October 2024

Sustainable Behavioral Health Integration Financing

Successful Practices and Opportunities

PBGH California Quality Collaborative

Executive Summary

Integrating behavioral health into primary care ensures providers deliver timely, patient-centered, comprehensive whole-person care while improving access to behavioral health services. Payers, providers and purchasers are invested in providing patients high-quality, readily accessible and cost-efficient behavioral health care. Integrated care has been proven to improve patient outcomes, enhance care team satisfaction and reduce total cost of care. In California, primary care providers face significant challenges in receiving reimbursement for integrated behavioral health services which hinders their ability to integrate these services into primary care settings and limits the expansion and scaling of behavioral health integration (BHI) across their larger network.

In 2024, the California Quality Collaborative (CQC) conducted a state-wide landscape assessment to identify, synthesize and disseminate successful practices that facilitate sustainable payment for BHI into primary care in commercial settings. This assessment involved interviews with organizations, including primary care providers that have integrated behavioral health services and commercial health payers such as health plans, managed behavioral health care organizations and independent physician associations (IPAs), to understand current practices, challenges and opportunities.

Key Report Findings

The assessment uncovered several critical challenges and opportunities for advancing BHI in California:

- **Delays in Payment Hamper Program Implementation and Expansion:** Delays in payment for integrated behavioral health programs hinder providers' ability to implement, sustain and expand these programs, exacerbating the already unmet behavioral health care needs of patients across California, slowing the spread of much-needed services to vulnerable populations.
- **Health Plans Must Take a Leadership Role:** Health plans can play a pivotal role in promoting BHI as part of their strategy to improve access and quality of behavioral health care. By actively championing BHI, they can enhance coordination between physical and mental health services, increase access to care, improve patient outcomes and optimize resources. Streamlining processes, such as reimbursement and credentialing, will make care delivery more efficient and support providers in delivering comprehensive care.

Drawing on insights gathered from the interviews and a multi-stakeholder convening, this issue brief presents CQC's recommendations for providers and payers, including health plans, provider organizations, managed behavioral health care organizations (MBHOs), purchasers and regulators. These recommendations on contracting, credentialing, billing and strategy aim to facilitate payment for BHI and improve behavioral health access and quality across California.

Introduction

When a primary care provider sees a patient for a visit, three out of four appointments include a behavioral health concern, such as depression, anxiety or substance use. Additionally, patients with behavioral health conditions have higher clinical rates of chronic medical conditions, including hypertension and diabetes. However, many patients are unable to access necessary behavioral health treatment due to barriers to care, provider shortages across the care continuum, fragmented care, high out-of-pocket costs and gaps in insurance coverage. Today, the United States faces a behavioral health access crisis resulting from decades of misaligned investment, a workforce that does not meet the growing needs of a diverse population and continued administrative silos in health care.[1] These gaps have been exacerbated by the additional demand placed on mental health providers due to the COVID-19 pandemic.

Payers, providers and purchasers are invested in providing patients comprehensive, readily accessible and cost-efficient behavioral health care. Integrating behavioral health into primary care ensures providers can deliver timely, patient-centered, high-quality and whole-person care while enhancing access to behavioral health services and ongoing medical care. Behavioral health integration (BHI) also improves provider and care team satisfaction[2] and can reduce the total cost of care.[3] Patients have reported an improved care experience and greater patient activation in integrated settings.[4]

In California, primary care providers face significant challenges in receiving reimbursement for integrated behavioral health services, which hinders their ability to integrate these services into primary care settings and limits the expansion and scaling of BHI across their larger network. By investing in administrative efficiencies to ensure timely, consistent and transparent payment for BHI, both individual organizations and collective efforts from payers and providers have the potential to increase access to behavioral health care, ensuring essential services reach the patients and improve lives in the communities they serve.

Scope

In 2024, the California Quality Collaborative (CQC) conducted a state-wide landscape assessment to identify, synthesize and communicate successful practices that facilitate sustainable payment for BHI into primary care in commercial settings. This assessment involved interviews with 11 organizations, including primary care providers that have integrated behavioral health services and commercial health payers such as health plans, managed behavioral health care organizations and independent physician associations (IPAs), to understand current practices, challenges and opportunities.

Background

The fragmentation of behavioral health care can be traced back to the deinstitutionalization of mental health in 1965, a federal cost-saving measure that led to decades of under-resourcing.[5] Beginning in the 1960s in California, the closure of large psychiatric state hospitals, followed by community hospitals, resulted in the discharge of half a million former patients ill-equipped to manage their conditions.[6] Recent investments have been made to strengthen behavioral health care settings, including the 2005 Mental Health Services Act reform, which directed tax revenue to increase funding for county mental health programs focused on prevention, early intervention, training and infrastructure for the community mental health system.[7] Additionally, the California Advancing and Innovating Medi-Cal (Cal-AIM) Medi-Cal transformation project[8] invests more in behavioral and mental health specialty services and will run select pilots for administrative integration efforts across the care continuum.[9] Despite these efforts, patients with mental health and substance use needs must navigate a complex system involving multiple entities with different responsibilities and funding streams, including health plans, community behavioral health providers, primary care providers, county mental health and substance use disorder plans.

Other environmental factors shaping California's health care delivery system include a large population, diverse demographics and complex interplay of policy and economic factors, including a high degree of delegation between entities paying for health care. With 93 different insurers across Medi-Cal, Medicare and commercial lines, providers must navigate administrative processes required by their multiple payer partners.[10]

The complicated and fragmented payment structures specific to behavioral health integration (BHI) in the primary care setting can be traced back to California's history of "carving out" responsibility for behavioral and mental health services from risk-bearing delegated provider organizations. The two most common carve-out scenarios, which can occur simultaneously, are:[11]

Historical policy and market conditions leading up to California's current delivery system arrangements for payment for integrated behavioral health are explained extensively in CQC's 2020 paper, Weaving Mental Health and Physical Health Outside the Safety Net.

Carve-out Scenario #1: Behavioral health insurance carve-out from physical health benefits

Health insurance plans can, and often do "carve out" or delegate responsibility for mental health benefits to an MBHO, which may be internal or external to the health plan. The MBHO maintains its own provider network and handles claims, utilization management and care coordination processes.

Carve-out Scenario #2: Capitated contracts that exclude behavioral health

Capitated contracts between health plans and delegated provider groups define responsibility and risk through arrangements known as the Division of Financial Responsibility (DOFR). Many commercial DOFRs exclude responsibility and risk for behavioral health, with health plans retaining responsibility rather than delegating it to the provider groups, with different impact depending on the BHI model chosen (detailed within the Implementation: BHI Model and Payment Considerations section). Specifically, in the Primary Care Behavioral Health (PCBH) integration model, providers within delegated groups must develop administrative workflows with each payer's MBHO, which operates its own distinct processes. Since the Collaborative Care Model (CoCM) is billed under medical benefits, in some cases, CoCM services are included in a capitation rate from already-negotiated contracts; in other cases, the DOFR excludes four specific CoCM CPT codes, which would then be reimbursed on a fee-for-service (FFS) basis through medical claims.

Given the complexity of the payment landscape, payers (including health plans and provider organizations) have a key role and many opportunities to facilitate financial integration supporting BHI, including incentives, training and increased reimbursement.[12]

Table 1. California's Commercial Health Plans and Managed Behavioral Health Organizations

Health Plans (Commercial)	Managed Behavioral Health Organizations (MBHOs)
Aetna	Aetna
Anthem/Elevance	Carelon
Blue Shield of California	Magellan Health
Cigna	Evernorth
Health Net	Internal as of 1/2024, formerly Managed Health Network (MHN)
Sharp Health Plan	Magellan Health
United Healthcare of California	Optum Health
Western Health Advantage	Optum Health

Implementation: Behavioral Health Integration Models & Payment Considerations

When primary care providers implement behavioral health integration (BHI), they often choose between two widely used models: Primary Care Behavioral Health model (PCBH) and Collaborative Care Model (CoCM). Both models have demonstrated clinical improvements and cost reductions.[13] [14] Each model includes specific Current Procedural Terminology (CPT) codes for billing, guidelines for the billing provider and general approaches applying the patient's benefits as outlined in Table 2 below.[15] [16]

Table 2. Behavioral Health Integration Models: Summary and Common Codes

Primary Care Behavioral Health model (PCBH)

Model Summary

- Available for primary care population for any behaviorally-influenced concern
- Adds licensed behavioral health professional (licensed master or doctorate level) as behavioral health consultant
- Frequently billed under behavioral health benefits by licensed behavioral health provider using standard psychotherapy and health and behavior codes

Common Current Procedural Terminology (CPT) codes (under Behavioral Health Provider)

Psychotherapy CPT Codes

- 90832 – 30 min (16-37 minutes)
- 90834 – 45 min (38-52 minutes)
- 90837 – 60 min (53+ minutes)

Health and Behavior CPT Codes

- 96156 – Assessment
- 96158 – Intervention, individual (30 min)
- 96159 – Intervention, individual extended (15 mins)
- 96164 – Intervention, group

General BHI CPT Code

- 99484 – 20+ minutes

Collaborative Care Model (CoCM)

Model Summary

- Targets specific population (mild-to-moderate depression) using registry and Patient Health Questionnaire-9 and psychotropic medication
- Adds psychiatric consultant (psychiatrist) and behavioral health care manager (bachelor's level or above)
- Frequently billed under medical benefits, "incident to" primary care provider

Common Current Procedural Terminology (CPT) Codes (under Primary Care Provider)

CoCM CPT Codes

- 99492 – Initial month of service (36-85 minutes)
- 99493 – Subsequent months of service (31-75 minutes)
- 99494 – add-on codes (30 minutes add-on following 99492 or 99493)
- G0512* – FQHCs/RHCs, initial and subsequent

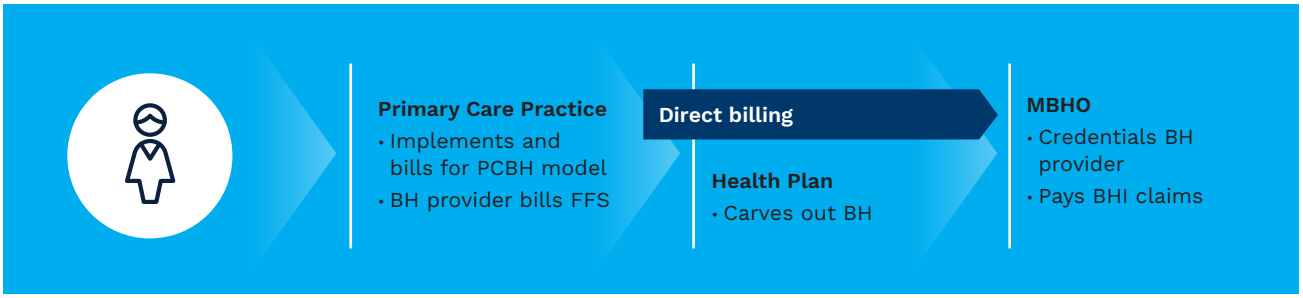
General BHI CPT Code

- 99484 – 20+ minutes

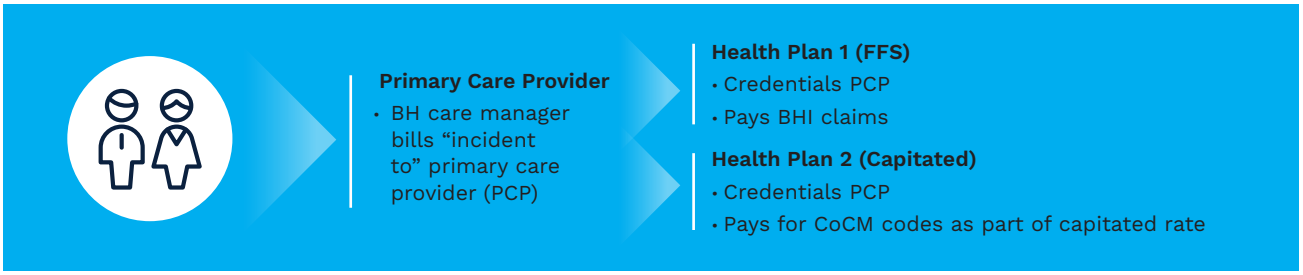
Figure 1: Common Payment Pathways in BHI

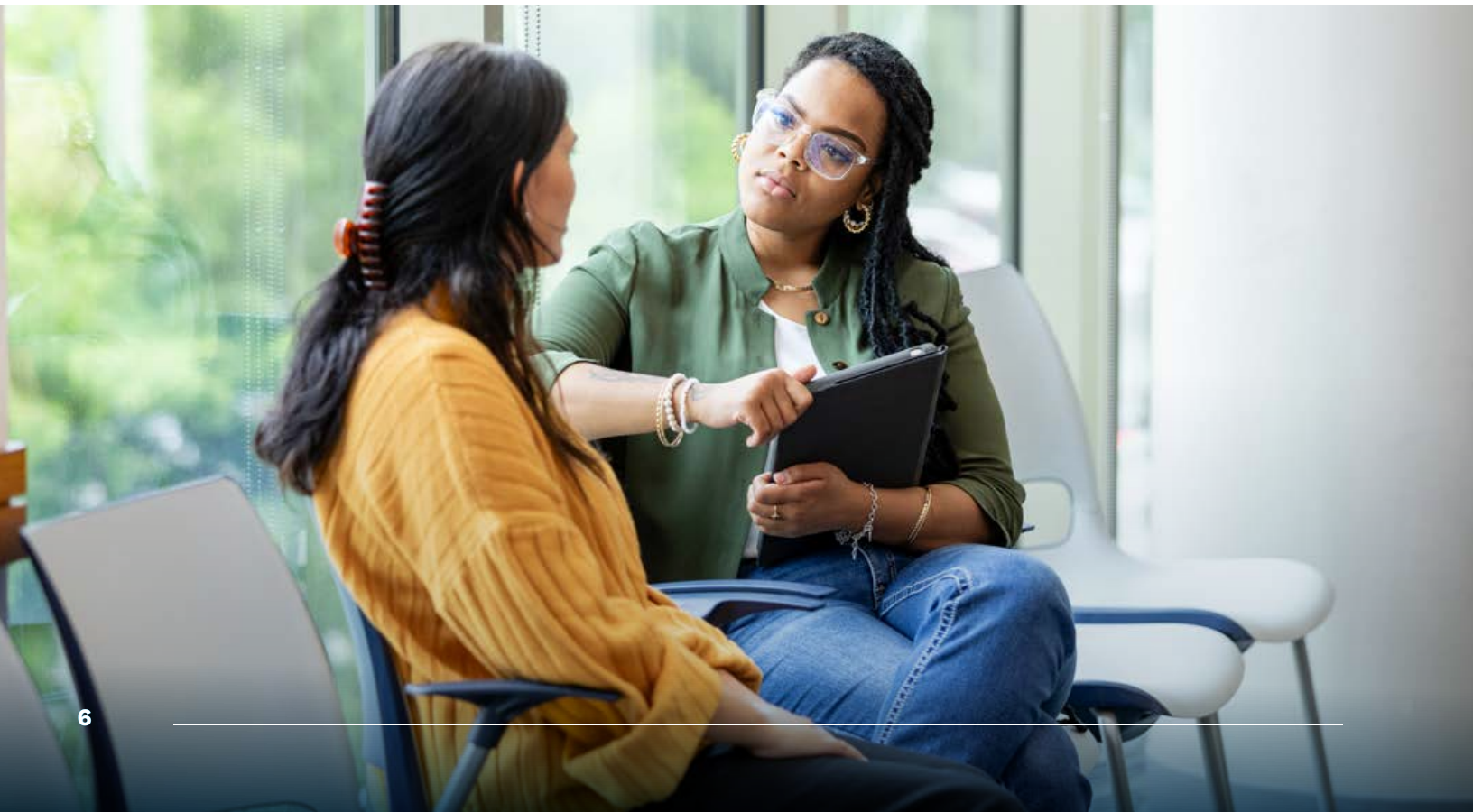
The visuals below demonstrate two common payment pathways for BHI based on models implemented.

Primary Care Behavioral Health Model



Collaborative Care Model





Interview Findings

CQC's interviews focused on primary care providers' contracts with commercial health plans across a mix of product lines, including accountable care organizations (ACOs), health maintenance organizations (HMOs) and preferred provider organizations (PPOs) and different payment arrangements, including FFS and capitation. In this issue brief, the term providers is being used to refer to primary care clinics and systems.

Providers

The four providers interviewed had varying levels of experience in behavioral health integration (BHI), ranging from those just beginning preparatory work for billing and coding to those with over two years of implementation. Two providers use the PBCH model, one provider employs the CoCM and one provider uses both models. A fifth interviewee serves California primary care practices as an external vendor of embedded integrated behavioral health services.

> *"Our organization is ready to go deep into behavioral health integration. We think it's a massive, critical way to meet the needs of our community."*
>
> *— provider*

Implementation and Billing

Providers generally secured short-term grant funding to support the initial development and first year of BHI implementation. However, once billing began, provider organizations consistently experienced challenges in getting reimbursed for integrated claims by health plans, requiring significant administrative resources to resolve issues with each health plan individually. Providers operating under FFS arrangements experienced greater billing and payment success compared to those in value-based payment arrangements.

- After at least one year of implementation, providers were generally able to initiate billing for both the CoCM and PCBH models. Organizations that had been implementing BHI for at least two years reported successful reimbursement for BHI services. One organization noted a 90% success rate for paid claims under the CoCM model; another organization that uses both models reported an 80-85% success rate for PCBH paid claims and a 20-50% success rate for CoCM paid claims, with the lower success rate largely resulting from challenges related to risk arrangements. Due to less demand for CoCM and psychiatry consults, only 11% of that organization's BHI program employs CoCM.
- Successful billing arrangements were achieved only after many months of working with individual health plans to troubleshoot and resolve billing rejections and denials. These issues were often caused by a lack of clarity in documentation and guidance from health plans regarding their specific BHI coding, administrative processes and requirements.
- Organizations attributed their initial success to early buy-in and strong support from their internal billing and claims departments. Teams that had staff with prior experience working with behavioral health payers played a key role in helping providers navigate the complexities of BHI billing and coding, as well as in resolving both internal and external glitches that led to claim denials.

- Notably, payment for BHI services appeared to be facilitated in a FFS environment compared to value-based or capitated arrangements, likely due to faster processing time for FFS claims and clearer delineation of responsibility and risk. The organization using both models reported that only 20-50% of CoCM claims are successfully reimbursed through FFS, while claims under capitated contracts were not paid due to their exclusion from those payers' risk arrangements. Although CQC's interviews included a small sample of providers, further exploration of how capitation affects BHI reimbursement may be valuable for payers aiming to support integration.
- Finally, including BHI in value-based contracts requires revisiting individual contract arrangements through the DOFR. This process is time-consuming and can trigger broader strategic discussions within organizations, making them hesitant to pursue this step without rigorous internal preparation and favorable contracting conditions. The implications of this finding are further explored in the Conclusion and Next Steps section of this brief.

Claims and Billing Support

Providers experienced a lack of operational troubleshooting support for BHI claims and billing from health plans, which slowed implementation and diverted limited resources from patient care to administration.

> *"What can plans do to make it easier to do behavioral health integration? Pay."*
>
> *— provider*

- Providers often found it challenging to locate the right health plan contact who could answer BHI-related questions. Even when the right contact was identified, plans were unable to consistently answer specific provider questions, such as those regarding credentialing of behavioral health providers and health plan billing policies.

> *"It shouldn't be that hard to figure out what you need to do to get paid for behavioral health integration."*
>
> *— provider*

- If claims were not being paid due to technical reasons, it often took several months for health plans to identify the issue and implement a solution, which can impact the integrated sites' ability to receive essential reimbursement. Regular meetings with health plans prioritize strategic discussions, such as access and contracting, and are not an appropriate venue for troubleshooting payment issues related to a few specific CPT codes. However, it remains unclear where providers can go to problem-solve technical "glitches" related to BHI payment.
- Unforeseen ad-hoc requests from plan administrators revealed a lack of understanding of how integrated care is delivered. For example, some providers received requests for prior authorization for CoCM services, which contradicts best practice.[17] It took one practice a year and a half to resolve this issue with a payer regarding prior authorization.
- The longer the delays in receiving payment for an integrated program, the slower providers can scale and expand their integrated programs, exacerbating patients' unmet needs for behavioral health care across California. Once patients and care teams experience the benefits of integrated care, there often is an internal groundswell of support. However, the lack of reliable and predictable financing becomes a barrier to sustaining BHI at the current site and spreading to additional clinics.

- Given the number of plans and delegated entities that providers work with, there was a general desire for administrative alignment and a more streamlined approach to processes and workflows. Clinical administrators and ancillary teams (e.g. billing, coding, revenue cycle, front office staff) who engage with multiple plans must juggle different requests and manage tracking multiple processes for similar services.
- Finally, due to the general challenges in getting reimbursed for the most common conditions seen in integrated care (e.g., mild-to-moderate depression, anxiety), providers were hesitant to expand their integrated programs to include other clinical conditions that integrated care can successfully address, such as weight management.[18] Health plans might consider supporting BHI programs, which can help patients across multiple conditions, as a better investment than offering costly, single-condition medications, such as GLP-1 for weight loss.

Patient Impact

Providers frequently expressed a desire to offer the same standard of care, including same-day integrated behavioral health visits, to all patients who need them. However, because most providers work with multiple payers — including commercial, Medicare and Medi-Cal — some payment arrangements make it challenging to provide and receive payment for these integrated visits for all patients.

- Patients often do not understand that their behavioral health benefits may be "carved out" of their medical benefits. Some providers noted the lack of behavioral health plan contact information included on patient plan benefit cards.
- Providers often find themselves acting as the first line of behavioral health financial support, providing extensive support for patients to prevent patients from receiving bills they should not be responsible for, facing claim denials or encountering unexpectedly high co-pays. One provider mentioned how "overwhelmed" patients can feel when faced with unforeseen bills or denials and shared that clinic staff will often help patients navigate their benefits, often because a charge was incorrectly processed.
- While some providers advise patients to call their insurance companies, they are reluctant to put patients in a financially compromising position regarding BHI coverage, especially if it may delay receiving care. At the same time, providers must balance their internal revenue, which places the burden on patients to invest time in finding the right plan contact to clarify coverage or risk going without necessary care or facing higher out-of-pocket bills. In some cases, to support patients receiving the care they needed and avoiding additional stress, practices elected not to submit claims to prevent patients from being charged.

> *"Doctors want to support all their patients [with behavioral health integration], regardless of payer."*
>
> *— interviewee*

Credentialing

Operational leaders noted that credentialing behavioral health providers often involves delays, ranging from 3 to 6 months, as well as inconsistent policies and communication for tracking down additional required information.

> *"The right arm is not talking to the left arm."*
>
> *— provider*

- Providers were sometimes asked to open their behavioral health provider panel for all plan/MBHO members when attempting to credential for PCBH providers, which is not operationally possible due to the daily demands from a primary care practice's patient population.
- Providers also highlighted the time and effort needed to credential behavioral health providers with multiple plans.
- Organizations that utilize external organizations like the Council for Affordable Quality Healthcare (CAQH) to submit for credentialing requests, similar to those used for medical providers, frequently experience rejections. In some cases, the CAQH system might not even notify the practice that of a rejection until the credentialing lead follows up directly.
- Organizations reported poor communication, particularly when working with MBHO plans, regarding credentialing corrections. The credentialing process is slower for behavioral health providers as compared to their medical counterparts. One opportunity is to merge or align the MBHO and health plan credentialing processes to make them less complicated and time-consuming.

Oversight

Some providers expressed confusion about who the "final decision maker" might be on operational and clinical issues with compliance and billing implications, such as from the Centers for Medicare and Medicaid Services and/or California's Department of Managed Care and Department of Health Care Services.

- Examples shared include uncertainty about whether a physically signed written consent is required from patients (which is particularly challenging during and after the COVID-19 era with telehealth visits), or the extent to which physicians need to "sign off" on orders by the behavioral health care manager (for CoCM).*
- If there is formal regulatory guidance specific to BHI, it is not clear to health care providers. Some providers ended up needing to hire external legal counsel or implementation support from consulting organizations, which added costs to BHI implementation.

> *"It hasn't always been clear what CMS and California has necessitated to practice BHI."*
>
> *— provider*

* Note: Written patient consent is not required in the Collaborative Care Model; verbal patient consent is recommended [AIMS Center].

Strategic Planning and Sustainability

Finally, providers expressed general concerns about current reimbursement rates for BHI visits, and how they have not kept pace with California's rate of inflation and staffing costs. Integrated programs that are making close to their profit margins today will find it harder to do so in the next few years unless rates are increased.

- Long term, most providers were looking for a rate of return on BHI that let them draw down enough funding to be able to pay for their cost with a small window for error (e.g., 7–10% rate on return) and buffer for changes in reimbursement and services provided.
- One organization recommended that integrated visit rates should have a standard payment floor across payers of 125% the Medicare rate, which would allow providers to launch BHI programs that could be financially sustainable faster and weather trends such as inflation and behavioral health workforce development.
- For organizations that start BHI initially supported by grants, providers see the need to measure and demonstrate the positive impact of their work to leadership and payer partners. While a grant can provide "breathing room" during development and implementation, BHI programs need to show value, including capturing revenue and return on investment, to internal administrators and leaders to ensure program longevity.
- Although interviewees mentioned a desire for every primary care physician to have access to an integrated behavioral health provider for their patients, high-level strategy around scaling BHI depends on an organization's ability to receive timely, consistent and transparent payment for BHI services across the majority of payers.

Payers

Among the four commercial plans interviewed, two contract with external MBHOs; one plan utilizes an MBHO that is a subsidiary of its holding company and another plan recently merged with its MBHO, which was formerly a subsidiary of the holding company. Other payer types interviewed included two MBHOs (one interviewed alongside their holding company health plan partner and the other as the subsidiary MBHO to a plan) and one IPA.

Carving Out and Contracting

All commercial plans interviewed worked with MBHO counterparts, either internally or externally, to administer and manage behavioral health benefits.

- The two health plans with external MBHO counterparts maintained frequent conversations around behavioral health oversight, quality and access.
- The two health plans with internal MBHOs had different levels of administrative alignment. One health plan that had recently incorporated their MBHO in-house had a general process for credentialing and establishing FFS contracts for behavioral health. While these plans still had two separate billing platforms at time of the interview, they were working to streamline them into one. Another plan with a subsidiary MBHO works collaboratively on behavioral health strategy, quality and access while operating separately. This MBHO's contract included metrics for quality and access, and the MBHO provided behavioral health data to the plan on a quarterly basis, which the plan shared with its provider network.
- Most plans did not discuss BHI with their MBHO partners. However, several plans mentioned that they were planning new strategic collaborations with their MBHOs that would include BHI.

Support and Engagement

Some plans had experience providing support to providers for BHI, while others expressed support for BHI goals, but were still in the planning stages to determine how to best assist providers in planning for, implementing and expanding their integrated programs.

> *"We are currently asking ourselves: what are our options as a plan to increase BH integration?"*
>
> *— health plan*

- Some plans were unaware of which providers in their network provide integrated care. One plan was developing a survey to better understand which providers have integrated behavioral health. Other plans run reports based on claims for BHI (see CPT codes listed in Implementation: Payment Considerations). Most plans did not collect information on providers interested in implementing BHI.
- One health plan had offered subsidized direct technical assistance through consultants for organizations ready for or already engaged in implementation. Another plan provided the initial funding for a behavioral health consultant to ACO participants for two years of their BHI program. Although this pilot closed due to COVID-19 response, there are plans to relaunch it.
- This plan also provides information to providers through a 'Behavioral Health Integration Quick Reference Guide,' which includes the billing codes accepted, and conducts meetings with provider billing staff.

Credentialing

Plans and MBHOs described similar timelines and provider support for credentialing.

- Plans mentioned that credentialing requirements came from regulatory agencies and most timelines were not in their control. One plan shared their credentialing process took an average of 30-45 days to complete. California regulation, effective January 1, 2023, requires health plans to credential behavioral health providers within 60 days of application receipt.[19]
- One plan mentioned they had a quick reference guide for potential behavioral health providers to assist with credentialing. This plan also has a designated credentialing support person and direct provider relations liaison specifically for behavioral health providers to address any issues.
- All plans interviewed stated they did not require BHI providers to open their panels to be credentialed. One plan shared that while they asked behavioral providers about opening their panels, they did not require the providers to open their panel. As BHI expands in California, inquiries from plans about opening panel could cause credentialing confusion for new BHI programs.
- Three plans are investing in reducing the administrative burden of integration, including streamlining the credentialing process for behavioral health providers.

Claims, Billing and Payment

Plans shared there were often technical system issues that led to payment denials for BHI claims. However, plans were not always aware that billing and claims errors are occurring unless providers alert them and it often takes time to implement systemwide corrections if an issue is identified.

"Primary care providers should not have to figure out how to get paid."

— health plan

- Some plans were consolidating their claims system for internal operational integration, which will facilitate claims processing. Some health plans mentioned that there could be challenges related to making sure the correct provider license type and procedure codes are entered accurately to be processed and paid.
- Most plans confirmed they were not seeking pre-authorization for PCBH CPT codes. While most plans include the CoCM codes in their fee schedule, there was occasional confusion, particularly due to professional risk arrangement under medical contracts, which resulted in some denials for CoCM CPT codes.

IPAs and Behavioral Health Integration

There are specific complications related to how other delegated payers, such as IPAs, pay for behavioral health integration (BHI). Given the lack of transparency and consistent reported information, IPA involvement in BHI is difficult to track.[20]

- In 2019, California's medical landscape consisted of 43% of Californians served by IPAs. A common scenario is an IPA with HMO contracts in which the plan will pay the IPA a per member per month (PMPM) agreed upon rate to manage members' medical health. The member is empaneled to a primary care physician (PCP) who sits under the IPA and receives payment for medical care provided.
- There are differing scenarios that can occur when IPAs are asked to pay BHI claims. For example, if a provider has a CoCM program, the PCP will submit claims to the IPA for the services as a medical claim billed "incident to" the PCP. These claims are routed to the IPA and may be denied if the IPA views the CoCM codes as behavioral health, which would fall outside of their medical risk arrangement. For PCBH claims, it is unclear if the IPA works with the MBHO or the health plans.

As existing literature and research on strategies of IPAs to support BHI is limited and, given the reach of IPAs, there is a critical need to more deeply investigate and strengthen the IPA role in BHI to improve the overall health outcomes of the state's residents. Developing successful models for IPA involvement in BHI will require collaborative efforts, and additional clarity and guidance around how to address payment for integrated services in delegated, capitated environment. Health plans must provide support within their contracted risk arrangements, while IPAs need to offer strategic and operational backing to providers engaged in or interested in developing and implementing BHI.

Recommendations

Based on the interviews and a multi-stakeholder meeting which reviewed interview findings, CQC provides the following recommendations, each including:

Opportunity Areas

Action Steps Supporting the Opportunity Areas

Action steps are assigned to providers, payers — including health plans, provider organizations and MBHOs — and the broader health care industry, including regulators and purchasers. If implemented, these steps would facilitate payment for behavioral health integration (BHI) and improve behavioral health access and quality across California. Opportunity Areas and Action Steps organized by audience are included in the Appendices.

		Providers	Payers	Regulators	Purchasers
1. Contracting					
1.1	Integrated administrators need to partner often with their internal business counterparts to align on strategic planning and positioning				
»	**Providers:** Connect regularly with internal business team (e.g., payer strategy, managed care, value-based teams) to ensure that integrated program needs and outcomes are incorporated into contracting strategy and can represent behavioral health integrated programs accurately when negotiating	●	●		
»	**Payers:** Invite a BHI provider representative to meetings (if organizations offer integrated services)				
1.2	Plans that "carve out" behavioral health should maintain oversight as well as regular collaboration with their MBHO partners that includes reviewing BHI visit and access data				
»	Ensure regular meetings incorporate a review of quality and access reports that include BHI services (e.g., claims for BHI)		●		
1.3	Purchasers can support and incentivize BHI				
»	Add depression screening to required quality measures				
»	Ensure BHI is part of the organization's benefits behavioral health strategy				●
»	Include BHI standards in plan contracts (e.g. including clear standards, aligning with regulatory guidelines, tracking performance metrics)				

	Providers	Payers	Regulators	Purchasers
2. Credentialing				
2.1 Providers should be credentialed with all medical and behavioral health plans (medical and MBHO) to ensure insurance coverage for more patients	●			
2.2 Identify and implement efficiencies in credentialing processes for behavioral health providers				
» **Plans:** Monitor average credentialing time cycle for behavioral health, identify roadblocks and brainstorm solutions to ensure compliance with the 60-day cycle required by California law (Health & Safety Code § 1374.197)[21]				
» **Plans:** Ensure credentialing information behavioral health process is documented, with plan role (including contact information) provided for questions		●	●	
» **Regulators:** Support streamlining credentialing requirements for behavioral health providers (e.g., follow-up communication regarding errors); consider potential to align credentialing processes across plans and MBHOs				

	Providers	Payers	Regulators	Purchasers
3. Billing				
3.1 Providers should strengthen revenue integrity and revenue cycle management, supportive of integrated claims and billing				
» Invest in comprehensive monitoring following BHI implementation launch to assure accurate and compliant documentation and coding	●			
» Hire internal billing and coding lead, ideally with experience in behavioral health, or provide behavioral health-specific trainings and resources available for processing behavioral health claims and working with behavioral health payers				
3.2 Providers should invest in education regarding BHI billing and coding				
» Develop a billing and coding care team resource that defines BHI services, billing codes and when to use them				
» Provide ongoing training and provider/care team reinforcement (e.g., via coding tip sheets and meetings)	●			
» Create a process for regularly updating education materials with current information				
» Include BHI billing and coding in standard training and onboarding materials				

		Providers	Payers	Regulators	Purchasers
	3. Billing				
3.3	Providers should bill for the services that they are providing to be able to identify what denials and rejections come through and get credit for clinical care already being provided (e.g., for example, depression screening has a discrete code)				
»	Review CQC's BHI Billing & Coding Codes (or similar internal resource) with providers to understand what services are currently being provided and being coded for and to identify services that could be coded and billed for				
»	Monitor what claims are being submitted, paid and rejected	●			
»	Investigate denials and rejections thoroughly (e.g., coding errors, missing/incorrect information, coverage, formatting)				
»	Invest in reporting to track patients' cost-sharing, enabling identification and analysis of unexpected data points (e.g., high co-pays, bills)				
»	For organizations in capitated arrangements, or those not yet billing for a specific service, consider using a zero-charge code to be able to track services				
3.4	Plans should provide organizations in their network that are implementing or planning to implement BHI accurate information regarding billing for BHI				
»	Aggregate information in a 'Health Plan BHI Implementation Guide' that includes billing codes accepted, documentation required and costs expected based on claims		●		
»	Provide a specific role (with contact information) for technical issues and escalation in the event of claims rejected or denied				
3.5	Plans can analyze the rates they are providing for behavioral health services across their network to improve behavioral health access and adhere to mental health parity requirements		●		
»	Evaluate rates across all providers and model changes that could incentivize integration				
3.6	Additional clarification statewide could be provided endorsing BHI				
»	Provide guidance to health plans, provider organizations and providers regarding clinical and billing appropriateness for integrated program codes and other compliance requirements (e.g., pre-authorization, patient consent)			●	
»	Ensure compliance with mental health parity standards to reduce administrative burdens, improve billing rates and requirements and ensure equitable access to care				

		Providers	Payers	Regulators	Purchasers
4. Strategy					
4.1	Providers and plans need to partner to better develop complementary strategies to improve behavioral health access and quality, including integrated behavioral health in primary care				
»	**Plans:** Share information with provider organizations to help them model if BHI is a financially sound investment (e.g., BHI codes accepted, expected payment)				
»	**Providers:** Use plan information to model out BHI implementation costs and expected revenue based on their payer mix and product lines	●	●		
»	**Plans:** Be proactive and upfront with their needs and expectations around BHI to support strategic planning				
»	**Plans:** Define and track which providers are providing BHI				
4.2	Plans can champion BHI as part of their behavioral health access and quality strategy				
»	Identify internal BHI leads and conduct educational sessions on BHI for relevant teams				
»	Understand which providers are providing integrated services by running reports based on CPT claims, surveying providers for interest and planning for BHI		●		
»	Reduce the administrative burden for BHI, including waiving co-pays for behavioral health visits, making BHI visits a preventive service and eliminating patient prior-authorization requirements for BHI				
»	Consider providing funding for providers ready to implement BHI or pay BHI codes at highest possible rates to facilitate upfront provider investment costs for BHI				
4.3	Ensure patients receive accurate information about accessing integrated services and have the contact details for billing inquiries				
»	Include information on patient benefits regarding behavioral health (if integrated or carved out), via documentation and patient benefit cards	●	●		
»	Market integrated programs to patients as appropriate				
4.4	Identify and measure the return on investment for BHI				
»	Determine internal and shared measures for BHI, including for domains of clinical outcomes, quality, financial, patient satisfaction and workforce	●	●		●

Conclusion and Next Steps

Behavioral health integration (BHI) solves for where the health care industry wants and needs to go in California – whole-person, advanced primary care. Given the experiences shared by the California delivery system, BHI financing needs to be supported, streamlined and simplified if provider organizations are to continue implementing and spreading this model.

Furthermore, there are also larger industry developments and opportunities that could facilitate BHI, both from operational and administrative perspectives:

- **Industry-wide shared definition of behavioral health integration** – one solution that could support many cross-industry initiatives would be the development of a shared definition of BHI, including appropriate CPT codes. Oregon's state coordinated care organizations, for example, brought together different stakeholders to create minimum BHI standards, which were written into state legislation.[22] A shared definition can help clarify requirements, facilitate and align strategic and contracting solutions and create shared expectations and oversight for clinical and operational BHI implementation.
- **Multi-stakeholder alignment** – Almost all interviewees noted the need to bring together organizations to collaborate and align on this work. Recent legislation in California, Senate Bill 1320 of 2024, may spark the opportunity for commercial plans to work together on administrative alignment by requiring plans to have a process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services.[23] While the focus of CQC's project was the commercial setting, many participants highlighted the opportunity for greater impact by bringing together Medi-Cal and Medicare payers and providers to share successful BHI practices and map out alignment opportunities, supporting the desire on behalf of providers to provide one standard of care for all patients, regardless of payer.

> *"Part of the calculation for us is what's the biggest bang for our buck? There are so many payers. We want a way to address all 40 payers at one time."*
>
> *— provider*

- **Carving behavioral health in** – California's de facto arrangement to carve-out behavioral health from medical plans has made the challenges around payment and accountability even more difficult. Payers have the ability to make the decision to carve back in behavioral health services and should consider the implications and investment to take those steps.

> *"If it was all paid by medical plans, behavioral health integration would be so much easier."*
>
> *— provider*

- **New payment arrangements** – More of the delivery system has made investments and strategic plans to move to population health management payments, which incentivize quality of care, patient experience and outcomes. As BHI payments were found to occur more easily in FFS, there should be further investigation to explore which payment models best support integration. Stakeholders could develop a road map with potential payment models inclusive of the requirements of BHI, including risk-sharing, provider and patient attribution and quality measures.

At the same time, improving BHI financing does not solve for some key areas impacting BHI implementation and spread. However, there are state-sponsored initiatives and federal activity underway that could be leveraged to make integration easier and more sustainable.

- **Staffing** – Statewide workforce shortages make it difficult to recruit and retain behavioral health professionals, especially psychiatrists.[24] These shortages are further exacerbated in more rural areas and among providers who speak multiple languages. In 2025, California's final state budget included allocation for stipends and scholarships for social workers, expanded social work education programs, additional Addiction and Psychiatry & Medicine fellowships and loan repayment for psychiatrists.

> ***"We need to think outside of box for our workforce. For example, California could join the national Social Work Compact [a national effort to support the mobility of licensed social workers through an interstate compact]. There are lots of associate social workers who would love to be placed in a medical setting."***
>
> ***— health plan***

- **Attribution and impact on total cost of care** – California's multi-stakeholder Office of Health Care Affordability (OHCA) Investment and Payment Workgroup provides input to OHCA on the development of primary care, alternative payment model (APM) and behavioral health definitions, data collection processes and benchmarks. OHCA will gather information from this stakeholder engagement to develop recommendations for benchmarks, including input to OHCA on the relationships between the APM, primary care and behavioral health components. In 2024, this group will define the attribution BHI for statewide reporting. There is still an opportunity within the research landscape to identify the impact of BHI on total cost of care. One issue raised during interviews, for example, that will require exploration is how BHI claims provided in a primary care setting will be attributed when routed and paid to an MBHO.
- **Data exchange** – A few interviewees mentioned that improved data sharing between medical providers and plans could facilitate improved understanding of patient care, such as inpatient admissions and screening data. Successful operationalization of California's Data Exchange Framework could facilitate this work.
- **Mental health parity** – Given new federal regulations on mental health parity released in 2024, it is imperative for all payers to consider how their behavioral health, including integration programs, demonstrates compliance with the intent of the new regulations.[25]

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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.

Appendices

CQC extends its gratitude to the individuals from the following organizations for their participation in the interviews.

Appendix 1: Interviewees

Organizational Affiliation	Stakeholder Type
Blue Shield of California	Health Plan
Cigna/Evernorth	Health Plan/MBHO
Common Spirit	Provider
Concert Health	Provider/Behavioral Health Vendor
Health Net	Health Plan
Hill Physicians Medical Group	IPA
Optum	MBHO
Pomona Valley Hospital Medical Center	Provider
Providence Santa Rosa	Provider
Sutter Health Family Medicine Residence Program	Provider
Western Health Advantage	Health Plan

Appendix 2: California Commercial Health Plans and Managed Behavioral Health Organizations

California's commercial health plan information was sourced from California's Office of the Patient Advocate[26] (excluding Kaiser Permanente North and South) and information on MBHOs was sourced directly from each health plan's website (updated as of the time of publication).

Health Plans (Commercial)	Managed Behavioral Health Organizations (MBHOs)
Aetna	Aetna
Anthem/Elevance	Carelon
Blue Shield of California	Magellan Health
Cigna	Evernorth
Health Net	Internal as of 1/2024 - formerly Managed Health Network (MHN)
Sharp Health Plan	Magellan Health
United Healthcare of California	Optum Health
Western Health Advantage	Optum Health

Appendix 3: Provider Action Steps

1. Contracting

1.1 Integrated administrators need to partner often with their internal business counterparts to align on strategic planning and positioning

- Integrated administrators: Connect regularly with internal business team (e.g., payer strategy, managed care, value-based teams) to ensure that integrated program needs and outcomes are incorporated into contracting strategy and can represent behavioral health integrated programs accurately when negotiating

2. Credentialing

2.1 Providers should be credentialed with all medical and behavioral health plans (medical and MBHO) to ensure insurance coverage for more patients

3. Billing

3.1 Providers should strengthen revenue integrity and revenue cycle management, supportive of integrated claims and billing

- Invest in comprehensive monitoring following BHI implementation launch to assure accurate and compliant documentation and coding
- Hire internal billing and coding lead, ideally with experience in behavioral health, or provide behavioral health-specific trainings and resources available for processing behavioral health claims and working with behavioral health payers

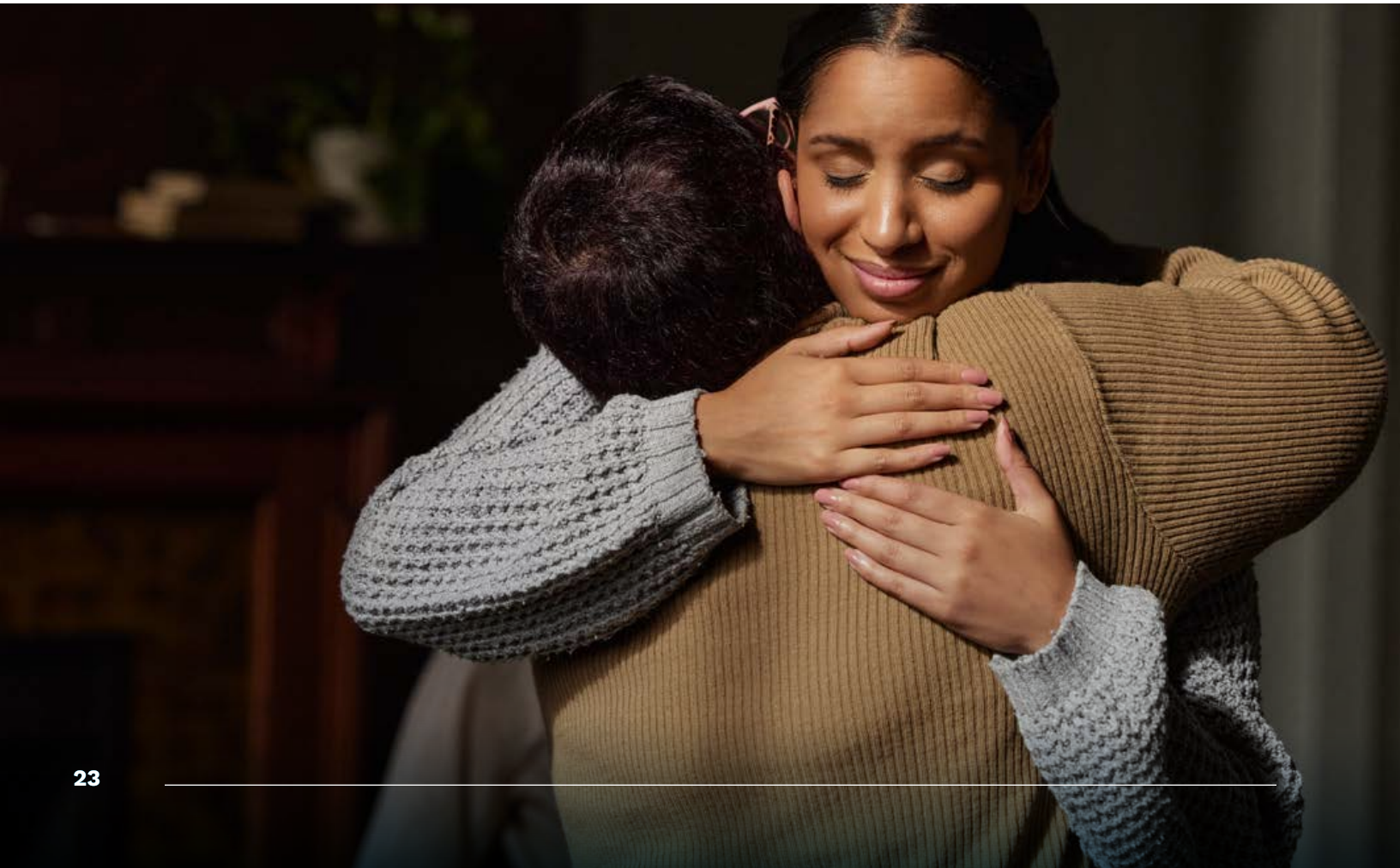
3.2 Providers should invest in education regarding BHI billing and coding

- Develop a billing and coding care team resource that defines BHI services, billing codes and when to use them
- Provide ongoing training and provider/care team reinforcement (e.g., via coding tip sheets and meetings)
- Create a process for regularly updating education materials with current information
- Include BHI billing and coding in standard training and onboarding materials

3.3 Providers should bill for the services that they are providing to be able to identify what denials and rejections come through and get credit for clinical care already being provided (e.g., for example, depression screening has a discrete code)

- Review CQC's BHI Billing & Coding Codes (or similar internal resource) with providers to understand what services are currently being provided and being coded for and to identify services that could be coded and billed for
- Monitor what claims are being submitted, paid and rejected
- Investigate denials and rejections thoroughly (e.g., coding errors, missing/incorrect information, coverage, formatting)
- Invest in reporting to track patients' cost-sharing, enabling identification and analysis of unexpected data points (e.g., high co-pays, bills)
- For organizations in capitated arrangements, or those not yet billing for a specific service, consider using a zero-charge code to be able to track services

4. Strategy
4.1 Providers and plans need to partner to better develop complementary strategies to improve behavioral health access and quality, including integrated behavioral health in primary care • Use plan information to model out BHI implementation costs and expected revenue based on their payer mix and product lines
4.3 Ensure patients receive accurate information about accessing integrated services and have the contact details for billing inquiries • Include information on patient benefits regarding behavioral health (if integrated or carved out), via documentation and patient benefit cards • Market integrated programs to patients as appropriate
4.4 Identify and measure the return on investment for BHI • Determine internal and shared measures for BHI, including for domains of clinical outcomes, quality, financial, patient satisfaction and workforce



Appendix 4: Payer Action Steps

1. Contracting
1.1 Integrated administrators need to partner often with their internal business counterparts to align on strategic planning and positioning • Invite a BHI provider representative to meetings (if organizations offer integrated services)
1.2 Plans that "carve out" behavioral health should maintain oversight as well as regular collaboration with their MBHO partners that includes reviewing BHI visit and access data • Ensure regular meetings incorporate a review of quality and access reports that include BHI services (e.g., claims for BHI)

2. Credentialing
2.2 Identify and implement efficiencies in credentialing processes for behavioral health providers • Monitor average credentialing time cycle for behavioral health, identify roadblocks and brainstorm solutions to ensure compliance with the 60-day cycle required by California law (Health & Safety Code § 1374.197)[27] • Ensure credentialing information behavioral health process is documented, with plan role (including contact information) provided for questions

3. Billing
3.4 Plans should provide organizations in their network that are implementing or planning to implement BHI accurate information regarding billing for BHI • Aggregate information in a 'Health Plan BHI Implementation Guide' that includes billing codes accepted, documentation required and costs expected based on claims • Provide a specific role (with contact information) for technical issues and escalation in the event of claims rejected or denied
3.5 Plans can analyze the rates they are providing for behavioral health services across their network to improve behavioral health access and adhere to mental health parity requirements • Evaluate rates across all providers and model changes that could incentivize integration

4. Strategy
4.1 Providers and plans need to partner to better develop complementary strategies to improve behavioral health access and quality, including integrated behavioral health in primary care • Share information with provider organizations to help them model if BHI is a financially sound investment (e.g., BHI codes accepted, expected payment) • Be proactive and upfront with their needs and expectations around BHI to support strategic planning • Define and track which providers are providing BHI
4.2 Plans can champion BHI as part of their behavioral health access and quality strategy • Identify internal BHI leads and conduct educational sessions on BHI for relevant teams • Understand which providers are providing integrated services by running reports based on CPT claims, surveying providers for interest and planning for BHI • Reduce the administrative burden for BHI, including waiving co-pays for behavioral health visits, making BHI visits a preventive service and eliminating patient prior-authorization requirements for BHI • Consider providing funding for providers ready to implement BHI or pay BHI codes at highest possible rates to facilitate upfront provider investment costs for BHI
4.3 Ensure patients receive accurate information about accessing integrated services and have the contact details for billing inquiries • Include information on patient benefits regarding behavioral health (if integrated or carved out), via documentation and patient benefit cards • Market integrated programs to patients as appropriate
4.4 Identify and measure the return on investment for BHI • Determine internal and shared measures for BHI, including for domains of clinical outcomes, quality, financial, patient satisfaction and workforce

Appendix 5: Purchaser Action Steps

1. Contracting

1.3 Purchasers can support and incentivize BHI

- Add depression screening to required quality measures
- Ensure BHI is part of the organization's benefits behavioral health strategy
- Include BHI standards in plan contracts (e.g. define clear standards, align with regulatory guidelines, stakeholder engagement, training and support, and performance metric)

4. Strategy

4.4 Identify and measure the return on investment for BHI

- Determine internal and shared measures for BHI, including for domains of clinical outcomes, quality, financial, patient satisfaction and workforce

Appendix 6: Regulator Action Steps

2. Credentialing

2.2 Identify and implement efficiencies in credentialing processes for behavioral health providers

- Plans: Monitor average credentialing time cycle for behavioral health, identify roadblocks and brainstorm solutions to ensure compliance with the 60-day cycle required by California law (Health & Safety Code § 1374.197)[28]
- Plans: Ensure credentialing information behavioral health process is documented, with plan role (including contact information) provided for questions
- Regulators: Support streamlining credentialing requirements for behavioral health providers (e.g., follow-up communication regarding errors); consider potential to align credentialing processes across plans and MBHOs

3. Billing

3.6 Additional clarification statewide could be provided endorsing BHI

- Provide guidance to health plans, provider organizations and providers regarding clinical and billing appropriateness for integrated program codes and other compliance requirements (e.g., pre-authorization, patient consent)
- Ensure compliance with mental health parity standards to reduce administrative burdens, improve billing rates and requirements and ensure equitable access to care

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