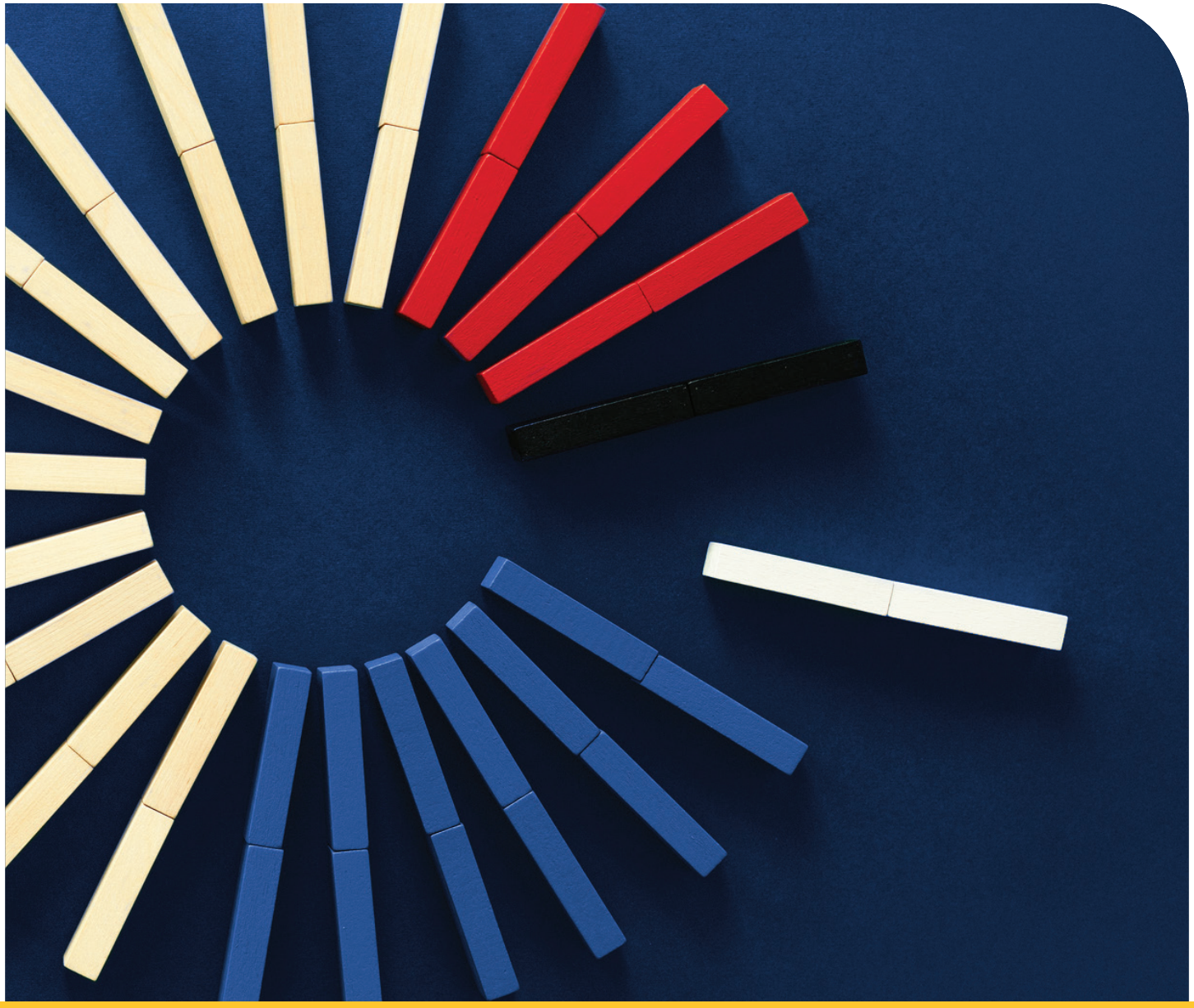

DECEMBER 2025

Aligning for Impact

A Shared Definition and Multi-Stakeholder Insights on Behavioral Health Integration in California

PBGH California Quality Collaborative

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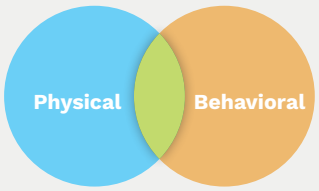
Introduction

Integrating behavioral health into primary care helps care teams deliver patient-centered, whole-person care, and is increasingly recognized as a critical component of Advanced Primary Care. In fact, three in four primary care provider visits typically address a mental or behavioral health concern such as depression, anxiety or substance use. Across the country, states are pursuing legislative and regulatory changes, payment models, multisector partnerships and delivery system redesign to strengthen access to behavioral health services within a patient's primary care home.

In California, recent investments have focused on redesigning specialty mental health with some efforts toward strengthening behavioral health integration (BHI) into primary care. In 2023, for example, Medi-Cal (California's Medicaid program) added the dyadic therapy benefit, provided to a child or adolescent and caregiver together, to the fee schedule.[1] California also made permanent provisions that allow federally qualified health centers (FQHCs) and rural centers to be reimbursed for services provided by associate licensed behavioral health clinicians, addressing a much needed increase of the behavioral health workforce.[2] In 2025, commercial health plans were also required to establish a process to reimburse providers for integrated mental health.[3]

Whole-Person Care



Behavioral health integration connects physical and behavioral health in primary care to ensure patients receive coordinated support across their full range of needs.

Even with policy advancements, numerous financing and administrative barriers continue to impede sustainable implementation of BHI in

Why This Work Matters

California lacks a shared, statewide definition of BHI and has inconsistent approaches across payers and delivery systems and has inconsistent approaches to implementing BHI. Establishing common language and attributes is essential for alignment, payment reform and scalable implementation.

Methods Snapshot

State Interviews:

Colorado, Pennsylvania, Texas, Virginia

California Key Informants:

Delivery system, payers, regulators, purchasers, patients/caregivers

Sources of Insights → Two Opportunities:

BHI Definition and Attributes + Multi-stakeholder alignment recommendations

primary care. To help address these barriers, the California Quality Collaborative (CQC) launched a multi-year Behavioral Health Integration Initiative to advance integration across California's primary care delivery system. By engaging providers, health plans, purchasers and other stakeholders, CQC aims to improve access to high-quality, cost-efficient, whole-person care that enhances patient outcomes, strengthens care team satisfaction and reduces total cost of care.

In 2024, CQC conducted a series of interviews focused on identifying sustainable financing practices to support BHI. Many interviewees observed that the lack of statewide consensus on how BHI is defined and interpreted made it challenging to incentivize and sustain the clinical work. Additionally, because California has numerous payers and complex payment arrangements that do not incentivize, and sometimes hinder, integrated care, CQC examined successful multi-stakeholder initiatives from other states to identify approaches that could inform California efforts.

To build on those findings, CQC initiated work in 2025 to:

- Facilitate statewide alignment on a shared definition of BHI through discussions with a broad array of California stakeholders.
- Conduct stakeholder interviews with key informants from Colorado, Pennsylvania, Texas and Virginia to examine distinctive strategies and common factors that drive BHI adoption in primary care.

This paper presents findings from both efforts, offering definitions of BHI and behavioral health providers for California. It also proposes a framework and set of operational attributes tailored to the state's diverse and complex health care landscape. These definitions and attributes are intended to advance a flexible, inclusive and contextually relevant model of BHI that reflects lessons learned about achieving multi-stakeholder alignment. Together, these efforts offer practical steps for California and other states seeking to advance integrated care.

Sustainable BHI Financing Brief

To learn more about challenges around payment for BHI in the commercial setting, see CQC's insights in Sustainable Behavioral Health Integration Financing: Successful Practices and Opportunities.

Methodology

BHI Attributes

Discussions were designed to explore the degree of consensus around BHI definitions and attributes. As a starting point, key informants were provided with draft definitions of BHI and behavioral health clinicians (BHCs) along with BHI attributes developed in Oregon as part of the state's Patient Centered Primary Care Home (PCPCH) initiative (see Appendix A). CQC used a 2015 iteration of these attributes because that framework offered a higher-level conceptual approach that better reflected California's current stage of integration and provided a more suitable starting point for identifying alignment across topic areas rather than delving into the detailed operational specifications in Oregon's later iterations.

In spring 2025, CQC conducted a series of interviews with key informants representing the health care industry in California, including the delivery system, health plans, regulators, public purchasers and patient representatives. Key informants included organizations with existing investment or experience in BHI, participants in CQC initiatives, feedback from CQC's BHI Initiative Advisory Group and stakeholders engaged in other regional or statewide BHI policy and/or delivery system work.

Two types of interviews were conducted:

- A virtual discussion with multiple key informants who serve on CQC's BHI Initiative Advisory Group.
- 60-minute, semi-structured discussions with key informants from 11 stakeholder groups across the aforementioned categories. Several additional stakeholders were invited but declined to participate.

Key informants received a discussion guide that included questions addressing:

- Recommendations to adapt Oregon's definitions for BHI and BHCs[4] to the California context
- The organization and content of Oregon's seven attributes for Patient Centered Primary Care Homes that provide integrated care[5]
- Whether operational specifications for BHI attributes would be useful and, if so, whether Oregon's approach could serve as a model for California
- Additional context for BHI, such as the informant's organizational definition of BHI and the potential impact of a uniform standard)

Because terminology for BHI elements varies across models (e.g., attributes, standards), this paper uses BHI attributes throughout.

Multi-stakeholder Alignment

Key informant discussions were designed to elicit approaches to multi-stakeholder alignment on BHI among four states with demonstrated experience in this area. Participating states were intentionally chosen to explore different dynamics and contexts in several areas, including the maturity and scale of their BHI initiative, states where behavioral health was carved in and carved out, and implementation of a range of clinical models used for BHI, including the primary care behavioral health (PCBH) model[6] and the Collaborative Care model[7] ("Collaborative Care"). Experts on CQC's BHI Initiative Advisory Group provided recommendations on states to consider.

Multi-Stakeholder Alignment

For the purposes of this paper: Formalized collaboration among organizations that may include payers, providers, purchasers, state agencies, academic partners, patient advocacy groups and community-based organizations.

Key informants were provided with a discussion guide that included questions addressing:

- State context for BHI implementation, including relevant legislative and regulatory initiatives, carve-out status, payment alignment
- Key activities that supported multi-stakeholder alignment, such as sectors represented, precipitating events, challenges, infrastructure
- Approaches to BHI implementation, including clinical models, quality/cost/efficiency outcomes, support to participating practices)
- Impact of BHI initiative
- Lessons learned
- Recommendations for BHI facilitators

State Learning Session

After interviews were complete, CQC hosted a webinar featuring all four states approaches to BHI, during which key informants and/or representatives from each state participated and spoke to elements of their work.[8] This paper reflects findings from both the interviews and webinar.

BHI Attributes

Cross-Cutting Themes

This section summarizes findings across California key informants, focusing on the most impactful areas of consensus that are not tied to a specific BHI attribute.

Oregon's attributes were developed as part of the state's PCPCH initiative, which launched in 2009 as part of a statewide strategy for health system transformation.[9] As a result, the language, structure and organization of the attributes were directly tied to the PCPCH framework. The Oregon attributes were also operationalized in a different context than BHI work in California. The PCPCH initiative was created as a result of 2009 legislation to improve primary care as part of broader transformation efforts.[10] While there is state-level work related to BHI in primary care in California, a similar legislative mandate does not exist.

"The Oregon standards were defined when the patient-centered medical home was more in vogue. Advanced primary care is an evolution and as our terms and standards change, we should align our approach to match."

—Key Informant

Early in CQC's interview process, many key informants observed that while the Oregon attributes made sense and addressed many relevant issues, they did not align with primary care frameworks common in California, like Advanced Primary Care[11] or the 10 Building Blocks of High-Performing Primary Care.[12] While most respondents found the attributes to be comprehensive, they also observed that BHI attributes rooted in a framework relevant to California would better align with state goals and initiatives.

"Behavioral health integration should connect to a framework that is more recognized in California."

—Key Informant

Oregon's 7 Attributes At a Glance

Proposed BHI attributes can be found here

Another theme across interviews was widespread alignment on the conceptual goals of BHI articulated in Oregon's attributes coupled with a strong desire for flexibility. Many key informants said BHI attributes should accommodate a range of staffing, population needs, geographies and maturity. Some key informants felt that BHI attributes should reflect a spectrum of BHI capabilities, with a baseline set of competencies for those beginning the BHI journey and more rigorous attributes that would reflect a mature model. Numerous key informants also felt attributes should be model agnostic so any practice offering integrated behavioral health, whether using Collaborative Care, PCBH or another approach, could meet requirements. Ultimately, key informants emphasized the importance of defining BHI attributes with enough specificity to guide implementation and operations without being overly prescriptive, and ensuring the attributes reflect a continuum of integration that works in different practice settings (e.g., small providers, rural, etc.).

This flexibility extended to the composition of care teams. Key informants supported a broader range of professionals beyond those referenced in Oregon's definition of BHCs. Many stakeholders cited a behavioral health care manager, a key member of the three-person team required for Collaborative Care,[13] as a role that should be reflected in the definition. Several other respondents emphasized the value of including other roles typical in non-specialty mental health, also known as mild-to-moderate behavioral health, such as lay counselors, community health workers and care navigators.

Concerns about financial alignment were raised by some, with several key informants noting that the current payment system does not reflect the work to develop, implement and sustain integrated behavioral health teams. In particular, one key informant described efforts to take a population-

based approach to integrated perinatal health and the challenge in sustaining staffing without a dedicated funding source.

In addition to these areas of alignment, there was one notable area of divergence. The Oregon BHI attributes included a set of specifications coupled with each attribute. Opinions varied on whether BHI attributes should include a set of operational specifications, which require a higher level of rigor and fidelity to demonstrate compliance. Similar to the discussion around the attributes themselves, some stakeholders stated that specifications would be overly prescriptive and likely challenging to meet across California's diverse primary care settings. Others felt specifications were important in facilitating a clear understanding of each BHI standard to guide implementation and establish a definitive requirement for what an attribute looks like in practice.

Oregon BHI Attribute Specification Example

The attribute addressing integrated behavioral health as part of routine care included staffing ratios for BHCs on a primary care team (e.g., for every six full-time equivalent staff, or FTEs, of primary care providers, a practice would need 1 FTE BHC).[14]

Findings by BHI Attribute

This section summarizes findings related to the seven attributes adopted by Oregon. It is organized by attribute and highlights areas where key informants proposed changes to better align with the California context. Gaps in the BHI attributes are also described.

Integrated behavioral health as part of routine care

This attribute describes how behavioral health services are reflected in routine care, with BHCs delivering a range of services onsite. Key informants were consistent in noting changes to the delivery system since the 2015 iteration of the Oregon attributes. Most discussions cited the COVID-19 pandemic as a watershed moment that dramatically increased the acceptability of services delivered via telehealth. While there was general agreement with the sentiment underlining this attribute, most respondents stated that providing routine care on site was not feasible in California for multiple reasons, including behavioral health workforce shortages impacting both rural and non-rural areas and also the ability of small and solo practices to have a caseload that would support an on-site behavioral health team. Further, partnerships with virtual-only mental health providers and increasing acceptability of telehealth were all cited as reasons why some element of virtual care should be acceptable in a BHI attribute. Several key informants pointed out, however, that virtual care should not be weighted the same as in-person care,

Process for developing BHI Definition & Attributes for California

and that in-person, on-site care enables a behavioral health provider to better understand the community context that may shape patient needs and to collaborate more effectively with onsite care teams.

"Routine primary care is defined as including behavioral health."

—Key Informant

Integrated BHC provides a broad array of comprehensive evidence-based behavioral health services

There was general agreement from key informants that BHI should include a range of evidence-based services, such as behavioral activation and cognitive behavioral therapy. Some identified additional services that should be reflected in this attribute, such as gender-affirming care and support for social risk factors. Other key informants agreed with the general concept but were careful to point out that only mental health and substance use disorder symptoms and diagnoses falling under non-specialty mental health should be treated in a primary care setting. One key informant also described the operational and staffing challenges inherent in providing such a broad array of behavioral services. That individual observed that some behavioral health providers, such as masters level clinicians, may not have training in all symptoms or diagnoses that present in primary care, for example, diabetes management and how it may relate to mood or how anxiety can be connected to certain breathing and lung issues.

"The reality is that virtual care is an important part of the system. But there is so much variation in what that can mean."

—Key Informant

Integrated BHC provides same-day open access behavioral health services

Perspectives differed on providing same day care for behavioral health. Some respondents felt that same-day behavioral health care was critical, particularly to connect with a patient when they may be most responsive and to avoid sliding into a "co-located specialty clinic" model. One respondent said that the phrasing used in the Oregon attributes would be "narrow and restrictive" for California. Others felt that a broad range of actions could be considered to meet the definition of same-day care (e.g., behavioral health screening, warm hand-off). Several also commented on how critical a same-day warm hand-off could be, noting that working with patients when they are likely open to care can dramatically impact willingness to receive behavioral health support.

On the other hand, several key informants pointed to the Medi-Cal prohibition on reimbursing for two services delivered on the same day in FQHCs, noting that this payment issue would make it difficult to operationalize same-day care in a sustainable way.[15] Still others proposed alternative language, citing terminology such "expedited access" to recognize the time sensitivity of this care, while also reflecting the realities of California's delivery system, including severe behavioral health workforce shortages, the amount of care delivered in rural and frontier settings in which it can be challenging to fill health care roles and the number of solo and small providers that make same day access to behavioral health challenging.

Primary care clinicians, staff and BHC utilize shared medical records and have a mechanism in place for collaborative care planning and co-management of patients

The Oregon attributes include shared medical records as a mechanism to enable care planning across care teams. While several key informants described a shared medical record as "a must" and "vital to success" others observed that the language could be adapted. One key informant described the language as too narrow and felt enabling BHI should look at broader sharing across the ecosystem, not just among primary care and behavioral health teams within the four walls of the practice. Agreeing with the spirit of the attribute, another key informant suggested focusing on the end goal of ensuring care team access to the same information on a patient's goals, progress and relevant health information rather than focusing specifically on access to a practice's electronic medical record.

"So much can be done virtually that can also be done in the clinic. And if you have an established connection between care team members before going virtual, collaboration can continue."

—Key Informant

BHC is an integrated part of the primary care team

Interviewees generally agreed that integrated care hinges on the effectiveness of care teams; team-based care was repeatedly cited as a key component of successful integration. As a result of the COVID-19 pandemic, many health care teams increased comfort with virtual collaboration models. Given that the Oregon attributes were developed prior to this, it's not surprising that they emphasize in-person care team collaboration. Numerous respondents agreed that care team collaboration could take place in a primarily virtual or hybrid setting and still be effective. Several also thought it was important to distinguish between being located in the same site and integration, noting that providers can be co-located and still lack the key components of system-wide integration.

PCPCH utilizes a population-based approach to delivering and coordinating integrated behavioral health services

There was general agreement among key informants about the importance of population-based care in the context of BHI. Several key informants cited the importance of universal screening, in part because of its contribution to taking an equitable approach to care. Numerous respondents also stated that attributes should reference measurement-based or measurement-informed care.

The integrated team includes psychiatric consultative resources

Another area of divergence was whether the inclusion of psychiatric consultative services should be required for a practice to meet a BHI standard. Some felt this was critical for direct patient care and to support clinicians with prescribing and other clinical questions. Others noted that while direct access would be ideal, workforce shortages would make that difficult to operationalize. One interviewee framed this as an aspirational attribute, with the caveat that the lack of psychiatric consultation should not prevent a practice or site from meeting an integrated behavioral health standard.

"There is no quality without equity."

—Key Informant

Other Observations

Multiple respondents noted that the 2015 iteration of the Oregon attributes, while generally comprehensive, lacked references to the importance of equity and cultural proficiency.[16] Another key informant observed the lack of content related to continuity, particularly noting how some virtual behavioral health models may not connect a patient to the same provider across visits and that continuity is important in behavioral health care and primary care. Others said it may be important to address bidirectional integration, such as primary care integrated into a behavioral health setting, which is a less common model in California.

Impact of Statewide Consensus

Key informants were asked to reflect on the utility of adopting a statewide, uniform set of attributes for BHI in California. There was universal agreement that such consensus would be beneficial. Most stated that a shared understanding of what BHI means would be valuable, given the current variability across the delivery system. Several pointed to state-level initiatives, including work by public purchasers, such as CalPERS and Covered California, and the value in creating policy and payment alignment across programs. They also noted this would harmonize policy with practice, establishing consistent expectations for what services would be offered in an integrated setting.

"How do people get the right level of care that they need, when they need it - where it's most convenient?"

—Key Informant

One key informant also said that having a statewide standard could impact the education and training of behavioral health providers. For example, this could set expectations about what it is like to work in an integrated system rather than in the more fragmented system that exists today. In the current system, behavioral health often remains siloed and behavioral health providers may not have regular, or any, communication with a patient's other providers.

Several key informants also felt that such a consensus would benefit their own organization, observing that having an external standard they could cite could be helpful as they work to educate, engage and invest in this area.

Revised BHI Definitions

Based on interviews, CQC proposes revised definitions for BHI and BHCs, with the original Oregon definition provided in Appendix A. With regard to the latter, CQC proposes to expand the definition beyond clinicians to include a broader range of behavioral health providers.

Revised APC Attributes

Given the consensus on connecting BHI attributes to a model with more relevance to California, CQC proposes using the Advanced Primary Care (APC) framework as the foundation for BHI attributes. This framework is broadly recognized in California and reflects the importance of primary care in patient engagement, the foundational role it plays in preventive care and its role in facilitating access to care delivered in other settings.

While APC already includes integrated care as general attribute (e.g., screening and referring for behavioral health), these attributes were established

The proposed revised definitions for California are:

Behavioral Health Integration:

Care provided to individuals and their families in a primary care setting by licensed primary care providers, behavioral health providers and other care team members working together to address one or more of the following: mental health, substance use disorder, health behaviors that contribute to chronic illness, life stressors and crises, social risk factors, developmental risk/conditions, stress-related physical symptoms, preventive care and ineffective patterns of health care utilization.

Behavioral Health Provider:

Behavioral health providers including licensed professionals (e.g., psychiatrist, psychologist, certified nurse practitioner with a specialty in psychiatric mental health, clinical social worker, professional counselor, marriage and family therapist), associate professionals (e.g., certified clinical social work associate), trainees, and allied professionals (e.g., behavioral health care manager, peer counselor) or any other clinician whose authorized scope of practice includes mental health or substance use disorder diagnosis and treatment.

when BHI models were not widely adopted in California. Since then, regulatory[17] changes have been implemented and APC attributes should be updated to reflect this progress. As such, the findings from this paper have been translated into proposed revised and expanded APC attributes to reflect capabilities related to integrated behavioral health (see Table 1). The revised attributes also include several minor stylistic changes. Changes are indicated by **bold type**. Revised APC attributes also include examples of how integrated behavioral health attributes could be operationalized in a primary care setting.

Table 1. Revised Advanced Primary Care (APC) Attributes

APC Attribute	APC Attribute Description **(Revised Language)**	Operationalizing BHI in APC Practices (Examples)
 **Person- and family-centered**	Care is designed around the needs and priorities of patients and families, encourages patient and family participation in improvement efforts and incorporates feedback. Patients share preferences and goals of treatment, engage in shared decision-making with their care team and should be made to feel their choices are respected and integrated into care plans. *(Note: this attribute was not changed.)*	• Care pathways and process flows reflect how patients access support for physical health, behavioral health and social health needs. • Shared decision-making processes are established for physical health and behavioral health needs. • Care teams tailor communication to meet language needs and cultural context, including addressing perceived stigma, cultural norms and barriers and preferred treatments.
 **Relationship-based**	Patients choose primary care providers **and teams (including behavioral health providers)** who best meet their needs. Patients consistently communicate with and receive care from their **selected providers** and supporting care team members, who work collaboratively with **them** and their family to build trusting relationships.	• Patients have the option to receive support from a consistent care team that knows the patient's physical, behavioral and social health history, regardless of whether services are provided on-site or by virtual-only providers.
 **Accessible**	Patients get the right care at the right time with an **integrated** care team that is familiar with their **medical and behavioral health** needs. Accessible care includes same-day care for **acute primary care** needs through in-person and virtual services with their care team, **same day facilitated connections (e.g., warm hand-offs) to behavioral health professionals, provider** availability after appointment hours, secure messaging with the **integrated** team and an online medical record.	• Practices work toward same-day access for behavioral health services; the spectrum of integration could begin with a protocol for a same-day warm hand-off to virtual or co-located behavioral health services and move toward same day care over time. • Warm hand-offs are provided to behavioral health support in a timely manner.

APC Attribute	APC Attribute Description **(Revised Language)**	Operationalizing BHI in APC Practices (Examples)
 **Comprehensive**	Patients receive **evidence-based routine** screening and care for behavioral and social needs **from their integrated** primary care team, as well as common procedures by their primary care team instead of scheduling a separate appointment with a specialist. Patients' care needs are proactively identified by **integrated** care teams that reach out for anticipated care needs and offer additional support for those patients at high or rising risk. **When patients' health needs change, their care team has a defined process for ensuring they are referred to the best place for subsequent care.**	• An array of integrated and evidence-based services for mental health and substance use disorder (SUD) care is available from the team or via referral to virtual or community-based providers. • Co-located or virtual providers may offer a range of services, including identification and treatment of mental health conditions like depression and anxiety, screening for SUD, providing medications for addiction treatment (MAT) and offering SUD support groups. • Offer support for behavior changes that impact chronic illness (e.g., addressing nutrition and exercise for patients with diabetes or obesity).
 **Team-based**	Patients know and receive care from **integrated primary care teams that include an array of professionals** (e.g., medical assistant, nurse, **pharmacist, health coach**, community health worker). This team includes **integrated behavioral health providers (e.g., behavioral health care managers, peer counselors). In collaboration with** the primary care provider, care team members communicate and coordinate across the team to address patients' needs and provide care appropriate to their training and expertise.	• Care pathways and process flows are designed around an integrated team and ensure that behavioral health symptoms associated with chronic physical health diagnoses are addressed. • Behavioral health providers participate in practice activities (e.g., care team meetings). • Daily huddles include the integrated care team and address behavioral health issues (e.g., flagging patients who might benefit from a warm hand-off to behavioral health, patients with complex conditions are reviewed to confirm physical, behavioral, and social health needs). • Practices with virtual behavioral health partners have documented mechanisms for collaboration across the care team.
 **Integrated**	Patients' physical, **behavioral** and social needs are communicated across their **integrated** primary care team and with other care providers and settings. Health information and care activities outside of the **integrated** primary care are **reflected in a comprehensive care plan. There are clear mechanisms in place for data sharing and collaborative management of patient's physical, behavioral and social health needs.**	• Care plans span physical health, behavioral health and social health needs. • There are established mechanisms to share care plans and for providers to work together to identify and address behavioral health and social risk factors. • EHRs are optimized for integrated care teams, including the following mechanisms where feasible: (a) PCPs and behavioral health providers document in the same record; (b) modules that offer progress tracking and task assignments are enabled; (c) role-based permissions are tailored so sensitive behavioral health information is only available to relevant team members; (d) secure messaging is enabled for teams to message one another about time-sensitive issues; and, (e) a patient-centered consent process offers patients the ability to indicate which parts of the record can be shared. • For practices with a virtual behavioral health partner, mechanisms to share data across providers are clearly defined and documented (e.g., BH partner documents directly in EHR, shared via secure email or other mechanism).

APC Attribute	APC Attribute Description **(Revised Language)**	Operationalizing BHI in APC Practices (Examples)
Coordinated	Patients are guided through care transitions between hospitals, emergency care, specialty care (including **external behavioral health** providers) and their **integrated** primary care teams. Patients can navigate across settings with established referral pathways to high-value specialist providers **and community-based organizations that address social needs**, with which the **integrated** primary care team exchanges information and coordinates care.	• Referral relationships are established with key community-based providers that address behavioral health and social risk factors. • Relationships may be formalized (e.g., a memorandum of understanding) to align referral expectations across each provider. • Practices have implemented improvements to efficiency, patient experience, and provider experience (e.g., EHR smart phrases for referrals, lists of vetted resources with capacity and/or care coordination support to help with patient navigation). • Closed loop referrals ensure that integrated care teams know when patients have accessed external care provided by referral.
Equitable	Patients receive and experience **care** and health outcomes that do not vary in quality or access due to personal characteristics, such as gender, race, ethnicity, language, socioeconomic status or sexual orientation/ gender identity. **Integrated** primary care teams proactively **monitor their patient's care** to identify, eliminate and prevent disparities across **access,** care and health outcomes.	• Behavioral health support is delivered by providers who are culturally responsive and language concordant. • Practices monitor data to address disparities in screening, diagnosis and follow-up for behavioral health conditions.

Multi-Stakeholder Alignment: Key Findings

Legislative and Regulatory Landscape

Each of the four states CQC interviewed (Colorado, Pennsylvania, Texas and Virginia) had a range of legislative and regulatory actions that advanced BHI implementation. In some cases, state legislatures directly appropriated funds to support stakeholder convening and practice-level transformation. All four states incorporated Collaborative Care CPT codes[18] into their Medicaid fee schedules, though the timing varied considerably. Some were early adopters of the codes while one state added them to the fee schedule as recently as 2025. The following section summarizes each state's legislative and regulatory foundation for BHI, highlighting policy decisions that created conditions to facilitate integration.

Pennsylvania's behavioral health services are carved out. Mental health and substance use disorder services are provided via subcontract with behavioral health managed care organizations (BH-MCOs) that are organized by county.[19] In Philadelphia, Community Behavioral Health, the BH-MCO for the county, partnered with the Health Federation of Philadelphia ("the Federation") to expand access and explore ways to streamline connection to outpatient therapy, laying the groundwork for later adoption of the PCBH model.

FQHCs in the state do not have a prohibition on billing for two services on the same day (e.g., a physical health service and a mental health service can be provided on the same day and both are eligible for reimbursement).[20] In addition, the county of Philadelphia earmarked funds for a clinician to serve as the director of BHI at the Federation to support Federation members on their BHI journey.

Several pieces of Texas legislation laid the groundwork for advancing BHI efforts. In 2013, the governor signed Senate Bill (SB) 58 into law, legislation to carve behavioral health services into its Medicaid managed care program. Subsequent legislation, SB 200, reorganized services and laid the foundation for the integration of primary care and behavioral health, including consolidation of both services within the state's Health and Human Services Commission. In this same timeframe, Texas increased mental health funding to local mental health authorities. In 2019, several notable actions increased BHI momentum:

- The Governor designated children's mental health as an emergency item, which elevated its importance in the legislative session.

State Snapshots

Colorado:

BH carve-out

State Innovation Model (SIM)

Pennsylvania:

BH carve-out

PCBH regional leadership

Virginia:

BH carve-in

Primary Pathways model

Texas:

Mix of BH carve-in and carve-out

Children's Mental Health focus

- The state legislature approved SB 11 which:
    - Established the Child Psychiatry Action Network (CPAN) to provide behavioral health consultation to primary care providers, including pediatricians.
    - Established the Texas Child Mental Health Care Consortium and allocated $99 million in funding for the next five fiscal years.

In June 2022, the state began covering Collaborative Care in its Medicaid program[21] and also leveraged federal funds to pilot an expansion of CPAN to perinatal populations (PeriPAN). The program was fully funded as a statewide initiative in 2023. Texas has also increased funding to support Collaborative Care expansion across the state.

Colorado's BHI trajectory reflects deliberate multiphase reform. Behavioral health is carved out, and the state pays for behavioral health services via capitated contracts with Regional Accountable Entities. Early investments, like Advancing Care Together,[22] provided a foundation for transformation efforts. Following this program, Colorado was awarded a Centers for Medicare and Medicaid Services Innovation Center (CMMI) State Innovation Model (SIM) award, which established a $65 million cooperative agreement focused on BHI.[23] In 2019, the Behavioral Health Task Force was created as one of the governor's signature initiatives. The governor also directed the Department of Human Services to create a roadmap to improve the behavioral health system and lead this work.[24] In related activity, 2022 legislation enabled the state's Division of Insurance to align payers on integrated care standards, embedding integration into statewide regulation. In addition, House Bill 22-1302 created the primary care and behavioral health statewide integration grant program and appropriated $33 million to support providers with BHI adoption.[25] Subsequently, the Department of Health Care Policy and Financing made available $29 million in grants to providers to establish or expand BHI.[26] A late adopter of Collaborative Care codes, Colorado added the codes to its Medicaid fee schedule in July 2025.[27]

The state of Virginia began funding its Task Force on Primary Care, the umbrella for the state's BHI work, in 2020. The Task Force was initially supported through philanthropic investment and now receives funding from the Virginia Department of Health.[28] Behavioral health services were carved into Virginia's managed care contracts starting in 2017, culminating in full integration by 2018. Medicaid reimbursement for Collaborative Care took effect on January 1, 2024.[29]

Multi-stakeholder Collaboration

Successful BHI benefits from the active engagement of diverse stakeholders who bring complementary strengths and represent different sectors. Payers, providers, purchasers, state agencies, academic and research partners, patient advocacy groups and community organizations each contribute essential perspectives that facilitate work to align the payment model, design clinical models, establish standards, build workforce capacity, train care teams and ensure that care reflects patient, community and provider needs. Described below are the primary vehicles for coordination and BHI implementation in Colorado, Pennsylvania, Texas and Virginia.

Colorado Health Extension Service

The Health Extension Service and its Steering Committee are coordinated by the University of Colorado School of Medicine's Practice Innovation Program. The Steering Committee includes representation from state agencies (e.g., Medicaid, the Division of Insurance), purchasers, the state academy of family physicians and other organizations. In collaboration with practice facilitators, the Steering Committee worked to design the *Building Blocks of Integrated Behavioral Health*, a framework to guide and standardize how primary care and behavioral health services can be effectively integrated in diverse practice settings.

Philadelphia Integrated Care Network

Convened by the Federation, the Integrated Care Network supports coordination across southeastern Pennsylvania FQHCs, county officials, philanthropic organizations and consultants on a range of delivery system and innovation topics, including BHI. According to the Federation, each played pivotal roles in building momentum toward BHI. The goal of their collaborative work is to facilitate access to integrated behavioral health by addressing long-standing barriers (e.g., cost, wait times, stigma) and strengthening team-based approaches and patient engagement.

Texas Child Mental Health Care Consortium ("the Consortium")

The Consortium was created to leverage the expertise and capacity of health-related institutions of higher education (e.g., medical schools) to address urgent mental health challenges and improve the delivery system for children and adolescents.[30] Members include Texas' 13 state-funded health-related institutions of higher education, the Texas Health and Human Services Commission, Meadows Mental Health Policy Institute (a key informant for this paper) and others. A complete list of participants is available on the Consortium website.[31] To advance BHI nationally and within Texas, the Consortium mobilized a broad coalition that includes pediatric and family physician medical societies, purchasers, employers, the National Alliance on Mental Illness, the American Psychiatric Association Foundation and other organizations.

Virginia Task Force on Primary Care ("the Task Force")

The Virginia Center for Health Innovation is a quasi-governmental organization. It leverages the Task Force and its Integrated Behavioral Health Subcommittee as the multi-stakeholder vehicle for BHI work. The goal of the subcommittee is to "promote expansion of integration of behavioral health and primary care through identification of administrative and policy barriers, aligning communication between payers and providers, sharing statewide resources and best practices and building consensus recommendations across health sectors."[32] The Task Force is co-chaired by one payer and one provider and includes frontline providers, health system administrators, health plans, employers, patient representatives, state officials and General Assembly members.[33] Medicaid managed care plans, primary care practices and experts co-designed a BHI model, Primary Pathways,[34] for BHI implementation across the state.

Behavioral Health Integration Framework

Key informants described how their work supported a range of models and frameworks for BHI efforts at the practice level. While each approach had specific components, most key informants described the need for flexibility so practices can adopt approaches that worked for their local context.

Colorado Building Blocks

Colorado's BHI approach, based on the *Building Blocks of Integrated Behavioral Health*[35] framework, was co-designed with payers and providers, which has influenced policy and practice in the state. The framework includes seven building blocks: leadership, data-driven quality improvement, team-based care, patient and family engagement, population management, access, and comprehensiveness and care coordination. Key informants noted that although the original focus of their BHI work was supporting practices in adopting Collaborative Care leveraging the Building Blocks, practice facilitators have flexibility to support providers to make progress where they can rather than approach integration with strict fidelity to a single model.

Pennsylvania Primary Care Behavioral Health

The Integrated Care Network uses the principles of the PCBH model in its BHI work. In this model, a licensed behavioral health specialist is embedded in the multidisciplinary primary care team to support patients and the care team with behavioral health. The Network designed its behavioral health consultation framework to leverage recovery principles, including patient-centered care, evidence-based interventions and integrated care.[36]

Texas Specialty Consultation + Collaborative Care

CPAN was created so that all Texas primary care practices could access a network of experts for behavioral health curbside consults (e.g., on-demand support during business hours) and vetted referrals to mental health services for youth and perinatal patients. In addition to CPAN, primary care practices can receive support to implement BHI through the Behavioral Health Integration and Guidance Initiative (BHIG). BHIG's goal is to equip pediatric primary care providers with tools to better detect and treat mild-to-moderate behavioral health conditions.[37] While many practices focus on implementing Collaborative Care, the approach to BHI is intended to be model agnostic.

Virginia Primary Pathways Model

Virginia's approach to BHI focuses on supporting practices to build capacity and implement processes that facilitate the delivery of integrated care. Its approach is known as the Primary Pathways Model,[38] a tiered payment and practice development framework. The framework is grounded in the Comprehensive Health Integration Model,[39] in lieu of the traditional Collaborative Care approach, because of the increased flexibility it offers.

Virginia Primary Pathways Model

Tier 1: At least one provider trained in BH, participate in state HIE; connectivity and embedding screeners in the EHR and using them)

Tier 2: Tier 1 & 50% of providers trained in BH; employed care manager; care compact with community BH

Tier 3: Employ virtual or on-site BH specialist, or use the Collaborative Care Model, or receive NCQA BH distinction

Technical Assistance

Technical assistance (TA) to primary care practices is a critical enabler of BHI implementation. While the design and delivery of TA varied across the four states, each sought to provide practices with structured support, coaching and resources to make integration feasible and sustainable. TA models included decentralized networks of practice facilitators, centralized hubs, large-scale consultation networks and tiered financial and training supports. The following examples from Colorado, Pennsylvania, Texas and Virginia illustrate how states tailored TA to local contexts while ensuring practices could advance BHI efforts.

Colorado's approach to TA was initially developed under its SIM work, where it embedded TA in local practice transformation organizations that deployed regional practice facilitators. In its current work, the Practice Innovation Program provides the change package, guidance to practice facilitators, and resources, while the practice facilitator works directly with the care delivery team in each practice. This decentralized approach enables practices to adopt new screening, coding and referral workflows. Colorado key informants noted that integration was accelerated when practice facilitation responded directly to a practice's transformation roadmap, rather than follow a prescribed set of supports. In addition to TA, participating practices receive an average award of $200,000, distributed over a three-year period, to address costs associated with implementation of BHI.

"Having an iterative process that's tailored and responsive . . . helps us consider our fidelity to practice principles rather than to model orthodoxy and helps us support practices."

—Key Informant

In Pennsylvania, the Federation developed centralized TA for PCBH implementation, offering onboarding, training and ongoing reinforcement to prevent clinicians from reverting to traditional models of siloed behavioral health. Longstanding relationships with health centers enable the Federation to tailor TA to each organization's setting and unique challenges. The Federation offers a Community of Practice meeting series that addresses workforce training, onboarding and advocacy for integrated care, among other topics. There are regular opportunities for shared learning, including a monthly continuing education training and a monthly convening of behavioral health directors. Health plans are often invited to the behavioral health directors meetings for real-time problem-solving and goal setting. The Federation also facilitates an annual multidisciplinary team meeting for each site to reflect on their degree of integration and operational issues. The Federation's BHI work is conducted in the context of an array of support to participating health centers to improve and expand access to care and quality for the communities they serve.

BHI efforts in Texas began, in large part, with the foundational work to create large-scale mental health access networks: CPAN for pediatric psychiatry, PeriPAN for perinatal populations and Texas Child Health Access through Telemedicine (TCHATT) for school-based care.[40] These initiatives provide real-time consultation and resources, improving capabilities for primary care and perinatal providers to address a broad range of behavioral health needs. Complementing these networks is participation in BHIG, available to all practices serving adolescents. BHIG offers tailored TA, including continuing education and live case consultations. In addition, a child psychiatrist is available for an in-person or virtual visit following a CPAN consultation. While BHIG TA to practices was initially delivered using a train-the-trainer model, Texas transitioned to directly providing TA to practices. Direct delivery better equipped BHIG's improvement team to support each health system in addressing the unique barriers and opportunities within their respective systems of care.

Virginia embedded TA within its Primary Pathways pilot, coupling financial support with direct guidance on EHR integration, screening adoption and workforce training. The Pathways' tiered approach supports a process for practices to move from an infrastructure with basic readiness to more advanced integration over time. Specific activities include a monthly call, online hub and crowd-sourced provider directory for community-based behavioral health providers. All practices and stakeholders come to the table with a spirit of learning and interest in exchanging best practices. Conversations that cross boundaries between plans and practices create transparency around the value proposition for each stakeholder and help people work together. Practices also receive upfront infrastructure funding and a prospective per-member per-month payment.

> *"We came to the table with a spirit of listening and learning and then tailoring, rather than prescribing. There was almost a visceral sigh of relief when people realized that we were there to listen to them . . . and help them get to where they want to go."*
>
> *—Key Informant*

Recommendations to Other States

Interviews with key informants resulted in a more nuanced understanding of each state's approach to support practices with BHI and make progress in advancing systems of integrated care regionally and statewide. Key informants were asked to offer recommendations to other states interested in advancing BHI efforts, revealing the following thematic areas:

- Engaging stakeholders and prioritizing shared goals
- Starting with existing momentum and alignment
- Embedding flexibility and responsiveness
- Connecting delivery system reform with payment reform
- Reducing data and reporting complexities

Regarding stakeholder engagement, each key informant described ways to initiate and sustain ongoing collaboration and the value of that collaboration to BHI efforts. One key informant described BHI progress as a "relationship process," noting that building buy-in early on through education and engagement helps create goodwill and supports collaboration when challenges arise. Another key informant emphasized the importance of thinking broadly about possible stakeholders, including consideration of health plans, schools, employers, purchasers and public agencies. To engage critical stakeholders, particularly legislators and state officials, it was suggested that actionable evidence and data at the community level are effective in helping to quantify impact and galvanize them toward action. Another key informant described collaboration with employers and health plans as pivotal in reframing BHI as an essential component of care delivery rather than an optional enhancement.

"Having public and commercial payers talking makes it easier. Transformation is two things, changing the delivery system and the payment model. If there isn't a change in the payment model, neither one along can be successful."

—Key Informant

Other suggestions included:

- Anticipate surprises and build in flexibility and additional capacity to address them as they occur.
- To build goodwill and ensure balanced input, create space for each stakeholder to share their perspective, organizational strengths related to BHI and how they can enhance BHI work.
- Employ consensus-based decision making as an effective tool in working across stakeholders.

"Part of our success is that we're model agnostic. We share the same goal of increasing access but different communities need different things."

—Key Informant

Key Recommendations for States Advancing BHI

- **Engage stakeholders early**
- **Start with existing momentum**
- **Embed flexibility in models**
- **Align payment and delivery reforms**
- **Reduce data/reporting burden**

Key informants agreed that there is not one best place to start in order to make progress on BHI goals. For example, two states had the greatest convergence of stakeholder engagement and alignment on pediatric initiatives, which became the focal point of integration efforts. Most also emphasized that flexibility in the clinical model was instrumental in supporting practices to make progress where they can. Several key informants recommended starting with small-scale efforts, noting that investment in broader initiatives might be facilitated by pilot data demonstrating improved outcomes. It was also recommended to start by finding interested health plans and practices willing to lead the way on delivery model and payment model changes. For example, Virginia initiated its BHI work with two payers and Pennsylvania's work began with its Medicaid managed care plan.

"Start where you are and continue to build."

—Key Informant

Discussions with key informants also spoke to financing BHI efforts, including changes to the payment model and providing funding to support start-up activities and ongoing infrastructure needs that may not be covered through reimbursement. "The payment model should be designed not just for a pilot program, but to support scaling and ongoing operations of a true integrated team," said one key informant. Another stated that, "prospective payment was important in recognizing the tremendous value that integrated care brings that may not be based on a CPT code." Others spoke about the financial burden of integration and that start-up and implementation funding should reflect these costs (e.g., IT and IT integration costs, training and associated time away from clinical care to participate).

Some key informants also spoke to challenges related to data and reporting. Several pointed to the value of ensuring a uniform data set across BHI and other practice transformation efforts. One key informant described their work to build consensus on both measure sets and payment models to reduce fragmentation. Another noted the limitations of clinical quality measures with benchmarks that explicitly speak to the success of BHI. This same key informant said it would be helpful to ensure providers can capture as much data as possible in discrete data fields to facilitate extracting data in a way that speaks to the impact of BHI. Another interviewee also emphasized the importance of data to support the provision of TA.

Conclusion

The collective insights described in this paper underscore the promise and the complexity of advancing BHI in California and across the United States. Comparative analysis reveals the importance of a shared, contextually relevant framework for integration that benefits from durable alignment across a broad array of stakeholders. Interviews with more than 20 key informants across both workstreams underscore that sustainable progress on BHI requires a balance between flexibility and standardization, between aspirational goals and operational feasibility and between model fidelity and local adaptation.

In California, there was clear consensus among key informants on the value of defining BHI and its attributes by leveraging an existing, relevant framework. Such alignment provides a foundation for coherent policy and payment strategies that strengthen practice transformation efforts and guide workforce development. Anchoring BHI attributes in the Advanced Primary Care framework builds on existing behavioral health and primary care reform efforts, reinforcing the importance of whole-person, team-based and equitable care.

Likewise, lessons from other states demonstrate that effective BHI relies on numerous factors that work in concert to support delivery system transformation. Common drivers include legislative and regulatory efforts that signal commitment by the state; funding and payment model changes that influence a practice's capacity to implement and sustain BHI; comprehensive and flexible TA to ensure care teams have the tools, training and coaching needed to translate policy into practice; and, flexible, model-agnostic approaches responsive to the local context. In addition, central to each state's progress has been a multi-stakeholder vehicle serving as a forum for stakeholders to develop models, address barriers and sustain momentum.

Similar to the four states highlighted in this paper, California's policy environment has already established some foundation to advance integration efforts:

- Regulators and public purchasers have increasingly focused on BHI. Established in 2022, the California Office of Health Care Affordability's enabling statute charges it with promoting and investing in BHI as part of its Behavioral Health in Primary Care module, among other responsibilities.[41]
- Commercial payers are now required to have a process to pay for integrated claims.[42, 43]
- Covered California and CalPERS each have requirements for health plans to demonstrate BHI work[44] and CalPERS articulated its goal of including BHI as part of the state's work on Advanced Primary Care.[45]
- Medi-Cal reimbursement for Collaborative Care

While California does not have an extant multi-stakeholder body overseeing BHI, opportunities for multi-stakeholder work are underway. For example, CQC manages a BHI Payer Workgroup, convening commercial plans to build internal infrastructure to support BHI. It has also planned a 2026 Health Care Leadership Summit focused on BHI, which will convene partners to identify and commit to actions that spread BHI across the health care system.

Behavioral health integration does not grow from a single reform. It requires a sustained process that includes alignment, flexibility and shared infrastructure.

While these efforts are important, the exploration of four states' path to BHI offer a roadmap for California to advance BHI efforts. State examples highlighted in this paper demonstrate that BHI is not a single reform but an evolving approach requiring flexibility, collaboration and persistence. And for California and other states beginning or deepening this work, the lesson is clear: start where you are,

engage broadly and build durable infrastructure that makes integrated care the norm rather than the exception. Along with alignment on how BHI is defined and measured, these elements create the backbone for providers in Advanced Primary Care practices to respond effectively to the behavioral health needs of their communities. As other states look to advance integration, lessons from California and other states offer valuable guidance for success and emphasize that integration is not an endpoint, but an ongoing process of implementation, adaptation and collaboration.

Ultimately, advancing BHI in California requires a collective commitment to systemic alignment and coordinated action. By adopting shared definitions, common attributes and a cohesive policy framework, California can accelerate its transition to a primary care system that seamlessly integrates behavioral health, enhances patient outcomes and supports care teams in this transformational work. The framework proposed here offers not only a roadmap for California but also a model for other states seeking to bridge policy and practice in pursuit of equitable, high-quality, integrated care.

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About the California Quality Collaborative (CQC)

California Quality Collaborative (CQC), a program of the Purchaser Business Group on Health, is health care improvement program dedicated to helping care teams gain the expertise, infrastructure and tools they need to advance care quality, be patient-centered, improve efficiency and thrive in today's rapidly changing environment. CQC is committed to advancing the quality and efficiency of the health care delivery system across all payers, and its multiple initiatives bring together providers, health plans, the state and purchasers to align goals and take action to improve the value of health care for Californians.

calquality.org

Appendix A:

Oregon Definitions for Behavioral Health Integration and Behavioral Health Clinicians + Oregon Standards

Integrated Behavioral Health Alliance of Oregon

This document establishes a structure for behavioral health integration as a fundamental component of the patient centered primary care home (PCPCH). It is a clear description of behavioral health integration in PCPCHs. It uses integration models supported by research and national consensus.* CCOs and other stakeholders can reference this framework when determining what resources are necessary in the system to ensure integrated service delivery for all Oregonians. This framework also could be used to support the development of statewide benchmarks for integration success and could likewise inform policy decisions.

This document overviews the following topics:

- Principle statement of the Integrated Behavioral Health Alliance of Oregon (IBHAO)
- Definition of Integrated Health Care
- Definition of Behavioral Health Clinician
- Recommended minimum standards for PCPCHs providing Integrated Health Care

IBHAO Principle Statement:
Behavioral health care is an integral component of the Patient Centered Primary Care Home (PCPCH) that focuses on the psychological and social determinants that affect overall health. Integrated Behavioral Health Alliance of Oregon (IBHAO), a workgroup of CCO Oregon, is defining the scope and standards of excellent, evidence-based behavioral health provision in the state of Oregon that is essential to achieving the Triple Aim.

Definitions:
"Integrated Health Care" means care provided to individuals and their families in a patient centered primary care home or behavioral health home by licensed primary care clinicians, behavioral health clinicians and other care team members working together to address one or more of the following: mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises, developmental risk/conditions, stress-related physical symptoms, preventative care, and ineffective patterns of health care utilization.

"Behavioral Health Clinician" means: a licensed psychiatrist, a licensed psychologist, a certified nurse practitioner with a specialty in psychiatric mental health, a licensed clinical social worker, a licensed professional counselor or licensed marriage and family therapist, a certified clinical social work associate, an intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

*Adapted from AHRQ *Professional Practices in Behavioral Health and Primary Care Integration* 2015. http://integrationacademy.ahrq.gov/

Recommended Minimum Standards for Patient-Centered Primary Care Homes (PCPCH) Providing Integrated Health Care
CCO Oregon concepts developed by expert consensus—November 2015

Minimum Standard*	Specifications
Integrated behavioral health services are provided as part of routine care at the PCPCH including licensed Behavioral Health Clinician(s) (BHC) delivering an array of services on-site. BHC as defined in ORS 414.025.	BHC(s) provides care at the PCPCH with a ratio of 1 FTE BHC for every 6 FTE of Primary Care Clinicians (PCC). For example, a practice with 4 FTE PCC would need to have .67 FTE of a BHC (approximately 26.5 hours/week). For rural practices with behavioral health clinician shortages, integrated services may be provided virtually as long as other standards are met.
Integrated BHC provides a broad array of comprehensive evidence-based behavioral health services.	BHC services should be applicable to the PCPCH patient population served, including care for: mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises, developmental risks and conditions, stress-related physical symptoms, preventive care, and ineffective patterns of health care utilization per ORS 414.025.
Integrated BHC provides same-day open access behavioral health services.	Same-day open access services include warm hand-offs, brief assessments and interventions for patient and families, consultations to primary care clinicians and other care team members, and participation in pre-visit planning and daily huddles. Same-day open access services are provided in real-time at the point of care when behavioral health issues are identified at the PCPCH. On average, at least half of the BHC's hours at the practice each week must be available for same-day open access services.
Primary care clinicians, staff, and BHC utilize shared medical records and have a mechanism in place for collaborative care planning and co-management of patients.	Primary care clinicians, staff, and BHC document clinically relevant patient information in the same medical record system and participate in collaborative treatment planning and co-management via case conferences, consults, pre-visit planning and/or daily huddles.
BHC is an integrated part of the primary care team.	Primary care clinicians, staff, and BHC utilize shared physical space and the BHC participates in practice activities such as team meetings, daily huddles, pre-visit planning, and quality improvement projects.
PCPCH utilizes a population-based approach to delivering and coordinating integrated behavioral health services.	PCPCH utilizes universal behavioral health screening, care coordination, and panel management to monitor the behavioral health needs and outcomes of the PCPCH patient population. PCPCH utilizes written protocols for referrals to appropriate specialist(s) and hospitalization if clinically indicated.
The integrated team includes psychiatric consultative resources.	PCPCH identifies the psychiatric care needs of their population, determines viable psychiatric consultation strategies and provider options, and develops a care model hat includes these services.

* Adapted from AHRQ *Professional Practices in Behavioral Health and Primary Care Integration* 2015 http://integrationacademy.ahrq.gov/

*Adapted from AHRQ *Professional Practices in Behavioral Health and Primary Care Integration* 2015.
http://integrationacademy.ahrq.gov/

Appendix B:

Interviewees

- Blue Shield California (CQC BHI Initiative Advisory Group member)
- California Department of Health Care Access and Information: Office of Health Care Affordability
- California Department of Managed Health Care
- CalPERS
- Chinese Hospital (CQC BHI Initiative Advisory Group member)
- Cigna Healthcare
- Covered California
- Health Access California
- John Muir Health (CQC BHI Initiative Advisory Group member)
- LifeLong Medical Care
- Providence
- Rady Children's Hospital San Diego, now part of Rady Children's Health
- Scripps Medical Group (CQC BHI Initiative Advisory Group member)
- Share Ourselves
- Sutter Health

Appendix C

Key Informants (Multi-stakeholder Interviews)

Colorado:

- Allyson Gottsman, Colorado Health Extension System Program Manager
- Stephanie Kirchner, MSPH, RD, Senior Instructor, Department of Family Medicine, University of Colorado; Practice Transformation Program Manager

Pennsylvania:

- Natalie Levkovich, CEO, Health Federation of Philadelphia

Texas:

- Clare McNutt, PA-C, MSHS, Senior Vice President for Health System Integration, Meadows Mental Health Policy Institute
- Katie Steele, PhD, Director of Research and Learning, Center for Health System Transformation, Meadows Mental Health Policy Institute

Virginia:

- Lauryn Walker, RN, MPH, PhD, Chief Strategy Officer, Virginia Center for Health Innovation
- Stephen Horan, PhD, Founding President, Community Health Solutions (note: Dr. Horan participated in the webinar but was not interviewed)

Endnotes

1 California Department of Health Care Services. (2023, March 20). All-Plan Letter 22-029: Dyadic Services and Family Therapy Benefit. Accessed September 24, 2025 from: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-029.pdf

2 California Primary Care Association. (2023, May 23). Senate Bill 966 (Limón) FAQs. Accessed September 24, 2025 from: https://dyadiccare.ucsf.edu/assets/g-file/CPCA-SB-966-and-ASW_AMFT-FAQ_5.23.23.pdf

3 California Health & Safety Code § 1374.725

4 Integrated Behavioral Health Alliance of Oregon. (2015, November). Recommended Minimum Standards for Patient-Centered Primary Care Homes (PCPCH) Providing Integrated Health Care. Accessed July 22, 2025 https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/Recommended-PCPCH-Integrated-Care-Standards.pdf

5 Ibid.

6 Reiter JT, Dobmeyer AC, Hunter CL. The Primary Care Behavioral Health (PCBH) Model: An Overview and Operational Definition. J Clin Psychol Med Settings. 2018 Jun;25(2):109-126.

7 American Psychiatric Association. Learn About the Collaborative Care Model: Explore this effective model in integrated care [webpage]. Accessed September 16, 2025 from: https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn

8 The key informant from Virginia, Dr. Walker, was not available to participate in the webinar. Steven Horan, PhD, President & CEO of Community Health Solutions, presented in her stead.

9 Oregon Health Authority. Standards: How the PCPCH Recognition Criteria is developed [webpage]. Accessed July 31, 2025 from: https://www.oregon.gov/oha/HPA/dsi-pcpch/Pages/Standards.aspx

10 Oregon Health Authority. (Last Updated 2024, December 11). Patient Centered Primary Care Homes. Accessed August 1, 2025 from: https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH%20Program%20Fact%20Sheet%202024.pdf

11 California Quality Collaborative. (2022, April). Advanced Primary Care: Defining A Shared Standard. Accessed July 17, 2025 from https://www.pbgh.org/wp-content/uploads/2022/04/advanced-primary-care-shared-standard.pdf

12 Bodenheimer, T., Ghorob, A., Willard-Grace, R., & Grumbach, K. The 10 Building Blocks of High-Performing Primary Care. The Annals of Family Medicine Mar 2014, 12 (2) 166-171.

13 California Health Care Foundation. (2021, May). Psychiatric Collaborative Care Model in Medi-Cal. Oakland: author. Accessed July 21, 2025 from: https://www.chcf.org/wp-content/uploads/2021/05/PsychiatricCoCMBenefitMediCal.pdf

14 Integrated Behavioral Health Alliance of Oregon. (2015, November). Recommended Minimum Standards for Patient-Centered Primary Care Homes (PCPCH) Providing Integrated Health Care. Accessed July 22, 2025 https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/Recommended-PCPCH-Integrated-Care-Standards.pdf

15 California Primary Care Association (2025). 2025 Behavioral Health Survey Report. Retrieved from https://cpcaadmin.sharepoint.com/:b:/s/CPCAPublicSite/EUCGLw2xC3RInOG5uap7qfMBOd5uWL63fmwQshrZc0gPsw?e=7gymIv

[16] The most recent version of Oregon's PCPCH standards, released in 2024, include these concepts and related specifications. The standards are available on the Oregon Health Authority's website: https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/2025%20PCPCH%20Recognition%20Standards%20Quick%20Reference%20Guide%20-%20FINAL.pdf

[17] Examples of California regulatory changes include: the addition of Collaborative Care Model CPT codes to the Medi-Cal fee schedule, adding associate licensed behavioral health clinicians to the list of Medi-Cal billable providers, adding the dyadic therapy benefit to Medi-Cal.

[18] Three CPT codes are used to claim reimbursement for services delivered in the Collaborative Care Model: 99492, 99493, 99494.

[19] Commonwealth of Pennsylvania. *Behavioral Health Choices: Behavioral Health Managed Care Organizations (BH-MCOs)* [webpage]. Accessed September 12, 2025 from: https://www.pa.gov/agencies/dhs/resources/medicaid/bhc/bhc-mcos

[20] Pennsylvania Department of Human Services. *Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Prospective Payment System (PPS) Frequently Asked Questions.* Accessed September 12, 2025 from: https://pachc.org/wp-content/uploads/2024/02/UPDATED-FQHC-RHC-FAQs-2016.pdf

[21] Texas Medicaid & Healthcare Partnership. (2022, April 15). *The Collaborative Care Model to Become a Benefit of Texas Medicaid June 1, 2022* [webpage]. Accessed September 17, 2025 from: https://www.tmhp.com/news/2022-04-15-collaborative-care-model-become-benefit-texas-medicaid-june-1-2022

[22] *Advancing Care Together* was a four-year practice redesign to test strategies to integrate primary care, behavioral health and substance use disorder care. The program was operational from 2011 to September 2014. More information on the program can be found in *Early Lessons from Advancing Care Together* available here: https://archive.thepcc.org/sites/default/files/center-materials/Early%20Lessons%20from%20Advancing%20Care%20Together%207_16_14.pdf

[23] Colorado Department of Health Care Policy & Financing. *Integrated Care Sustainability Policy* [webpage]. Accessed September 12, 2025 from: https://hcpf.colorado.gov/integrated-care-sustainability-policy

[24] University of Colorado Anschutz. (2020, August 1). *Our Recent Work: Colorado Behavioral Health Task Force Recommendations Report* [webpage]. Accessed September 18, 2025 from: https://medschool.cuanschutz.edu/farleyhealthpolicycenter/our-work/news/recent/colorado-behavioral-health-task-force-recommendations-report

[25] Colorado General Assembly. HB22-1302: Health-care Practice Transformation. Accessed September 19, 2025 from: https://leg.colorado.gov/bills/hb22-1302

[26] Colorado Legislative Council Staff. HB 22-1302: Revised Fiscal Note. Accessed September 19, 2025 from: https://leg.colorado.gov/sites/default/files/documents/2022A/bills/fn/2022a_hb-1302

[27] Path Forward. (2025, July 8). *Medicaid in Colorado and Tennessee Now Covers Collaborative Care*. Accessed September 17, 2025 from: https://pathforwardcoalition.org/policy/medicaid-in-colorado-and-tennessee-now-covers-collaborative-care/

[28] Milbank Memorial Fund. (2025, March 12). *Five States Leading Efforts to Increase Primary Care Spending*. Accessed September 18, 2025 from: https://www.milbank.org/publications/states-lead-efforts-to-increase-primary-care-spending/

[29] Virginia Department of Medical Assistance. *Coverage of Collaborative Care Management (CoCM) Services* [Bulletin]. Accessed September 17, 2025 from: https://vamedicaid.dmas.virginia.gov/bulletin/coverage-collaborative-care-management-cocm-services

[30] The University of Texas System. *Overview* [webpage]. Accessed September 9, 2025 from: https://tcmhcc.utsystem.edu/overview/

[31] The University System of Texas. TCMHCC: Overview [webpage]. Accessed September 25, 2025 from: https://tcmhcc.utsystem.edu/overview/

[32] Virginia Center for Health Innovation. (2024, September). Virginia Task Force on Primary Care. Accessed September 18, 2025 from: https://www.vahealthinnovation.org/wp-content/uploads/2024/10/Virginia-Task-Force-on-Primary-Care-One-pager_2024.pdf

[33] Ibid.

[34] Virginia Center for Health Innovation. *Primary Pathways: Paving the Way for Behavioral Health Integration* [webpage]. Accessed September 10, 2025 from: https://www.vahealthinnovation.org/primary-pathways/

[35] Eugene S. Farley, Jr. Health Policy Center & the Practice Innovation Program at the University of Colorado Anschutz Medical Campus. (2022, June). *The Building Blocks of Behavioral Health Integration*. Accessed September 15, 2025 from: https://wellbeingtrust.org/wp-content/uploads/2022/06/BHI-Framework-June-2022.pdf

[36] Health Federation of Philadelphia. *Philadelphia Integrated Care Network (PICN)* [webpage]. Accessed September 9, 2025 from: https://healthfederation.org/philadelphia-integrated-care-network-picn

[37] Meadows Mental Health Policy Institute. *Behavioral Health Integration and Guidance Initiative* [webpage]. Accessed September 17, 2025 from: https://mmhpi.org/project/behavioral-health-integration-and-guidance-initiative/

[38] Virginia Center for Health Innovation. *Primary Pathways: Paving the Way for Behavioral Health Integration* [webpage]. Accessed September 10, 2025 from: https://www.vahealthinnovation.org/primary-pathways/

[39] The National Council for Mental Wellbeing. (updated 2025, January). *Comprehensive Health Integration (CHI) Framework: Roadmap to Design, Implement and Sustain Physical Health-Behavioral Health Integration*. Accessed September 9, 2025 from: https://www.thenationalcouncil.org/wp-content/uploads/2025/02/25.02.10_CHI-White-Paper.pdf

[40] TCHATT provides telemedicine or telehealth programs to school districts to help identify and assess the behavioral health needs of children and adolescents and provide access to mental health services.

[41] California Office of Health Care Affordability. (2025, August). Proposed Behavioral Health Spending Definition and Measurement Methodology. Accessed September 24, 2025 from: https://hcai.ca.gov/document/ohca-proposed-behavioral-health-definition-august-2025/

[42] California, Health & Safety Code § 1374.725

[43] California Department of Managed Health Care. All-Plan Letter 24-023 (OPL) - Newly Enacted Statutes Impacting Health Plans (2024 Legislative Session). Accessed September 29, 2025 from: https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL24-023(OPL)-NewlyEnactedStatutesImpactingHealthPlans(2024LegislativeSession)_1.pdf?ver=pTIM7g7dnX3EcRmQPw1xkg%3d%3d

[44] American Medical Association. Working With Employers to Enable Behavioral Health Integration [webinar]. Accessed September 25, 2025 from: https://edhub.ama-assn.org/steps-forward/video-player/18976192?widget=personalizedcontent&previousarticle=0

[45] CalPERS. (2024, June 11). Meeting: State Of California Public Employees' Retirement System Board Of Administration Pension & Health Benefits Committee Open Session [Meeting Minutes]. Accessed September 25, 2025 from: https://www.calpers.ca.gov/documents/202406-pension-2024-0611-phbc-transcript-a/download

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