Advancing Behavioral Health Integration

Collaborative Strategies for Sustainable Change

Nicole Stelter, PhD, LMFT

Director, Behavioral Health Clinical Strategy & Programs,
Blue Shield of California

Caity Haas, LCSW, MHA, ACM

Principal Clinical Program Manager, Behavioral Health Clinical Strategy & Programs
Blue Shield of California

Muriel LaMois, MPH

Program Manager, Industry Initiatives
Blue Shield of California

September 2025

Table of Contents

Acknowledgements

Blue Shield of California Industry Initiatives thanks Karen Shore, PhD, Golden State Health Policy, and Sarah Kang, MPP, BluePath Health for their support in the production of this paper.

Golden State Health Policy works to translate research to inform evidence-based health policy through policy analysis, program evaluation, and research.

Learn more at goldenstatehealthpolicy.com

BluePath Health provides healthcare consulting to health systems, government and commercial payers, technology providers and grant makers. They develop forward thinking policies and strategies that improve care delivery and community health.

Learn more at bluepathhealth.com

Thanks to Kristina Mody, MPH, the California Quality Collaborative, for the expertise provided through multiple interviews and her extensive research that shaped the development of this paper, as well as the stakeholders who agreed to be interviewed for this paper. The recommendations in this paper are solely those of Blue Shield of California; inclusion of organization names as interviewees below does not indicate their endorsement of the paper.

Additional thanks to Claire Baki, Margeaux Cardona, Andy Chasin, Robby Franceschini, Andrew Kiefer, Emma Schlosser, and Sarah Summer at Blue Shield of California for their review and support in the production of this paper.

Thank you to Emphasis Media for design support for the paper.

ORGANIZATIONS & INDIVIDUALS INTERVIEWED*

- AIMS Center at the University of Washington
- Altais
- California Primary Care Association
- California Quality Collaborative
- Center for Substance Abuse Prevention
- Key Medical Group
- Providence Health & Services
- Sutter Health
- Brian Sandoval, Psy.D.
- Julian Mitton, M.D.

* *This list omits organizations that did not authorize acknowledgement.*

Executive Summary

Nearly one in five U.S. adults live with a diagnosed behavioral health condition[1], but patients often struggle to access the care they need.

Behavioral Health Integration (BHI) has emerged as a powerful, evidence-based method to deliver high-quality behavioral health care in primary care and other medical settings. Given that 80% of Americans saw a primary care physician in the past year, BHI can remove the burden from patients by connecting them to behavioral health services where they are already receiving care. **Integrating behavioral health into primary care creates a more holistic and patient-centered system of care** where behavioral and physical conditions are treated concurrently under a comprehensive care plan leading to better health outcomes.

Despite the benefits of BHI, the healthcare system has struggled to scale and sustain integrated models due to challenges stemming from industry misalignment, fragmentation, and lack of financial investment.

Provider organizations can face barriers to implementing BHI in their practices due to high upfront costs, necessary technological investments, and the additional time and effort required of already busy clinicians for training and workflow development. Once implemented, providers often report that complexities in navigating billing and reimbursement can threaten their ability to sustain BHI programs.

Collaboration across providers, payers, government agencies, and other stakeholders can help address the barriers to BHI by providing clarity, improving administrative processes, and increasing financial investment. Opportunities include improving engagement and alignment across health plans, establishing statewide spending measurements and benchmarks, and increasing access to training and technical assistance. This paper provides case studies on how health plans can build effective partnerships with provider organizations to support BHI as well as how stakeholders can work together to develop a statewide definition of BHI that can advance greater alignment and investment across policy, industry practices, and other integration-focused initiatives.

> **Behavioral health integration represents an opportunity to create a more comprehensive, person-centered system of care.**

Behavioral health integration represents an opportunity to create a more comprehensive, person-centered system of care that concurrently identifies and treats behavioral health alongside medical conditions. Through stakeholder collaboration, aligned industry investment, and supportive policymaking, the healthcare system can address barriers to scaling and sustaining BHI models, increasing patient access to high-quality, evidence-based care.

Integrated Care: The Foundation for a Robust Behavioral

Need for behavioral health services is high and continues to rise nationally, but patients often struggle to access treatment.

A 2022 survey estimated that more than one in five adults in the United States (about 59.3 million people), have a mental health diagnosis, but among those, over 28% of people were unable to access treatment.[II] Even when patients connect to care, 20% of adults receiving outpatient mental health care drop out before completing the recommended course of treatment.[III]

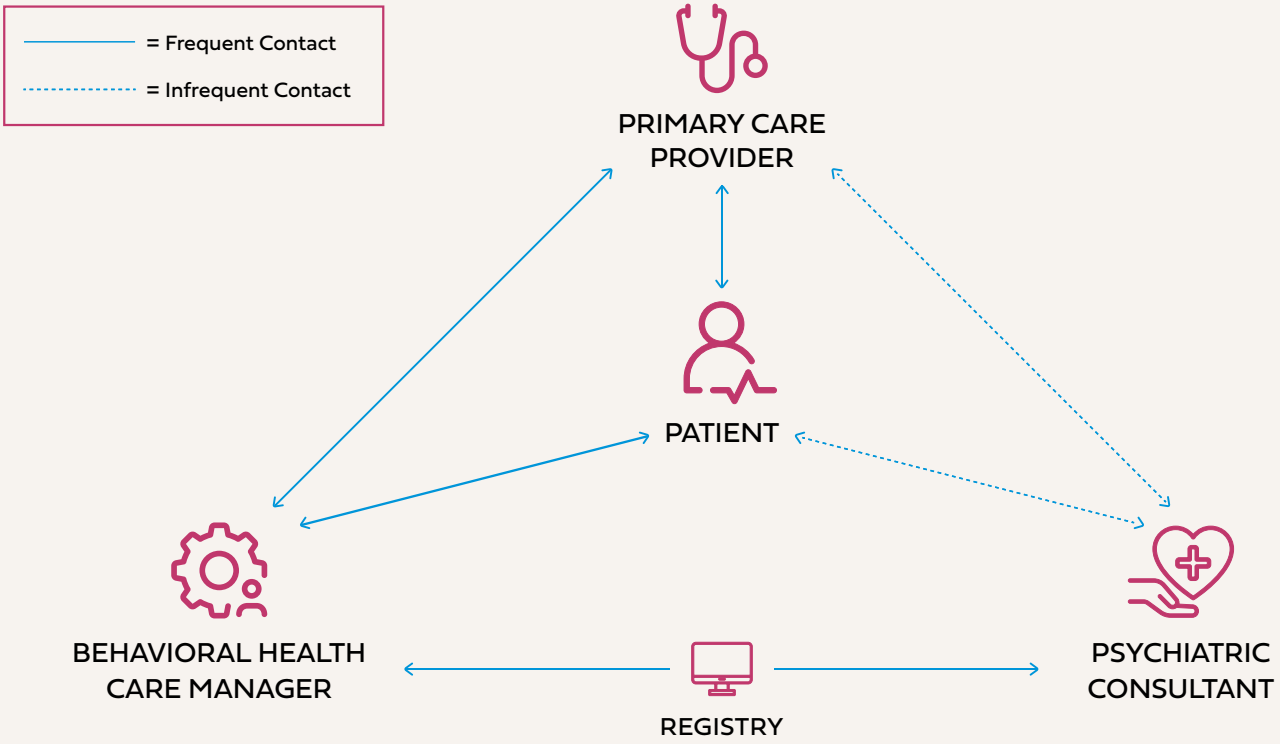
Behavioral health integration (BHI) has emerged as a powerful, evidence-based foundation for a robust behavioral healthcare system. BHI, such as the Collaborative Care Model and the Primary Care Behavioral Health Model, puts behavioral health professionals and resources into primary care and other medical settings enabling the concurrent and comprehensive treatment of medical and behavioral health. Given that 80% of Americans saw a primary care physician in the past year, BHI can remove the burden from patients by connecting them to behavioral health services where they are already receiving care. Patients who receive behavioral health care in a primary care setting are also more likely to complete their course of treatment, and BHI has been shown to more than double the effectiveness of treatment.

Behavioral health is closely linked to physical health: **70% of patients with a behavioral health condition have a medical comorbidity, while more than 30% of patients with a physical condition also have behavioral health needs.**[IV] Integrating behavioral health into primary care creates a more holistic and patient-centered system of care where behavioral and physical conditions are treated concurrently under a comprehensive care plan leading to better health outcomes.

Primary care providers working in an integrated system report a **higher level of productivity as well as feeling more satisfied and confident in managing behavioral health conditions.**[V] Over 60% of psychotropic medications, such as antidepressants, mood stabilizers, or other drugs that influence brain activity, are prescribed in primary care settings.[VI] Integration puts staff and resources into the care team to effectively monitor and address outcomes. For example, the Collaborative Care Model adds a psychiatric consultant and behavioral healthcare manager to the care team which enables a level of ongoing monitoring of patient status not otherwise possible, leading to more effective treatment and medication management (see figure on next page).

Despite the benefits of BHI, the healthcare system has struggled to scale and sustain integrated models due to challenges stemming from industry misalignment, fragmentation, and lack of financial investment. Stakeholders across the healthcare ecosystem have an opportunity to work together to create a solid foundation for integrated care and improve behavioral health services and health outcomes for millions of Americans.

Principles of the Collaborative Care Model



Patient-Centered Care Team:

Primary care and behavioral health providers collaborate effectively using shared care plans that incorporate patient goals.

Population-Based Care:

Care teams share a defined group of patients tracked in a registry to ensure no one falls through the cracks.

Measurement-Based Treatment:

Treatment plans clearly articulate personal goals and clinical outcomes that are routinely measured by evidence-based tools; treatments are actively changed until clinical goals are achieved.

Evidence-Based Care:

Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition.

Accountable Care:

Providers are accountable and reimbursed for quality of care and clinical outcomes.

Adapted from the AIMS Center, Principles of Collaborative Care (text and graphic).

Challenges to Scaling and Sustaining Behavioral Health Integration

As the healthcare industry works to build a more integrated system, provider organizations face a number of challenges starting and maintaining successful BHI programs.

These barriers can be significant, threatening the sustainability of established BHI programs or discouraging some organizations from pursuing integration altogether. The California Primary Care Association's 2025 Behavioral Health Survey Report shows that community health clinics reported a decrease in offering fully integrated mental health services compared to 2018 and 2020. It reports this decrease is likely due to resource limitations, workforce and staffing challenges, and structural difficulties.[VII]

Outlined below are challenges to implementing and sustaining BHI programs, as described through interviews with provider organizations:

IMPLEMENTATION CHALLENGES:

Upfront Costs: The cost of implementing a new BHI model can be difficult for practices to accurately estimate, but typical costs include hiring and training clinical staff, updating technology, and leveraging IT resources. The Meadows Institute analyzed the cost of instituting the Collaborative Care Model (CoCM) in 10 health systems across the country and found that the median upfront cost in the first three months of implementation was $160,000 per clinic, with a range of $49,000 to $650,000 per clinic.[VIII] Many practices depend on grant funding to support the first one to three years after launching a new BHI program.

Technology: For CoCM, a registry[IX] needs to be developed or implemented by a vendor to track patient- and population-level outcomes, among others. The launch of this registry is both expensive and time-consuming. Although grant funding for behavioral health providers may be available, many funding opportunities require co-location of behavioral health providers and their partners, which is not required with the CoCM and is not feasible for all practices. When primary care and behavioral health care are integrated but providers are not co-located, practices will need technology that supports virtual care.

> **The ability to stand up and use a comprehensive registry to track patient outcomes in a longitudinal fashion is a challenge. You have to lean into a measured outcome approach that takes time and understanding to integrate into existing data systems and EHRs. There is an institutional hesitancy to jump in because of those expectations.**
>
> *- Provider Quote*

Provider Capacity: While many providers report increased satisfaction and productivity after implementing BHI, getting a program started requires time and effort from already busy clinicians. Integrated care is not always taught during medical school education, so training is necessary in addition to developing new workflows and incorporating new technologies. Primary care providers are also the target audience for many different patient care initiatives, and some interviewees noted that they can experience pilot project fatigue.

SUSTAINABILITY CHALLENGES:

Carveouts: In states like California, where responsibility for behavioral health is often delegated to a managed behavioral healthcare organization (MBHO), payers and providers face additional challenges in navigating reimbursement for behavioral health integration. While CoCM codes are billed under medical benefits, the Primary Care Behavioral Health model uses general behavioral health codes and are typically billed under a patient's behavioral health benefit.[X] Some providers reported challenges knowing when to submit a claim to a health plan or to an MBHO. Health plans might not be aware that Collaborative Care is billed as a medical benefit, leading them to improperly deny CoCM claims submitted by primary care providers.

Payer Engagement: Historically, not all health plans have provided reimbursement for Collaborative Care codes, although that is changing. However, even when a health plan does reimburse for Collaborative Care, provider organizations report experiencing frequent delays in payment or improper rejection of claims. It can be challenging to identify the correct point of contact within a health plan to resolve issues, and it can take months to a year to establish reliable reimbursement processes with a health plan. Additionally, finding the right contact at the health plan who is aware of the challenges of this particular type of billing can be extremely challenging.

> **Educating payers about accepting these [CoCM] codes is the second biggest roadblock overall in a provider's daily work for integrated care.**
>
> *- Provider Quote*

Variations In Billing & Reimbursement: There is significant variation across health plans' processes and requirements related to behavioral health integration. Providers must navigate differences in minimum required standards of BHI, such as whether a health plan requires co-location of practitioners. Required documentation, credentialing, prior authorization, and other requirements also vary, not just across different health plans, but also different lines of business within health plans. Differences in reimbursement rates can create challenges for accurate financial forecasting and planning. For the financial sustainability of provider practices, experts recommend that commercial plans pay BHI codes at parity with Medicare or higher.[XI] Additionally, in states such as California, federally qualified health centers (FQHCs) are not able to be reimbursed for both medical and mental health services billed on the same day, impacting the sustainability of their integrated programs.

Out-of-Pocket Costs: Although integrated behavioral health services are designed to be offered at minimal or no cost to patients, even modest additional out-of-pocket costs in the form of co-pays or co-insurance can discourage patients from participating in integrated programs. Out-of-pocket costs were noted by multiple interviewees as the greatest barrier for individuals to consent to this model of service.[XII]

Advancing Behavioral Health Integration Through Collective Solutions

Collaboration across providers, payers, government agencies, and other stakeholders can help address the barriers listed above by providing clarity, improving administrative processes, and increasing financial investment for behavioral health integration. Aligned action as described below is critical to overcoming challenges and creating a strong foundation upon which integrated care models can be scaled and sustained.

Health Plan Engagement and Alignment can help ease administrative burden for providers and improve financial sustainability through more reliable reimbursement. The California Quality Collaborative (CQC) has convened a workgroup of six health plans across the state to develop and implement tools that support best practices in BHI financing. Templates for the tools developed through the workgroup will be shared publicly at CalQuality.org.

ACTION ITEMS:

- Health plans should adopt Collaborative Care billing codes and other BHI codes. The Centers for Medicare and Medicaid Services has also proposed establishing three new G-Codes for BHI services in the CY2026 Medicare Physician Fee Schedule proposed rule (GPCM1, GPCM2, GPCM3). Once finalized, payers and MBHOs should adopt these codes as well.

- Health plans should implement tools such as BHI FAQs for internal use and for their networked providers to clarify processes, documentation, and other requirements for BHI billing to support timely and accurate reimbursement. The CQC is developing payer-validated templates that will be published on their website in Q4 2025.

- Health plans should work with regulators, providers, and other stakeholders such as neutral conveners to streamline processes where possible (e.g., aligning credentialing processes across plans and MBHOs).[XIII] Additional alignment on compliance requirements such as pre-authorization and patient consent can further reduce administrative burden.[XIV]

- Health plans should build strong partnerships with their provider networks regarding behavioral health integration. See the case study below for further details.

Establishing Statewide Spending Measurements and Benchmarks focused on behavioral health integration can increase financial investment. In California, the Office of Health Care Affordability (OHCA) has set a statewide benchmark recommending be allocated to primary care by 2034.[XV] This includes a specific module to account for spending on behavioral health in primary care.[XVI] The annual investment benchmark will be measured across health plans and OHCA will include an analysis of primary care spending and performance against the benchmark in its annual report.[XVII] Spending targets such as this can have a significant impact on advancing integration and promoting high-value system performance.[XVIII]

ACTION ITEMS:

- In California, OHCA is still working to develop a health plan benchmark(s) for increasing behavioral health spending. While BHI is included as part of the primary care benchmark, a benchmark increasing spending specifically for BHI would help focus critical and time-sensitive investment necessary to scale and sustain BHI programs.
- Other states can advocate for regulators to create a stakeholder workgroup similar to OHCA's Payment and Investment Workgroup to develop recommendations for benchmarks. Participants should include representatives of health plans, providers, hospitals, consumer advocates, purchasers, among others.
- In measuring and benchmarking BHI, it is important to include data on non-claims-based payments in addition to claims-based payments. Solely increasing payment for BHI services is not sufficient to scale BHI programs; non-claims based payments such as practice transformation and infrastructure payments are also necessary.
- A statewide definition of BHI can create a strong foundation for other statewide efforts to scale and sustain BHI. See case study on page 10 for details.

Training and Technical Assistance is critical for practices building integrated care teams and developing new workflows. Health plans, government agencies, and grant makers can provide financial support, and even pool funding to cover the cost of training and technical assistance for provider organizations implementing integrated behavioral health models. Policymakers should also work to expand and reform graduate medical education to include behavioral health integration in required curriculum.

ACTION ITEMS:

- Provider-to-provider education can be particularly effective in supporting adoption of BHI. Learning directly from other providers about the effectiveness and methodology of BHI, as well as hearing about self-reported improvements in provider satisfaction and productivity, can help encourage providers to implement at their own organization. Health plans, government agencies, and grant makers can help to convene and financially support these learning collaboratives
- Funders can also support access to qualified technical assistance, which is a critical tool to successfully navigate the staffing changes, new technology platforms, and workflow development necessary for BHI. As one example, health plans can contract with technical assistance vendors and provide access to their networks. Comprehensive technical assistance can include pre-implementation coaching, workflow optimization, and ongoing support post-launch.

Case Study on Collective Solutions

Health Plan and Provider Partnership: Advancing Integrated Care Through Strategic Collaboration

Health plans can play a vital role in supporting the success of behavioral health integration by working with provider organizations to supply the financial, operational, and strategic support necessary to sustain these programs.

Strong partnerships between health plans and providers can also help plans improve data related to BHI services. This allows them to better identify services their members are receiving, uncover gaps in member access to BHI services, and support program evaluation and quality improvement efforts.

In order to expand member access to integrated behavioral health services, Blue Shield of California developed a strategy to proactively engage provider organizations and offer financial and technical assistance to support the implementation and success of BHI programs.

KEY COMPONENTS INCLUDE:

- **Network Analysis:** Identifying provider organizations that were submitting claims for Collaborative Care services enabled Blue Shield of California to engage these organizations to offer support services. The analysis additionally helped Blue Shield identify and address gaps in member access to BHI services.
- **Provider Engagement:** Building relationships with providers who are interested in sustainable behavioral health solutions for their populations and offering ongoing implementation support, training, and program management.
- **Technical Assistance:** Blue Shield of California partnered with the AIMS Center at the University of Washington to provide cost-free technical assistance including provider training, workflow development, and evaluation to providers implementing BHI programs.
- **Designated Point of Contact:** A clear health plan resource for behavioral health integration who is the point of contact enables providers to quickly troubleshoot issues or clarify information on required processes and documentation. This supports timely and accurate reimbursement for integrated services.

Case Study on Collective Solutions

Statewide Definition of Behavioral Health Integration

A statewide definition of behavioral health integration creates a shared vocabulary and establishes clear expectations on the components and care team members required for integrated care. Statewide adoption of a shared definition can help advance behavioral health integration by supporting greater alignment and investment across policy, industry practices, and several other states have developed a statewide definition for behavioral health integration, including Oregon, Washington, Virginia, and Pennsylvania.

While states may adopt different definitions that best fit the structure and needs of their population, there are consistent core components that should be addressed:

- Standardization that allows for flexibility in BHI model while maintaining minimum standards
- Practitioners allowed to bill for behavioral health integration services
- Minimum staffing requirements

EXAMPLES OF STATEWIDE DEFINITIONS:

- Oregon (convener: CCO Oregon)
- Washington (convener: The Bree Collaborative)

OTHER KEY CONSIDERATIONS FOR HOW TO DEVELOP CONSENSUS FOR A STATEWIDE DEFINITION INCLUDE:

- **Network Analysis:** Identifying provider organizations that were submitting claims for Collaborative Care services enabled Blue Shield of California to engage these organizations to offer support services. The analysis additionally helped Blue Shield identify and address gaps in member access to BHI services.
- **Neutral Convener:** Identify a lead convening body that is neutral and influential in your state to both industry and regulatory leaders.
- **Stakeholder Engagement:** All relevant entities should be represented in developing a definition including health systems, FQHCs, provider groups, and health plans.
- **Multi-Payer Alignment**: Most clinics have three or four different types of payers. Aligning payers ensures care can be provided uniformly across all lines of business, reducing administrative burden and preventing disparities in care.
- **Regional Factors**: Understand if there are regional variations that need to be addressed before a standardized definition can be adopted statewide.
- **Existing Standards:** A statewide BHI definition can be easier to incorporate if it is connected to already existing standards. Oregon integrated their definition into already existing primary care standards.

Conclusion

Behavioral health integration represents an opportunity to create a more comprehensive, person-centered system of care that concurrently identifies and treats behavioral health alongside medical conditions. Through stakeholder collaboration, aligned industry investment, and supportive policymaking, the healthcare system can address barriers to scaling and sustaining BHI models, increasing patient access to high-quality, evidence-based care.

Endnotes

i. Centers for Disease Control and Prevention. (2025). *About Mental Health.* https://www.cdc.gov/mental-health/about/index.html

ii. National Academies of Sciences, Engineering, and Medicine. (2024). *Expanding behavioral health care workforce participation in Medicare, Medicaid, and Marketplace plans: Behavioral health needs in the United States.* Washington, DC: National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK609444/

iii. Olfson, M., Mojtabai, R., Sampson, N. A., Hwang, I., *Druss*, B., Wang, P. S., Wells, K. B., Pincus, H. A., & Kessler, R. C. (2009). Dropout from outpatient mental health care in the United States. *Psychiatric services* (Washington, D.C.), 60(7), 898–907. https://doi.org/10.1176/ps.2009.60.7.898

iv. American Hospital Association. (2023). *3 Ways to Strengthen Physical and Behavioral Health Integration.* AHA Center for Health Innovation Market Scan. https://www.aha.org/aha-center-health-innovation-market-scan/2023-10-24-3-ways-strengthen-physical-and-behavioral-health-integration

v. Ibid

vi. Hughes, P. M., Annis, I. E., McGrath, R. E., & Thomas, K. C. (2024). *Psychotropic medication prescribing across medical providers,* 2016–2019. Psychiatric Services, 75(5), 477–480. Available at https://doi.org/10.1176/appi.ps.20230156

vii. California Primary Care Association. (2025). *2025 Behavioral Health Survey Report.* https://www.cpca.org/CPCA/HEALTH_CENTER_RESOURCES/Value_Based_Care/Behavioral_Health.aspx

viii. Meadows Institute Collaborative Care Implementation. *Costs Across 10 United States Health Systems.* Published May 2023, updated June 2023. https://mmhpi.org/wp-content/uploads/2023/04/COCM_Costs_Across_Ten_US_Health_Systems.pdf

ix. AIMS Center at the University of Washington. (2024). C*ollaborative Care Registry Design Considerations.* https://aims.uw.edu/wordpress/wp-content/uploads/2023/06/CoCM-Registry-Design-Considerations.pdf

x. California Quality Collaborative. (2024). *Behavioral Health Integration: Billing and Payment Codes.* https://www.calquality.org/wp-content/uploads/2024/11/CQC_BHI-Billing-and-Payment-Codes_CA_2024-1.pdf

xi. Meadows Mental Health Policy Institute. (2023). *Improving Behavioral Health Care for Youth Through Collaborative Care Expansion.* https://mmhpi.org/wp-content/uploads/2023/05/Improving-Behavioral-Health-Care-for-Youth_CoCM-Expansion.pdf

xii. Stakeholder Interview.

xiii. California Quality Collaborative. (2024) *Sustainable Behavioral Health Integration Financing: Successful Practices and Opportunities.* https://www.calquality.org/wp-content/uploads/2024/10/CQC_BHI-FIN-Issue-Brief_October-2024.pdf

xiv. Ibid.

xv. California Department of Health Care Access and Information. (2024). Primary Care Investment Benchmark. https://www.cpca.org/CPCA/HEALTH_CENTER_RESOURCES/Value_Based_Care/Behavioral_Health.aspx

xvi. California Department of Health Care Access and Information. (2024). Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Primary Care Investment Benchmark. https://hcai.ca.gov/wp-content/uploads/2024/10/Final_OHCA-Recommendations-to-Board-Proposed-Primary-Care-Investment-Benchmark-October-2024.pdf

xvii. California Department of Health Care Access and Information. (2024). Primary Care Investment Benchmark. https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/primary-care-investment-benchmark/

xviii. California Department of Health Care Access and Information. (2025). Promote High Value System Performance. https://hcai.ca.gov/affordability/ohca/promote-high-value-system-performance/