

Integrating Behavioral Health Care into Primary Care:

Advancing Primary Care Innovation in Medicaid Managed Care

CHCS Center for
Health Care Strategies, Inc.

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Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit

This module is part of ***Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit***, which was created to help states leverage their managed care contracts and request for proposals to advance innovation in primary care.

The two-part toolkit outlines strategies to support states in: (1) defining primary care priorities and advancing core functions; and (2) achieving primary care innovation goals through managed care contractual levers.

To view the full toolkit, visit www.chcs.org/primary-care-innovation.

Across the United States, behavioral health conditions — including mental illness and substance use disorders — are often underdiagnosed and treatment is delayed.¹ While behavioral health care is typically delivered separately from primary care, there is growing consensus that behavioral health should be integrated into primary care to help facilitate earlier diagnosis and treatment.^{2,3}

This module outlines strategies and considerations for integrating behavioral health into primary care for states operating in a Medicaid managed care environment, including a variety of activities and incentive arrangements.⁴

Design Considerations

✓ **How will the state define “behavioral health integration” in primary care?**

At the broadest level, behavioral health integration can describe any situation in which behavioral health and medical providers work together.⁵ Numerous overlapping terms have been used to describe behavioral health integration, which can create confusion and potentially inhibit implementation of effective interventions.⁶ Increasingly, health care experts have supported the idea that integration occurs along a continuum. The Center for Integrated Health Solutions, jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA), developed a widely adopted framework ranging from minimal collaboration to co-located care to fully integrated care.⁷ Likewise, some experts advocate for distinguishing between collaborative care, which involves behavioral health working *with* primary care, and integrated care, which involves behavioral health working *within* and as part of primary care.⁸

INTEGRATE BEHAVIORAL HEALTH CARE: Design Considerations Summary

Explore flexible versus prescriptive approaches.

- ✓ How will behavioral health integration be defined in MCO contracts — in a specific way that promotes uniform care delivery approaches, or more broadly to allow flexibility?
- ✓ How, if at all, will the state define what types of behavioral health screenings should be integrated into primary care?
- ✓ Which existing care models could be used to advance behavioral health integration?

Define the roles/responsibilities of the state, primary care teams, and MCOs.

- ✓ How will the state minimize barriers to integrated care?
- ✓ Which providers are expected to participate in integration activities?
- ✓ To what extent will the state encourage or require MCOs to work together on integration activities?

Determine how to measure, monitor, and reward progress.

- ✓ What financial or non-financial incentives will the state use to encourage uptake of integration among MCOs and providers?
- ✓ How will progress toward integration be monitored, and by whom — centralized via the state, or delegated to health plans?

Leverage payment reform to drive innovation.

- ✓ How, if at all, will the state dictate how MCOs should pay providers for integrated care (recognizing that many activities related to integrated care, such as provider consultations, are not typically reimbursed under a fee-for-service (FFS) model)?
- ✓ To what extent can the state align payment approaches with other payment initiatives that incentivize behavioral health (e.g., CPC+)?

Determine the need for additional investments.

- ✓ What additional funding may be needed to ensure adequate reimbursement for new activities, staffing, or infrastructure deployed by MCOs and/or providers?
- ✓ To what extent might states either develop or require MCOs to provide shared supports for smaller primary care practices that are not independently able to undertake more sophisticated integration activities?





States may choose to define behavioral health integration in primary care differently based on their priorities and existing health plan and provider market, as well as population needs.¹² For example, patient populations at low risk for complex behavioral health conditions might best be served in coordinated primary care and mental health practices where collaboration is facilitated by a care manager.¹³ Patients with serious mental illness or active substance use disorder (SUD) and multiple medical problems seen in traditional community mental health centers may need co-located care within partially or fully integrated provider practices to improve their outcomes.¹⁴

For example, **Oregon** requires its health plans to “understand and acknowledge” that integrated care spans a continuum ranging from communication to coordination to co-management to co-location to the fully integrated Patient-Centered Primary Care Home.¹⁵ **Louisiana** defines behavioral health integration “activities” for its Medicaid MCOs, such as: incentivizing providers to co-locate physical and behavioral health services; providing support for PCPs who screen for behavioral health issues and treat mild to moderate cases; and ensuring collaboration and communication among physical and behavioral health providers.

✓ ***Which providers are expected to participate in behavioral health integration activities?***

It is important to consider the providers to whom behavioral health integration expectations will apply. For example, will integration requirements apply only to particular providers or provider organizations, such as ACOs, PCMHs, or high-volume PCPs, or will they apply to PCPs in general? States with well-established PCMH programs may opt to define standards for behavioral health integration within those programs (see [Three State Approaches to Patient-Centered Medical Homes](#)), and then incent or require plans to contract with those providers.¹⁶ Other states may outline expectations for MCOs to increase the level of integration activities occurring across the continuum for all primary care and behavioral health providers.

Managed Care Procurement

Following is sample state managed care RFP language related to integrated behavioral health services:

Arizona.⁹ “To accelerate the focus on integration at the provider level, describe the Offeror’s specific and detailed value-based strategies that align incentives between providers and the Offeror in order to reduce fragmentation and improve member outcomes. The Offeror’s response must address value-based integration strategies for each of the following: [a.] integrated providers, [b.] behavioral health only providers, and [c.] physical health only providers.”

Kansas.¹⁰ “Contractor(s) shall provide a detailed description in its proposal detailing [a.] what type of clinical support it will offer to Providers treating Behavioral Health conditions (including but not limited to depression, anxiety and addiction) in the Primary Care setting. [b.] How it will promote and support Primary Care based Behavioral Health in pediatric and adult populations; what best practices and recommended protocols it will use to support the integration of medical and Behavioral Health care; and what materials and tools it will utilize in order to engage Members and Providers to improve integration.”

Oregon.¹¹ “Applicant must identify and address billing system and policy barriers to integration that prevent Behavioral Health Provider billing from a physical health setting. Applicant will develop payment methodologies to reimburse for Warm Handoffs, impromptu consultations, integrated care management services and all services for evidence-based treatments.”



States interested in broadly scaling integrated care within a wide range of primary care practices may want to consider moving away from an emphasis on a particular care model to definitions of functions that are more broadly applicable to a range of providers (e.g., those that do not require hiring new staff).²⁰ Such states may choose to reference the eight common elements and minimum standards of integrated care developed by the Washington State Bree Collaborative.²¹

✓ ***What are managed care organization requirements and responsibilities for integrated primary care?***

States may take many different approaches to promote integration through Medicaid MCO contracts. Given that states have different populations, patient needs, and provider/health plan markets, there is no “right” way to do this work. States may choose to be firm in their expectations regarding a precise standard by which to measure performance, or instead express interest in achieving a particular outcome (e.g., co-located providers) accompanied by an incentive, such as a bonus or favorable auto-enrollment policies. **New Hampshire** requires MCOs to ensure that physical and behavioral health providers offer co-located or integrated care as defined in SAMHSA’s Six Levels of Collaboration/Integration or the Collaborative Care Model to the extent feasible, and to provide annual reports to the state on continued progression toward integration.²² Alternatively, **Washington State** encourages “behavioral health-medical integration,” but provides MCOs with more flexibility to determine exactly what integration will look like. States might also choose to design and implement standardized statewide programs that advance behavioral health integration within primary care at the state-level, and then require or incentivize plans to participate in those.

States may also choose to define other expectations around specific MCO functions that support integrated care, such as data-sharing capabilities, provider network information, reporting requirements, or MCO workforce standards. For example, **Louisiana** requires MCO contractors to employ a full-time behavioral health medical director whom is charged with developing training for the MCO’s PCPs on specific behavioral health screening tools and collaborative care models, as well as provide all PCPs with a current list of referral providers, including behavioral health providers, on a quarterly basis.²³

Managed Care Contract Excerpts

Following is sample state managed care contract language related integrating behavioral health services:

New Hampshire.¹⁷ “The MCO shall ensure physical and behavioral health Providers provide co-located or Integrated Care as defined in the Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Six Levels of Collaboration/Integration or the Collaborative Care Model to the maximum extent feasible.”

“[T]he MCO shall include in its Behavioral Health Strategy Plan and Report efforts towards continued progression of the SAMHSA Integration Framework at all contracted primary and behavioral health Providers.”

Louisiana.¹⁸ “The PCP shall provide basic behavioral health services [defined term] and refer the enrollee(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services. The Contractor shall ensure that network PCPs fulfill their responsibilities including, but not limited to [...] conducting screens for common behavioral issues, including, but not limited to, depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, early detection, identification of developmental disorders/delays, social-emotional health, and SDOH to determine whether the enrollee needs behavioral health services.”

Washington State.¹⁹ “The Contractor shall promote behavioral health-medical integration through education, training, financial, and nonfinancial incentives...including but not limited to [a.] increased screening, identification, and referral for behavioral health conditions that commonly occur in primary care settings [; and b.] development of collaborative care models and co-location of primary care and behavioral health providers.”

✓ *How, if at all, have states defined what types of screenings should be integrated into primary care?*

Many integrated care models involve systematic screening of a target population to proactively identify patients in need of care. Integrated primary care may involve different types of behavioral health screening, including screenings for mental health and/or SUD.²⁴ Some states require MCOs to use a particular screening approach within primary care and/or train PCPs on implementation of that screening tool. **Minnesota**, for example, promotes Screening, Brief Intervention, and Referral to Treatment (SBIRT) for SUD, and allows plans and providers to choose among state-approved screening tools.²⁵ In **Oregon**, SBIRT is a covered benefit for all Medicaid patients and for a wide range of provider types.²⁶ Depression screening is another common integration activity within primary care, with some states similarly allowing plans and providers to choose among validated screening tools and others requiring use of a particular tool, such as the Patient Health Questionnaire-9.²⁷ States may also explicitly require MCOs to reimburse PCPs for behavioral health screening activity, as **Michigan** has done. Additionally, states may wish to clarify appropriate screenings for children in the context of early, periodic, and diagnostic services. For example, in its 2019 RFP, **Oregon** asks potential respondents to describe how it will ensure that periodic social-emotional screening for all children birth through five years is conducted in the primary care setting.

✓ *How will the state minimize barriers to integrated care?*

In order to minimize barriers to integrated care, states can: (1) stipulate that MCOs assess and maintain billing approaches and other policies conducive to integrated care; and (2) assess their own policies, laws, and regulations to assess whether any may be unintentionally impeding progress toward integration. At the MCO-level, **Virginia** requires that its contracted health plans demonstrate the ability to cover specialty consultant services (e.g., telepsychiatry) to interested PCPs and contract with network behavioral health providers that can provide assessments and other services via telehealth, as needed. **Oregon** asks potential contractors to identify and address any billing and policy barriers to integration, and to develop payment approaches to reimburse for historically unpaid activities, such as care managers or provider consultations.²⁸

States can also solicit stakeholder feedback and conduct research on their own policies around billing to ensure they are conducive with the provision of collaborative and integrated care. For example, does the state have any same-day billing policies that impede integration? The 21st Century Cures Act recognizes this potential barrier to behavioral health integration, suggesting that Title XIX of the Social Security Act does not prohibit separate payment for a “mental health service furnished to the individual by a provider at a facility on the same day a primary care service is furnished to such individual by such provider (or another provider) at the facility.”²⁹

✓ *How, if at all, will the state dictate how MCOs should pay providers for integrated care?*

Integrating behavioral health into primary care has been widely demonstrated to improve quality and reduce costs, particularly for the Collaborative Care Model (see [Care Delivery Models](#) for more details on this model).³⁰ However, uncertainty about implementation and maintenance costs, and lack of a clear pathway for reimbursement, has hindered

more widespread adoption. A study of integrated team-based care approaches found that integrated practices generate \$115 per patient less annually, on average, under traditional FFS payment methods. This means that, from a business perspective, provider practices confront financial disincentives for integrating care unless the payment model is changed. In general, approaches that can be used to pay for integrated care include: (1) new fee-for-services billing codes (e.g., **Washington State's** Collaborative Care Model codes); (2) care management payments (e.g., **New York's** case rates for qualified Collaborative Care Model providers); (3) bundled payments (e.g., **Minnesota's** Diamond model); and (4) primary care capitation (e.g., **Rhode Island's** primary care capitation framework).

States may consider how, if at all, to dictate the way MCOs should pay for integrated care. A state may require MCOs to use a particular payment model or pay enhanced rates for providers demonstrating certain capabilities. Alternatively, a state may defer to the plan to develop payment methodologies to reimburse for historically unfunded services, such as provider consultations or integrated care management. States may be tempted to rely on broad VBP targets in Medicaid managed care contracts to spur new payment models for integrated care. Early evidence suggests, however, that use of broad VBP targets or benchmarks typically does not translate into widespread use of VBP for smaller or independent providers, including PCPs and behavioral health providers. Additionally, states may want to consider how and whether to align payment models for PCPs participating in related federal initiatives, such as CPC+ or Primary Care First. For example, CPC+ has explicit requirements for participating practices to integrate behavioral health services, selecting from one of two different care delivery options: *Care Management for Mental Illness* or *Primary Care Behaviorist* (see [Care Delivery Models](#) for more details).³¹

✓ **How do you measure and reward performance related to integration?**

States may create financial incentives for health plans as well as providers that meet certain integration benchmarks and milestones, such as behavioral health services constituting a certain percentage of total claims for a primary care practice or demonstrating capacity to exchange information across providers through an electronic health record system. States might also require health plans to report on integrated care progress, similar to how **New Hampshire** requires its MCOs to report on continued progression of integration efforts for all contracted primary and behavioral health providers. States may also choose to assume some centralized responsibility for measuring and rewarding performance related to integration. For example, **Washington State** conducts an annual survey of providers related to value-based purchasing that includes questions about integration activities.³² States can also rely on national accreditation bodies to help identify practices that have demonstrated the ability to provide integrated care, such as via the National Committee of Quality Assurance's PCMH Distinction in Behavioral Health Integration.³³

✓ **To what extent will you encourage or require MCO collaboration on behavioral health integration activities?**

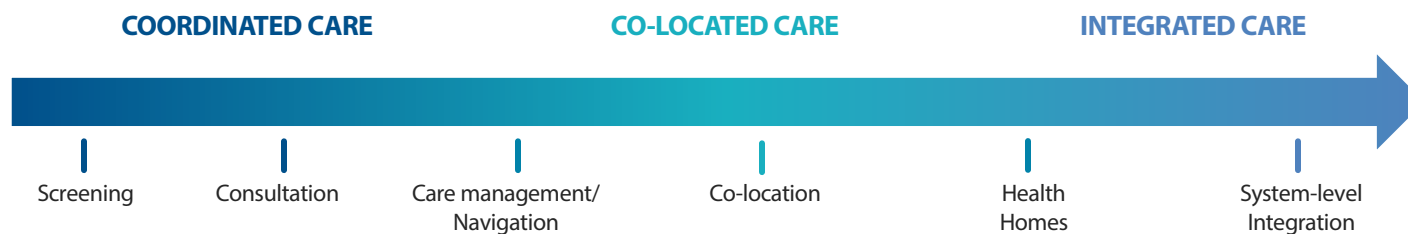
States operating in a Medicaid managed care environment may want to consider standardizing certain aspects of their integration efforts in order to reduce burden on providers and create seamless access to integrated care from the beneficiary's perspective. For example, **Pennsylvania's** Telephonic Psychiatric Consultation Service Program increases the

availability of peer-to-peer child psychiatry consultation teams to PCPs and other prescribers of psychotropic medications for children. The state's MCOs are required to contract with a telephonic psychiatric consultation team that provides real-time telephonic consultative services to PCPs and prescribers.³⁴ Pennsylvania required the physical and behavioral health MCOs to work together to collaboratively choose one psychiatric consultation team for each region. States might require MCOs to work together in a similar way to help fund or otherwise provide shared supports for smaller primary care practices that are not independently able to undertake more sophisticated integration activities.³⁵

Care Delivery Models

For states contemplating how to incent integration of behavioral health in primary care via Medicaid managed care, knowledge of existing care models serves to provide examples of off-the-shelf approaches so that states, health plans, and providers do not have to “start from scratch” in developing approaches. Below is a list of selected behavioral health integration models, roughly organized along the SAMHSA-HRSA Continuum of Physical and Behavioral Health Integration (**Exhibit 5**):

Exhibit 5. Continuum of Physical and Behavioral Health Care Integration³⁶



Care Delivery Model Examples

Screening

- **Screening, Brief Intervention, and Referral to Treatment (SBIRT)** is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. SBIRT enables PCPs to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work, or family issues. States may cover SBIRT services as a Medicaid State Plan service.³⁷

Consultation

- **Massachusetts Child Psychiatry Access Project** provides quick access to psychiatric consultation and facilitates referrals for accessing ongoing behavioral health care.³⁸ It encourages and supports PCPs integrating behavioral health resources into their practices. Many states have implemented similar programs.³⁹
- **Project ECHO**⁴⁰ is a telehealth mentoring model that enhances workforce capacity in underserved areas by providing community-based primary care teams with the evidence-based knowledge to manage patients with complex conditions.

The Extension for Community Healthcare Outcomes (ECHO) model provides an opportunity to promote expansion of access to treatment for a broad range of mental health and substance use disorders, particularly in underserved areas.^{41,42}

- **Vermont's Hub and Spoke Model** is used to expand access to medication assisted treatment for substance use disorders.⁴³ Under the model, nine regional opioid treatment facility "hubs" offer daily support for complex addictions, while 75 "spokes" or primary care practices offer ongoing opioid use disorder treatment.

Navigation

- **Collaborative Care Model (CoCM)**,⁴⁴ considered an advanced form of coordinated care, is an evidence-based approach for integrating physical and behavioral health services within PCMH or other primary-care settings.⁴⁵ It enhances routine primary care by adding two key services: (1) care management support for patients receiving behavioral health treatment; and (2) regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving.⁴⁶ CoCM is recognized as effective in treating a wide range of behavioral health disorders, including depression, anxiety, and SUD.
- **Care Management for Mental Illness** is one of the foundation behavioral health integration strategies under Comprehensive Primary Care Plus (CPC+). Selected CPC+ practices must develop capabilities using at least one foundational strategy. This strategy includes offering proactive, relationship-based care management, with specific attention to care management of the mental health condition (e.g., major depressive disorder/dysthymia, generalized anxiety disorder, and panic disorder).

Co-Location

- **Primary Care Behaviorist Model** is one of the foundational behavioral health integration strategies under CPC+. Selected CPC+ practices must develop capabilities using at least one foundational strategy. This strategy includes warm handoffs to a co-located behavioral health professional to address mental illness in the primary care setting and behavioral strategies for management of chronic general medical illnesses, and to facilitate specialty care engagement for serious mental illness.

Health Homes

- **Medicaid Health Homes**, made possible under Section 2703 of the Affordable Care Act, is designed to enhance coordination and continuity of care for Medicaid beneficiaries with complex chronic conditions across various care types and settings and to provide a "cost-effective, longitudinal 'home' to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions."⁴⁷ As noted in a Kaiser Family Foundation brief, "the comprehensive nature of health home services and the holistic approach to care place health homes further 'east' on the . . . integration continuum."⁴⁸

System-Level Integration

- **Oregon's "Fully Integrated" Patient-Centered Primary Care Home (PCPCH)**, integrated into Oregon Health Authority's broader CCO program, reaches the highest level of behavioral health integration. PCPCHs must provide integrated behavioral health services, including population-based, same-day consultations by behavioral health providers.⁴⁹ Further, physical and behavioral health providers must also use 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.

State Approaches

States have a number of options to consider in determining how best to advance behavioral health integration in primary care within a Medicaid managed care environment. One option is to take a centralized approach at the state level, by, for example, stipulating behavioral health integration requirements as part of PCMH programs, and then requiring or encouraging health plans to contract with PCMH providers.

Another option is to implement requirements within Medicaid managed care contracts. States may opt to be prescriptive about what exactly behavioral health integration in primary care settings should look like (e.g., by requiring health plans to implement specific care models), or defer to Medicaid MCOs on how exactly to define, implement, fund, and monitor integration of behavioral health into primary care. States may also choose to be prescriptive about some elements (e.g., training or screening requirements) and flexible on others.

Centralized	Prescriptive	Flexible
Oregon developed a Patient-Centered Primary Care Home (PCPCH) model with tiered expectations for behavioral health integration. Oregon requires its CCOs to assist in advancing providers along the spectrum of the PCPCH model (from Tier 1 to Tier 5), and ties incentive funds to a PCPCH enrollment measure. ^{50,51}	Minnesota requires MCOs to provide SBIRT in primary care clinics, which must use a “valid and reliable” screening tool approved by the state. ⁵²	Washington State requires MCOs to increase screening, identification, and referral for behavioral health conditions that commonly occur in primary care settings, and to develop collaborative care models and co-location of primary care and behavioral health providers. ⁵³
New York developed the New York State Patient-Centered Medical Home (NYS-PCMH) which includes enhanced standards for behavioral health integration, among other areas. ⁵⁴ New York also developed a program enabling PCPs who implement the Collaborative Care model (CoCM) to receive reimbursement for services provided. ⁵⁵	New Hampshire requires MCOs to ensure physical and behavioral health providers provide co-located or Integrated Care as defined in SAMHSA’s Six Levels of Collaboration/Integration or the Collaborative Care Model to the maximum extent feasible. ⁵⁶	Michigan requires MCOs to provide primary care training on evidence-based behavioral health service models for PCPs, such as SBIRT, and to reimburse primary care practices for behavioral health screening services. ⁵⁷

Measurement and Payment

States have increasingly integrated behavioral health integration measures and incentives into their Medicaid programs, such as through PMCH models, VBP initiatives, and MCO incentive and withhold arrangements.

State	Description
Value-Based Payment and Other Provider Funding Arrangements for Behavioral Health Integration	
Arizona ⁵⁸	Arizona requires MCOs to enter into at least two alternative payment model contracts with integrated providers that offer physical and behavioral health clinical integration.
California ⁵⁹	California proposed four behavioral health integration measures as part of the value-based purchasing measure slated to be used by health plans with contracted providers: (1) screening for clinical depression; (2) management of depression medication; (3) screening for unhealthy alcohol use; and (4) co-location of primary care and behavioral health services. ⁶⁰
Colorado ⁶¹	Colorado developed a primary care alternative payment model that offers enhanced rates for primary care services based on structural and performance measures. Primary care practices select 10 measures from a menu of 60+ options, including structural measures (e.g., screening and follow-up for at least three conditions, including behavioral health) and clinical measures (e.g., initiation and engagement of alcohol or other drug dependence treatment).
New York ⁶²	New York provides value-based monthly case-rate payments for eligible managed care beneficiaries enrolled in qualified collaborative care model programs. Enhanced PCMH payments are also distributed to providers designated as NY-PCMH through Medicaid MCOs for managed care members.
Washington State ⁶³	Building off Medicare's approach to payment for select behavioral health integration services, Washington's Medicaid program allows providers to bill for the collaborative care model, enhancing primary care by adding care management support and regular psychiatric consultation with a multidisciplinary care team. ⁶⁴ Providers must attest they are providing care consistent with the state's guidelines.
MCO Withhold and Incentive Arrangements	
Oregon ^{65, 66}	Oregon has 19 quality measures used to determine reward payments for CCOs in 2019, including: (1) PCPCH enrollment; (2) Screening, Brief Intervention, and Referral to Treatment; and (3) depression screening and follow-up plan, with providers choosing a standardized screening tool.
North Carolina ⁶⁷	North Carolina has proposed measuring the percentage of individuals with a mental health disorder, substance use disorder, and intellectual/developmental disabilities who have a primary care visit.

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About this Resource

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About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve beneficiaries of publicly financed care, especially those with complex, high-cost needs. To learn more, visit www.chcs.org.

ENDNOTES

¹ Tennessee Primary Care Associate. "Appendix 4: PCMH Distinction in Behavioral Health Integration." September 2017. Available at:

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³ Ramanuj, P., E. Ferencik, M. Docherty, B. Spaeth-Ruble, and H.A. Pincus. "Evolving Models of Integrated Behavioral Health and Primary Care." *Current Psychiatry Reports*, 21 (2019): 4.

⁴ Behavioral health integration can occur bi-directionally, whereby behavioral health services are integrated into primary care settings, and/or primary care services are integrated into behavioral health settings.

⁵ Agency for Healthcare Research and Quality. "What Is Integrated Behavioral Health Care (IBHC)?" Available at: <https://integrationacademy.ahrq.gov/products/ibhc-measures-atlas/what-integrated-behavioral-health-care-ibhc>

⁶ M. Gerrity. *Evolving Models of Behavioral Health Integration: Evidence Update 2010-2015*. Milbank Memorial Fund, May 2016. Available at: <https://www.milbank.org/wp-content/uploads/2016/05/Evolving-Models-of-BHI.pdf>.

⁷ SAMHSA-HRSA Center for Integrated Health Solutions. "A Standard Framework For Levels of Integrated Healthcare and Update Throughout the Document." March 2013. Available at: https://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

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⁹ Page 305. SOLICITATION # YH19-0001. AHHCS Complete Care Contracts. Arizona Health Care Cost Containment System Administration. Available at: https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH19/ACC_RFP_11022017.pdf.

¹⁰ Section E, P.34. Kansas Medicaid Managed Care Request for Proposal for KanCare 2.0. Available at: <https://admin.ks.gov/offices/procurement-and-contracts/kancare-award>

¹¹ Attachment 11. Behavioral Health Questionnaire. RFA OHA-4690-19 – CCO 2.0. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/10-CCO-RFA-4690-0-Attachment-11-BH-Questionnaire%20Final.pdf>

¹² Ibid.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ Oregon developed a tiered Patient Centered Primary Care Home (PCPCH) model with three increasingly advanced standards: (1) a screening and referral strategy for mental health and substance abuse; (2) a cooperative referral process (or co-location) with specialty mental health and substance abuse; and (3) integrated behavioral health services, including same-day consultations by behavioral health providers.

¹⁶ National Committee for Quality Assurance. "Distinction in Behavioral Health Integration." Available at: <https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/distinction-in-behavioral-health-integration/>

¹⁷ Section 4.11.1.6. P. 192. Appendix C. Medicaid Care Management Services. Model Contract. New Hampshire Department of Health and Human Services. Available at: <https://www.dhhs.nh.gov/business/rfp/documents/rfp-2019-oms-02-manag-appc.pdf>

¹⁸ Section 2.9.10.5.1.12, P. 120. Louisiana Medicaid Managed Care Organization Model Contract. Appendix B. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf

¹⁹ Section 14.5.1. Page 229. Washington Apple Health Fully Integrated Managed Care Contract. Amendment #5. Washington Health Care Authority. Effective July 1, 2019. Available at: https://www.hca.wa.gov/assets/billers-and-providers/ipbh_fullyintegratedcare_medicaid.pdf

²⁰ Bree Collaborative. "Behavioral Health Integration Report and Recommendations." January 2017. Available at: <http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Draft-Recommendations-2017-01.pdf>.

²¹ Ibid.

²² SAMHSA-HRSA Center for Integrated Health Solutions. "A Standard Framework For Levels of Integrated Healthcare and Update Throughout the Document." March 2013. Available at: https://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

²³ Section 2.3.3.4.4, page 51. Appendix B: Louisiana Medicaid Managed Care Organizations Model Contract. Request for Proposals # 3000011953. Louisiana Department of Health Bureau of Health Services Financing, 2019. Available at: http://ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf

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²⁵ For more information on SBIRT, see the *Improving Access to Screening, Brief Intervention, and Referral to Treatment Services for Adolescents: A Resource Center* available at: <https://www.chcs.org/resource/improving-access-to-screening-brief-intervention-and-referral-to-treatment-in-primary-care-for-adolescents-a-resource-center/>.

²⁶ For more information on the Oregon Health Authority's approach to SBIRT, see: Oregon Health Authority. Available at: <https://www.oregon.gov/oha/HSD/AMH/Pages/SBIRT.aspx>

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²⁸ Oregon CCO RFA, Attachment 11 – Behavioral Health Questionnaire, Oregon Health Authority. Available at: <https://www.oregon.gov/oha/OHPB/CCODocuments/10-CCO-RFA-4690-0-Attachment-11-BH-Questionnaire%20Final.pdf>

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