation, and well-child health and development promotion. Gathering data on time spent in nonbillable activities as well as reason for denial of certain services was beyond the scope of this study; however, these data are important for future research and advocacy.

Despite these challenges and across more than 600 visits and 591 direct service hours, an innovative, primary care practice-driven billing strategy resulted in revenue collection of more than 2015 USD $29,000 for integrated behavioral health services that were provided in primary care. Taking into account an average 28% billable productivity level (that was low because of more nonbillable activities necessary for program development) the calculated hourly reimbursement for direct services provides evidence to support sustainability of the direct service component of IPC through this model. More important, productivity analyses indicated that direct clinical service increased to approximately 42% in the third and fourth quarters of first year in a practice, likely because program development, workflow implementation, data collection, and evaluation activities became less focal and the practices learned how to more effectively utilize and bill for the services provided by the fellows. At this level of productivity, which translates to 887 billable service hours, fellows could generate nearly 2015 USD $44,000 annually, which would cover 64% of the costs for IPC personnel. Increasing clinical productivity to between 60 and 65% would have generated enough revenue to cover salary and benefits of IPC personnel.

These data also illuminate important considerations for practices interested in IPC with respect to the productivity requirements and policy changes necessary to sustain this type of practice. In fact, the data about productivity and billing/reimbursement that was gathered during the grant period showed an increase in billable time spent in the second half of the first year of implementation. Based on revenue generated for clinical activities and on successful program uptake, all four practices decided to invest in the hiring of the fellow after the grant period ended, although the employment and billing structure for each fellow differed.

Sustainability: Challenges and Possible Solutions

An understanding of payment models provides important context for payment reform discourse. The U.S. health care system has traditionally utilized a FFS model for reimbursement of rendered services. The FFS structure incentivizes providers to deliver more direct patient care, supporting volume instead of value. This model often excludes services such as health behavior change interventions, prevention and early identification, consultation, and care coordination from reimbursement, instead driving psychologists to only bill for patients with diagnosable mental health conditions that are seen face-to-face (Miller et al., 2017).
We successfully used a billing strategy and were reimbursed for most direct clinical services. However, our project continued to identify challenges in billing for prevention and health promotion activities and in adjusting schedules to maximize fellow availability to patients and providers. Barriers to integration in two of the practices included limitations in billing for well visits and access to traditional mental health CPT codes. These codes offer higher reimbursement for colocated care, resulting in reduced consultations during well visits and a significant reduction in same-day consultations and provider consultation capacity. Additionally, many states are still working to identify appropriate billing codes for services provided in IPC.

Further billing challenges included changes in personnel that resulted in coding inconsistencies, the lack of preventative care codes within the billing system, and decreased capacity for expanded practice across the continuum of integrated practice given inadequate reimbursement rates and payment structures. Unfortunately, even in a grant-funded project, the drive to increase billable services led to a more restricted practice for the fellows because the majority of consultations involved children with significant enough mental health and behavioral concerns to meet criteria for outpatient mental health treatment rather than for children with mild to moderate behavioral health concerns, which could be best addressed within the practice. However, just because these children likely met criteria for outpatient mental health did not mean that diagnosis-driven services billable under specialty mental health codes were provided through the IPC model; rather, behavioral health consultation determined whether a specialty mental health evaluation was indicated and if the patient would likely qualify for these services.

Additionally, Colorado has continued to discuss the lack of financially sustainable billing strategies for IPC services despite state- and national-level influences pushing for integration of medical and mental health services as well as value-based health care. Some of the Medicaid mental health carve out services have now offered an enhanced payment rate to further explore financial sustainability. Under this billing strategy, psychologists are able to request a set billing rate per encounter that is higher than traditional billing rates and psychologists can offer services without some of the constraints of traditional psychotherapy billing. For example, psychologists are able to utilize prevention codes or H codes that do not require a billable diagnosis, formalized treatment plans, or prior authorization. This allows psychologists to better provide warm handoffs in clinic and other brief preventative services with increased likelihood that these services will be reimbursed at a rate that either approaches or reaches financial sustainability. Psychologists are also able to provide brief therapy services utilizing traditional therapy codes, but these therapy services must not exceed six visits within a 6 month timeframe.

Billing codes and reimbursement policies for psychologists providing IPC services vary across states. State offices (e.g., the Colorado Health Care Policy and Finance) are responsible for identifying which billing codes are open, the minimum documentation requirements, policies for using the codes, and reimbursement rates of these codes. Psychologists can obtain additional information from the credentialing departments of insurance carriers and the American Academy of Pediatrics’ coding newsletter (American Academy of Pediatrics, 2017).

These examples illustrate promising efforts made by specialty mental health systems and the FFS physical health system to work together and support systems of care that meet evolving patient needs and best practices. While the work described in this study provides an alternative to specialty mental health billing, we believe it complements the mental health carve out system to provide care for patients with preventative care, health and behavior, mild to moderate severity, and family system needs that may be more comprehensively addressed within either a physical health or an integrated physical and mental health service system.

**Practice Transformation**

At the practice level, operational and procedural changes were uniquely adapted and implemented across all four practices to enable efficient and comprehensive utilization of integrated behavioral health services. In addition to changes in workflow and direct service, business operations, billing and reimbursement, data collection, and engagement with system-level efforts around behavioral health integration were
apparent. Transformation also occurred in health care provider capacity to address mental health, behavioral, and developmental issues as a result of having IPC fellows available for consultation and collaboration. Calculating the benefit of transforming provider practice is challenging as the benefits are realized across all patients and not restricted to those seen by IPC fellows. Overall, providing comprehensive care to children and families fundamentally transformed the practices’ understanding of a medical home.

**Lessons Learned**

The work of integration extends far beyond simply embedding a mental health clinician into a primary care practice. It involves significant investment in becoming familiar with the practice, pediatric health professionals, and patient populations. Implementing integrated behavioral health services in community-based practices requires individualized development of services, workflows, and structures within the parameters of integrated practice. Training, support, and technical assistance are vital to successfully launching, implementing, and maintaining this type of practice. Additional time and attention must be paid to understanding the system of care (e.g., resources and referrals) available within the community to help address child and family needs.

When new practices are being cultivated and integrated and behavioral health services are being established, program development, initial implementation, data collection, evaluation, and iterative practice transformation require significant investment that is not recoverable through direct service billing. Initial productivity levels are by necessity lower; as the program becomes more established and workflows and practice guidelines are operationalized, increased productivity can be realized. Considerable nonbillable effort is required to secure funding and oversee implementation of integrated behavioral health services in community-based settings; the current health care landscape does not account for or fund these efforts.

**Policy and Systems Implications**

Policy regarding IPC service provision continually changes. At the time of the pilot program, many payor sources did not provide clear billing and coding recommendations. As a result, practices interested in IPC initially piloted their initiatives for practice transformation through grants or in-kind funding. Some practices utilized physician extender codes to obtain reimbursement for IPC services when behavioral health providers were either not credentialed or could not become credentialed with payor sources. Since the time of data collection for the pilot program, billing options have continued to change in the state of Colorado and nationally. Payor sources have shifted and now recommend or require psychologists to obtain credentialing to bill for services using billing codes that are allowable based upon contracting. However, this process is often expensive, cumbersome, and time consuming, as each payor maintains a different empanelment process and it may take months for applications to be processed. Some insurance payors with full panels now offer an option to disclose that services are being provided in IPC settings to allow psychologists to remain empaneled in a more streamlined process.

Private insurance payors do not reimburse for prevention codes, but do sometimes reimburse for health and behavior codes that are not reimbursed by Medicaid mental health carve outs. Traditional psychotherapy codes may also be used with private payor sources. However, psychologists in IPC contracting with a private payor may require prior authorizations, payment of a second copay, or payment toward the insurance deductible. These additional costs associated with accessing IPC services may create a treatment barrier for families who cannot afford to pay for an unanticipated recommendation for IPC services during a medical visit.

**Conclusions**

Implementing integrated behavioral health services for pediatric populations seen in primary care is a challenging endeavor that requires relationship cultivation, technical assistance and support, program development, and implementation guidance. These key components of initial implementation are costly, which may explain why practices do not dedicate resources such as program development and administrative time, to their integrated clinicians. However, as illustrated in this study, it is essential for pediatric psychologists to have protected time dedicated to program development, evalu-
Developing sustainable integrated behavioral health services is difficult, particularly in light of an evolving health care system where the vast majority of mental health services are FFS while primary care payment reform allows for bundled payments and is beginning to incentivize value over volume. Our efforts demonstrate the feasibility of providing integrated behavioral health services in community-based private practices, characterizing the services, billing for them, and tracking revenue that is generated. Although current health care policy and practices create barriers to accessing integrated care for some of the highest need and vulnerable patients who are most in need of mental health services and least likely to access them outside of primary care, innovative practices such as the one described in this article help mitigate the barriers. It is imperative that psychologists continue to advocate for health care policy and systems change that will enable them to provide comprehensive prevention, early intervention, and health behavior change services in IPC.

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