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# ****I. PURPOSE****

The purpose of this document is to outline operational responsibilities for [health plan name] to facilitate behavioral health integration in primary care, establish a process to reimburse providers for mental health services integrated with primary care, aligning with the organizational goals of enhancing patient experience, improving population health, reducing costs and supporting network providers. This policy assists health plans with compliance with California Health & Safety Code § 1374.725.[[1]](#endnote-1) [[2]](#endnote-2)

# ****II. DEFINITIONS****

A. Behavioral Health Integration (BHI)

Behavioral health integration (BHI) is the systematic coordination of primary and behavioral health care, focusing on merging mental health, substance use and primary care services to improve patient outcomes.[[3]](#endnote-3) Two BHI models primarily adopted are the Collaborative Care Model (CoCM) and the Primary Care Behavioral Health (PCBH) model.[[4]](#endnote-4)

B. BHI Models & Payment

* The **Primary Care Behavioral Health (PCBH)** model has licensed behavioral health professionals, such as a psychologist, as a behavioral health consultant (BHC) and core member of the primary care team. The BHC provider bills for services independently.
* The **Collaborative Care Model (CoCM)** provides structured care management for patients with behavioral health conditions, usually mild-to-moderate depression. Under the CoCM payment model, services are typically provided by a team consisting of a primary care physician (billing provider), a behavioral health care manager (billing “incident to” the primary care provider) and a psychiatric consultant.

Both models use different ICD and CPT codes, which also include different requirements in billing providers and locations.[[5]](#endnote-5)

# ****III. Department Responsibilities for Behavioral Health Integration (BHI)****

1. Credentialing:Credentialing processes for both medical and behavioral health providers must adhere to current standards and regulations for providers implementing behavioral health integration, including PCBH and CoCM.

* **BHI Credentialing in PCBH:** For a new PCBH program, credentialing licensed behavioral health providers integrated within primary care involves submitting separate applications to both health plan name and behavioral health partner (Managed Behavioral Health Organization name or internal department name). Providers must use a data portal, such as the Council for Affordable Quality Healthcare (CAQH), to submit individual applications to each primary health plan.
* **BHI Credentialing in CoCM:** In a Collaborative Care Model (CoCM) program, if CoCM CPT codes are categorized under the medical Division of Financial Responsibility (DOFR), credentialing is generally not necessary for existing medical providers. However, if these codes fall under behavioral health benefits, credentialing may be required.

**Responsibilities:**

* Incorporate behavioral health providers into current credentialing workflows:
  + Provide detailed guidance as to approach for associate-level roles (e.g., ASW, APCC, AMFT, RPA), specifying whether they are eligible to independently credential and bill, must bill under a licensed clinician, or are not eligible for credentialing and billing
  + Communicate expected credentialing timeline to providers (e.g., up to 60 days after completion of credentialing application)
  + Upon receipt, notify applicants within 7 days if complete
* Ensure credentialing behavioral health process is documented, with plan role (including contact information) provided for questions
* Ensure providers know these pathways and have support resources available for questions (e.g., to check status, etc.)
* Monitor internal average credentialing time cycle for behavioral health; identify roadblocks and brainstorm solutions to ensure compliance with the 60-day cycle required by California law (Health & Safety Code § 1374.197)
* Track (Managed Behavioral Health Organization name or internal department name) credentialing timelines and proportion of applications approved

1. Billing & Claims: **BHI may necessitate billing under both medical and behavioral health benefits. Having a process for paying for integrated services is a component of the SB 1320 requirements.**
   1. **Billing in PCBH: In the Primary Care Behavioral Health (PCBH) model, claims are often submitted through behavioral health benefits. Claims and reimbursements are handled by** Managed Behavioral Health Organization name/BH department or internal department name.
   2. **Billing in CoCM: In the Collaborative Care Model (CoCM), claims are generally submitted through medical health benefits. Depending on the health plan, reimbursement may follow a fee-for-service structure or be included under a capitated contract.**

**Responsibilities**

* Identify specific role(s) (with contact information) for technical issues and escalation in the event BHI claims are rejected or denied internally or by a Managed Behavioral Health Organization name/BH department
* Ensure Explanation of Benefits includes information on how the claim can be appealed
* Document and provide BHI billing guidance to both internal operations and network providers, including billing codes accepted, documentation required, and costs expected based on claims
* Ensure claims and/or clearinghouse systems are equipped to accommodate BHI-specific billing codes
* Ensure parity in reimbursement rates and processing times between medical and behavioral health claims
* Remove requirement for pre-authorization or chart reviews to approve coverage for CoCM-related services

1. **Provider Relations: Provider relations teams should be able to support network providers around BHI implementation, credentialing, billing, and reimbursement processes.**

**Responsibilities**

* Invest in internal training and education so provider support teams can engage with providers about interest in BHI and value to patients as well as the practice/organization
* Identify specific role(s) (with contact information) to support providers/organizations with BHI
* Provide training and education to support providers to submit BHI claims, and necessary data system changes (e.g., electronic health records) and follow the correct credentialing path
* Educate providers about integration options if not yet integrated through “BHI Provider Implementation Guide” resource

1. Medical/Behavioral Health Collaboration:Medical/behavioral health payers should collaborate to ensure alignment with Behavioral Health Integration (BHI) goals and achieving seamless integration of behavioral health services within the broader healthcare system.

**Responsibilities**

* Ensure regular meetings between the medical department and Managed Behavioral Health Organization name/BH department
* Ensure identification of which plan/department will be responsible for reimbursement of the provision of mental health and substance use treatment services that are integrated with primary care services
  + Identify how provision of mental health and substance use disorder treatment services that are integrated with primary care services will be communicated between plans
  + Amend the plan-to-plan contract (if needed) to reflect who is responsible for reimbursement of the provision of mental health and substance use treatment services that are integrated with primary care services
* Establish a standing agenda that includes the following:
  + Review of quality and access reports that include BHI services (e.g., claims for BHI, troubleshooting, access data)
  + Identify and align key performance measures that are currently monitored by both plan and MBHO/BH department
  + Evaluate whether additional measures should be collected to further monitor quality and access (e.g., cost savings to the health plans by providing care at the lowest level possible)

1. Data Analytics:The success of BHI implementation depends on robust data collection and analysis. Insights derived from these systems empower health plans to refine care delivery strategies, address community-specific needs, improve behavioral health outcomes in partnership with providers, and uncover which providers may be good candidates for BHI implementation. Health plans may also explore opportunities to strengthen BHI partnerships by leveraging data-driven insights to enhance collaboration and care quality. For example, some health plans provide social determinants of health and BHI service utilization to support informed decision-making and continuous improvement with provider partners.

**Responsibilities**

* Understand which providers are delivering integrated services by running reports based on claims​ (e.g., CoCM codes)
* Leverage quality and access data to identify which providers may benefit from BHI​ or are good candidates for BHI (e.g. strong performers on depression screening)
* Identify what BHI data providers regularly receive, and what they do not have access to
* Analyze survey information from providers for understanding and interest in BHI
* Gather return on investment (ROI) related data to justify or continue enterprise-wide investment into BHI
* Ensure compliance with this policy and other established policies and procedures for behavioral health integration

1. Enterprise Strategy: Develop a seamless, patient-centered healthcare experience for your members and operational support for your provider organizations by advancing behavioral health integration through strong interdepartmental buy-in, collaboration and resources.

**Responsibilities**

* Obtain executive buy-in to ensure alignment and commitment to facilitate behavioral health integration with provider partners
* Allocate necessary resources to support the initiative effectively
* Determine what success looks like for supporting BHI at enterprise level (e.g., inclusion in organization-wide OKRs)

# ****VI. ATTACHMENTS****

* [Link appropriate attachments]

# ****VII. POLICY OWNERS****

* Executive Sponsor(s): Name
* Lead(s): Name
* Department SME(s): Department(s) & Name(s)

# ****VIII. REVISIONS****

* [Insert revision details]
* [Insert what this document replaces]

# ****IX. FREQUENTLY ASKED QUESTIONS****

**Q1. *Is written consent required for Behavioral Health Integration (BHI)?***

**A1. Per CMS guidance, prior beneficiary consent is required for all of the BHI codes, recognizing that any applicable rules continue to apply regarding privacy. The consent will include permission to consult with relevant specialists, including a psychiatric consultant using Collaborative Care, and inform the beneficiary that cost sharing could apply to in-person and non-face-to-face services provided. Consent may be verbal (written consent is not required) but must be documented in the medical record.**[[6]](#endnote-6)

**Q2. *Is prior authorization necessary for Behavioral Health Integration (BHI)?***

**A2. Per the American Psychiatric Association, prior authorization should not be required for CoCM codes.**[[7]](#endnote-7) **For PCBH, prior authorization may be required by the Managed Behavioral Health Organization, yet organizations should understand that prior authorization creates administrative barriers to accessing timely integrated care.**

**Q3. *Is one model more effective than the other (e.g., CoCM or PCBH)?***

**A3: No, each model has its strengths and is designed to address different needs. The Collaborative Care Model (CoCM) and Primary Care Behavioral Health (PCBH) are complementary approaches, and their effectiveness depends on the specific goals, resources, and context of the organization or population being served.**

**Q4: *What are the benefits of Behavioral Health Integration (BHI) for health plans and their members?***

**A4: BHI delivers significant advantages for both health plans and their members. According to a Milliman study, BHI demonstrates a strong return on investment (ROI) by treating the patient at the lowest level of care (initial onset of symptoms) and reducing overall healthcare costs while improving mental health outcomes.**[[8]](#endnote-8) **Additionally, BHI aligns with the principles of the Quadruple Aim, enhancing patient experience, improving population health, reducing costs, and supporting healthcare provider well-being.**

# ****X. REFERENCES****

1. California, [Health & Safety Code § 1374.725](https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.725.&nodeTreePath=4.9.15&lawCode=HSC) [↑](#endnote-ref-1)
2. Department of Managed Health Care, [All-Plan Letter 24-023](https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-023(OPL)-NewlyEnactedStatutesImpactingHealthPlans(2024LegislativeSession)_1.pdf?ver=pTIM7g7dnX3EcRmQPw1xkg%3d%3d) [↑](#endnote-ref-2)
3. Agency for Healthcare Research and Quality, “[What is Integrated Behavioral Health](https://integrationacademy.ahrq.gov/about/integrated-behavioral-health)?” [↑](#endnote-ref-3)
4. California Quality Collaborative, [BHI Implementation Snapshot: Selecting an Integration Model](https://www.pbgh.org/resource/bhi-snapshot-selecting-an-integration-model/) [↑](#endnote-ref-4)
5. California Quality Collaborative, [[BHI Billing & Payment Codes](https://www.calquality.org/wp-content/uploads/2025/09/CQC_Billing-and-Payment-Codes_CA_2025_Final_Revised-09.2025.pdf)](https://www.calquality.org/wp-content/uploads/2025/09/CQC_Billing-and-Payment-Codes_CA_2025_Final_Revised-09.2025.pdf) [↑](#endnote-ref-5)
6. Center for Medicare and Medicaid Services[, Frequently Asked Questions about Billing Medicare for Behavioral Health Integration](https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/behavioral-health-integration-faqs.pdf) (BHI Services) [↑](#endnote-ref-6)
7. American Psychiatric Association, [Best Practices for Reimbursing the Collaborative Care Model in Medicaid](https://www.psychiatry.org/getmedia/3b44bcf3-cd09-4efc-8b46-12a1d17d4d81/APA-Best-Practice-for-Reimbursing-CoCM-in-Medicaid.pdf) [↑](#endnote-ref-7)
8. Milliman, [Potential economic impact of integrated medical-behavioral healthcare: Updated projections for 2017](https://www.milliman.com/en/insight/potential-economic-impact-of-integrated-medical-behavioral-healthcare-updated-projections) [↑](#endnote-ref-8)