

Integrating Physical and Behavioral Health

Addressing Co-occurring Mental Health and Substance Use Disorders with Chronic Physical Illnesses



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Integrating Physical and Behavioral Health: Addressing Co-Occurring Mental Health and Substance Use Disorders With Chronic Physical Illnesses

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ABSTRACT

Mental illness and substance use disorder (SUD) are common, with over 60 million Americans experiencing a mental illness in 2024 and nearly 50 million experiencing an SUD. Medical comorbidities are highly prevalent in these populations and represent the leading cause of premature mortality among those with severe mental illness. Despite the public health imperative to improve coordinated management of medical, mental health, and substance use–related conditions, the U.S. health system has historically segregated the financing, organization, and delivery of behavioral health services from general medical care. Evidence demonstrates that integrating care for populations with co-occurring conditions can improve health outcomes. Integration models vary in their focus (mental health or SUD services in medical settings versus medical care in specialty behavioral health settings), health professionals involved, spatial arrangements, health information technology infrastructure, and financing mechanisms. The Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have advanced demonstrations and new billing codes to support and reimburse integration activities. However, significant challenges remain, including financial sustainability, the role of health information technology in communication and information sharing, and workforce development. This report describes the evolving landscape of integrated care in the United States, including established frameworks that emphasize interdisciplinary teams, clear communication systems, and care coordination across providers.

HIGHLIGHTS

- Many individuals with mental illness and SUD have medical comorbidities. Yet the health system has traditionally treated these conditions in separate and distinct systems of care.
- Evidence demonstrates that integrating care for individuals with mental health, substance use, and medical needs can improve health outcomes.
- Models for integrating care face implementation challenges that have inhibited broader scale-up, including difficulties related to financial sustainment, workforce, health information technology, and organizational change.
- Alignment of financial incentives and delivery system structures is needed to support integration as a standard approach for populations with mental health, substance use, and medical needs.
- There are many efforts underway through policy, finance, and research that aim to prioritize integration, making this an important priority for mental health leaders.



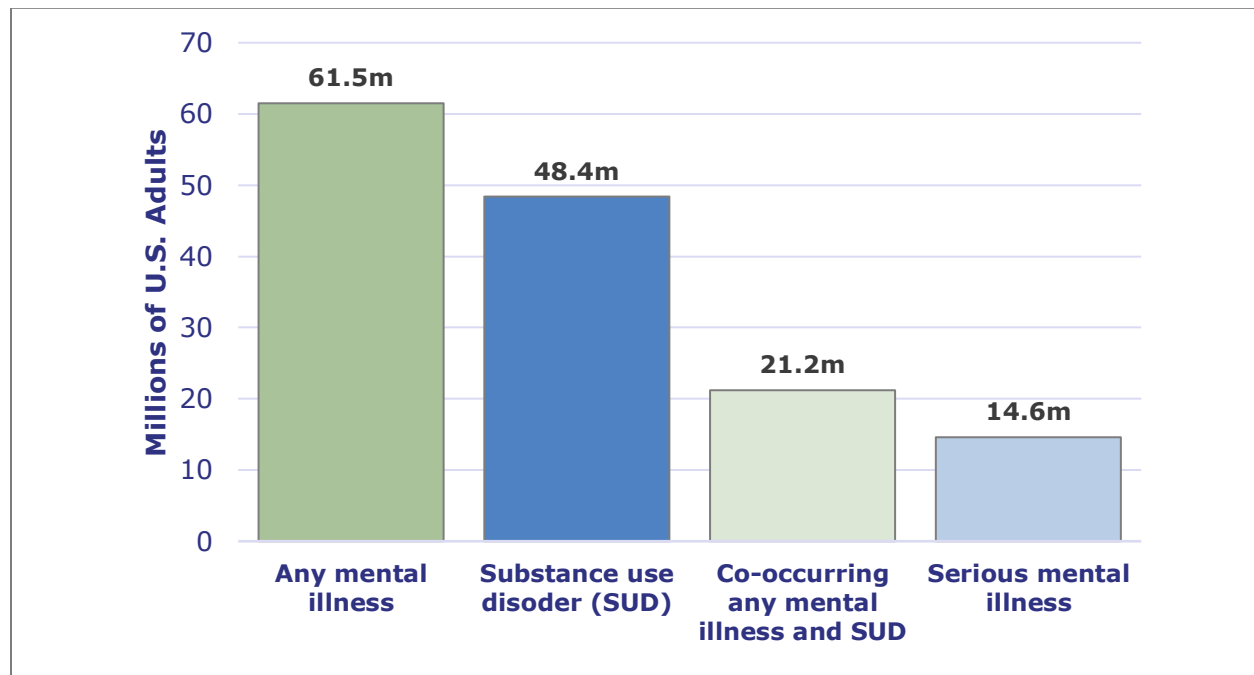
POLICY CONSIDERATIONS

1. Populations with mental health, substance use, and medical needs are heterogeneous. Integration approaches should be adapted to illness severity and level of need.
2. Efforts to reorient financing incentives to support integration are needed, including increased uptake and utilization of behavioral health integration codes and expansion of alternative payment models. Rigorous research should evaluate what types of financing mechanisms are most effective in incentivizing delivery system change.
3. To realize the full potential of health information technology in facilitating integrated care, policymakers must address system-level technology inequities that undermine information sharing between medical and behavioral health providers.
4. Workforce challenges must address the multitude of issues related to workforce constraints on achieving integrated care, including workforce shortages, uneven geographic distribution, insufficient training for practicing in integrated care settings, and variable reimbursement rates.
5. Policymakers and leaders should familiarize themselves with integration models and efforts across Medicaid, Medicare, private payors, and state-funded programs and services, and maximize partnership across systems to examine and deliver high-quality integration models.

INTRODUCTION

Integrating mental health and/or substance use services with medical care recognizes the overlap in populations affected by these conditions and the benefits of addressing these health issues through a comprehensive care strategy. Large numbers of Americans experience mental illness or substance use disorder (SUD) (**Figure 1**). Nearly one in four adults in the United States had a mental illness in the past year, according to 2024 data from the National Survey on Drug Use and Health, and about 5 percent of adults have a serious mental illness (SMI),¹ such as schizophrenia or bipolar disorder. Close to 50 million Americans ages 12 or older had an SUD in the past year. Mental illness and SUD are highly comorbid. Among adults with any mental illness, about one third also have an SUD, while nearly half with SMI have an SUD.² Despite the significant need for mental health and substance use treatment, less than a quarter of adults with mental illness and less than 4 percent of adults with SUD received treatment in 2024.³

Figure 1: Number of U.S. Adults Experiencing Mental Illness or SUD in 2024



Source: Center for Behavioral Health Statistics and Quality. (2025). Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health (HHS Publication No. PEP25-07-007, NSDUH Series H-60). Substance Abuse and Mental Health Services Administration.

Those with mental illness or SUD experience higher rates of co-occurring physical health conditions, such as cardiovascular disease, diabetes, respiratory conditions, and communicable diseases like HIV/AIDS, than populations without these behavioral health conditions.^{4,5,6} Estimates of the prevalence of these conditions vary but generally run higher in populations with more severe mental illness or



SUD.⁷ People with SMIs such as schizophrenia or bipolar disorder experience premature mortality of 10–20 years earlier than the general population, often due to unrecognized, or undertreated, comorbid physical health conditions.^{8,9}

Individuals with mental illness or SUD and medical conditions may need ongoing management that requires coordination across specialty mental health and/or SUD providers, primary care physicians (PCPs), and medical specialists.¹⁰ However, providers are often distributed across different care delivery systems and may be financed through different mechanisms, creating a fragmented environment that complicates access to and continuity of services.¹¹ Engaging in healthcare services for complex conditions may also be hindered by social and economic needs, such as housing or transportation.^{12,13} The siloing of mental health and SUD treatment from general medical care may also reinforce the already high levels of stigma toward people with mental health and substance use conditions as separate delivery and financing systems raise concerns regarding equity.¹⁴ Additionally, delivering health care and other services in a fragmented system may impose financial strain on payors and the health system by reducing care quality or generating duplications, contributing to other inefficiencies.¹⁵

Care integration seeks to address issues related to fragmentation and discontinuity by creating a more cohesive approach to patient care and incorporating elements of population health management.

Integration of services may extend across the continuum of care from prevention, screening and diagnosis, treatment services across a spectrum of intensity, and crisis response to case management, peer support, and social services. It is an exciting time in the work of integration, with several initiatives and policy priorities at the state and federal levels advancing this work. For this reason, behavioral health leaders are well positioned when they understand various options for integration and can think creatively and in a coordinated manner with other system leaders who touch on this work.

To reduce fragmentation, California's Whole Person Care Pilot Program, a Medicaid 1115(a) waiver demonstration project, is focused on improving the integrated delivery of health, behavioral health, and social services for those with complex care needs.

FRAMEWORKS FOR CHARACTERIZING THE KEY COMPONENTS OF INTEGRATED CARE

Integrated care is conceptualized and defined in many ways. Integration typically involves some elements of team-based care, including communication and collaboration across different types of providers. Providers involved in integrated care approaches include primary care clinicians, psychiatric and/or substance use specialists (e.g., psychiatrists, psychologists, psychiatric nurse practitioners, substance use counselors, etc.), medical specialists, nurse care managers, and case

managers. These providers may or may not be co-located physically or practice as part of an integrated health system that facilitates communication and information sharing (e.g., through a shared electronic health system). To address the barriers presented by siloed treatment services, numerous models and frameworks have been developed over the last several decades to characterize what constitutes integrated care, determine its key elements, and offer shared definitions. Below, we describe several of these frameworks or models for conceptualizing the key components of integrated care.

The Comprehensive Health Integration framework

The National Council for Mental Wellbeing’s Center of Excellence for Integrated Health Solutions, with support from the Substance Abuse and Mental Health Services Administration (SAMHSA), conceptualized the Comprehensive Health Integration (CHI) framework as a tool to guide physical and behavioral health integration. It defines integrated services as “the provision and coordination by the treatment team of appropriately matched interventions for both physical health and behavioral health conditions, along with attention to social and environmental factors that affect health, in the setting in which the person is most naturally engaged,” which can be “any physical health or behavioral health setting.”¹⁶

In addition, the CHI framework recognizes that integration can occur bidirectionally, with

medical or physical health services integrated into behavioral health (i.e., specialty mental health or substance use treatment) settings and vice versa. The CHI framework defines eight domains of integration processes or services, including screening and referral, care coordination, and community interventions to address social and environmental factors that affect health.

The goal of the CHI framework is to support different actors in the health system, including providers, payors, and policy officials, to assess progress toward what the CHI framework refers to as “integratedness,” or “the degree to which programs are organized to deliver integrated physical health and behavioral health prevention and treatment services to individuals or populations, as well as to address social and environmental factors that affect health.”¹⁷ The CHI framework notes that “integratedness” involves measuring both structural and process-related factors that support integration.¹⁸

Comprehensive Health Integration (CHI) Framework: Eight Domains of Integration Processes or Services

1. Screening, referrals, and follow-up
2. Integrated prevention and treatment
3. Ongoing care coordination
4. Personalized self-management support
5. Interdisciplinary teamwork
6. Systematic quality improvement
7. Community interventions
8. Financial and administrative sustainability

The CHI framework builds on prior integration frameworks that include SAMHSA’s six levels of collaboration and integration,¹⁹ the Agency for Healthcare Research and Quality’s Framework for Measuring Integration of Behavioral Health and Primary Care,²⁰ the continuum-based Behavioral Health Integration²¹ and General Health Integration²² frameworks, among others.

SAMHSA’s six levels of collaboration/integration

The SAMHSA framework outlines six levels of collaboration/integration ranging from Level 1, involving minimal collaboration, to Level 6, in which full collaboration has been achieved within an organization (**Table 1**).²³ The levels capture the extent to which physical space is shared for the team within the same facility, the consistency of communication, the degree of understanding of the roles of providers involved in patients’ care, the extent to which providers involved in patients’ care use shared information systems, and the blending of cultures.

Table 1: SAMHSA’s Six Levels of Collaboration/Integration

Level 1 Minimal collaboration	Minimal collaboration involves operation in separate facilities, use of separate information systems, rare communication driven by provider need, and limited understanding of the roles of providers. Providers develop separate treatment plans for patients and treat physical health and behavioral health needs as distinct. At this level, the business model involves no funding or sharing of resources, and the physical health and behavioral health settings operate autonomously, leading to potential duplication or gaps in care.
Level 2 Basic collaboration at a distance	Basic collaboration at a distance still involves separate facility-level provision of services, with distinct information systems. Communication, however, occurs periodically rather than rarely and providers may have a better sense of one another’s roles in patient care. Results of screening and assessment, as well as treatment plans, may still occur separately but may be shared through mechanisms such as state health information exchanges. Providers may have greater recognition of the value of collaboration and information sharing than in Level 1. Operationally, billing is still done separately although some resources may be shared for joint projects. Information sharing at this level may not be sufficient to change individual provider plans or reduce risk of duplication or gaps in care.
Level 3 Basic collaboration on-site	Basic collaboration on-site is the first level at which physical health and behavioral health providers may be part of the same facility but not necessarily within the same office/space in the facility. They may still be using separate information systems but are communicating more regularly about shared patients. Clinicians may operate according to more shared guidelines for screening or criteria for referral, with referral processes facilitated by proximity. Service plans involve a greater degree of information sharing. Billing still happens through separate funding structures; facility expenses may be shared.

Level 4 Close collaboration on-site with some system integration	<i>Close collaboration on-site with some system integration</i> involves providers working from the same space within the same facility; sharing information systems, including medical records; and communicating in person as needed. Collaboration and shared treatment planning may be focused on patients with more severe needs. Referrals may have better follow-through than in lower levels of integration. Physical health and behavioral health providers have a sense of their colleagues' roles and culture. The business model may be increasingly integrated, with shared infrastructural expenses.
Level 5 Close collaboration approaching an integrated practice	<i>Close collaboration approaching an integrated practice</i> also involves providers working from the same space in a shared facility. Communication and collaboration is frequent, and physical health and behavioral health providers have regular team meetings to discuss patients overall as well as specific patient cases. Providers have a more sophisticated understanding of colleagues' roles and culture than in Level 4. Screening processes and treatment plans are done collaboratively, as is delivery of evidence-based practices. Providers practice team-based care for patients, and patients experience these settings as a "one-stop shop" that addresses their health needs holistically. Funding is more integrated at this level, including billing practices.
Level 6 Full collaboration in a transformed/merged integrated practice	<i>Full collaboration in a transformed/merged integrated practice</i> is the highest level of integration, according to this framework. Practices at this level have addressed some of the system-level challenges experienced at Level 5 and view themselves as part of a team with blended culture and roles. Population-based screening and response to screening results is standard protocol, and treatment plans are developed collaboratively by physical health and behavioral health providers. Funding is fully integrated across multiple revenue streams, and resources are shared across the practice. At this level, challenges relate to sustainability and determining expectations around outcomes.

Source: Center for Integrated Health Solutions. (2020). Standard framework for levels of integrated health care. National Council for Mental Wellbeing.

https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf



Atlas of Integrated Behavioral Health Care Quality Measures

Developed by the Agency for Healthcare Research and Quality's Academy for Integrating Behavioral Health and Primary Care, the *Atlas of Integrated Behavioral Health Care Quality Measures* (known as the IBHC Measures Atlas) seeks to support a system for measuring progress toward integrated care.²⁴ The IBHC Measures Atlas includes a framework for understanding integrated care measurement, the organization of existing measures by this framework, and the goals of potential users of these measures. The Atlas is intended to support users in selecting measures relevant to their contexts and purposes. Target users of the Atlas include providers and teams seeking to understand the degree to which they are providing integrated care, health leaders and advocates interested in understanding progress toward integration, and researchers who are evaluating integration.

The *Atlas of Integrated Behavioral Health Care Quality Measures* defines integrated behavioral health as “a practice team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach, to provide patient-centered care for a defined population.”

The IBHC Measures Atlas's framework is a lexicon that defines integrated care and describes its key functions.²⁵ This lexicon defines integrated behavioral health as “a practice team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach, to provide patient-centered care for a defined population.”²⁶ The lexicon defines integrated care as involving both clinical functions, including biopsychosocial assessment and care, teamwork, and a systemic clinical approach, and organizational supports, including continuous data collection that facilitates learning; alignment of leadership, operations, and the business model; and connections with the populations being served.

Aligning integrated care frameworks with populations

In addition to the frameworks and models described above, scholars have noted that certain approaches to integration may be differentially suited to certain subpopulations. For instance, in describing reform models aiming to improve integration of care, Bao and colleagues²⁷ distinguished populations by severity of illness (mild to moderate behavioral health versus serious conditions) as well as payor type. They noted that certain integration models, particularly primary care-based models such as the patient-centered medical home, may be more appropriate for patients with mild to moderate conditions in part due to greater feasibility of managing this population's care from the locus of the primary care

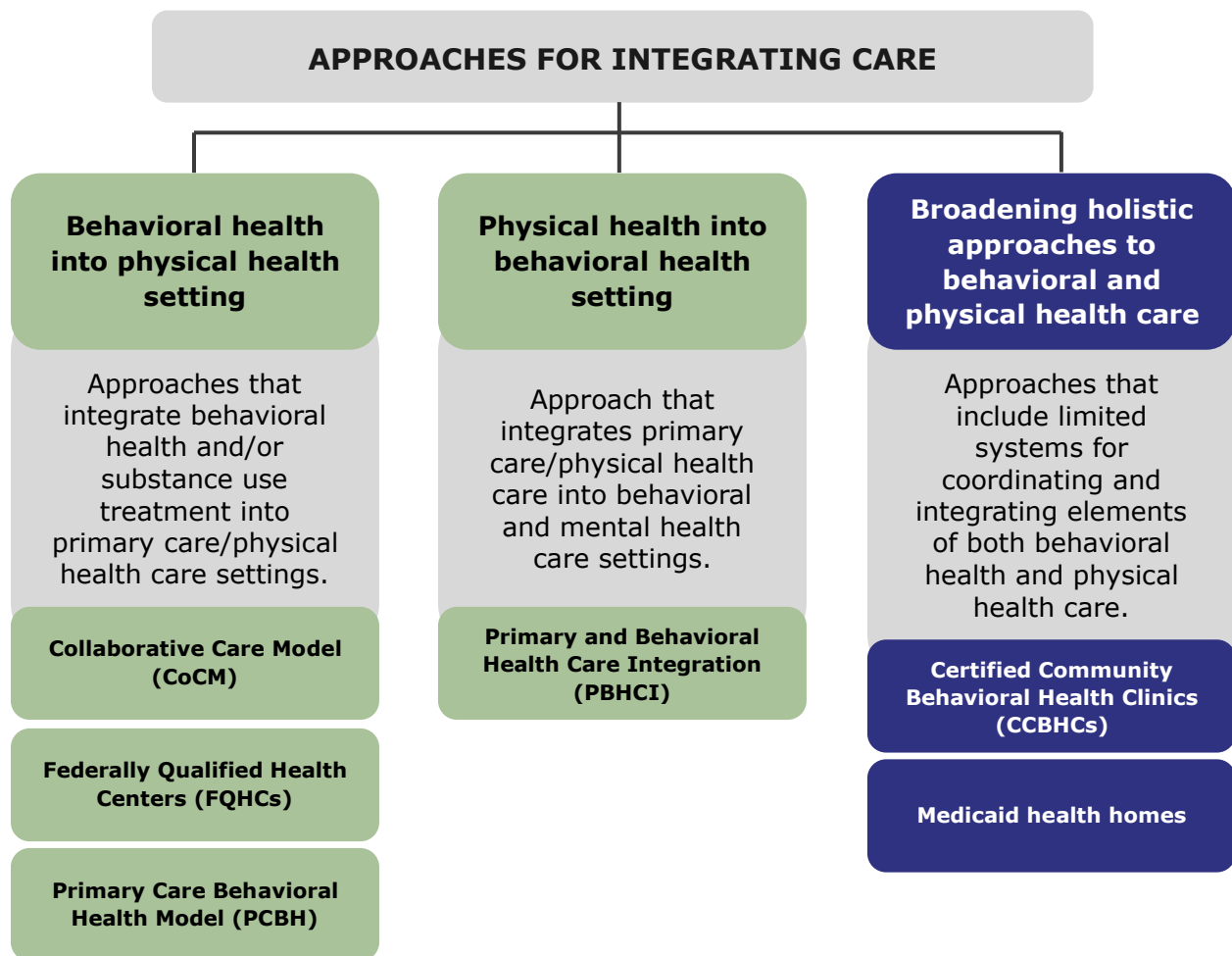
setting. On the other hand, primary care settings may have more limited expertise and ability to manage patients with more severe behavioral health conditions, who may benefit from models based in the specialty behavioral health setting, such as behavioral health–based health homes. Payor type also correlates with patient socioeconomic need and potentially varying degree of access challenges. As a result, certain models (at least the financing components) may be more appropriate for deployment through certain payor segments.



APPROACHES FOR INTEGRATING CARE

Approaches for integrating care can be organized into broad categories (**Figure 2**): (1) those that integrate behavioral health components into primary care/physical health settings, (2) those that integrate physical health components into mental health settings (commonly called “reverse integration”), and (3) strategies that have aspects of integrated care in behavioral health settings.

Figure 2: Approaches for Integrating Care: Behavioral Health Integration in Primary Care Settings, Reverse Integration of Physical Health in Behavioral Health Settings, and Aspects of Integrated Care in Behavioral Health Settings



Approaches integrating behavioral health into physical health settings

The Collaborative Care Model

Overview: The Collaborative Care Model (CoCM) is an approach developed in the 1990s by researchers at the University of Washington that focuses on addressing mental health or substance use concerns in primary care contexts.²⁸ It builds on the principles of the Chronic Care Model, which deploys a team-based, patient-centered approach to managing chronic disease. It is also known as the psychiatric CoCM.

Five Core Components of the Collaborative Care Model (CoCM)

Patient-Centered Care Team	A primary care clinician works alongside a behavioral health care manager and a psychiatric consultant
Population-Based Care	A patient registry is used to provide population-based care
Measurement-Based Care	Oriented around capturing progress toward patient-defined health goals
Evidence-Based Care	Evidence-based treatments, interventions, and prescribing
Accountable Care	Providers and organizations are held accountable by quality standards

Model design: The CoCM involves a team-based approach to mental health and substance use management in primary care, led by a PCP working alongside a behavioral health care manager and a psychiatric consultant. In addition to this patient-centered team, the other core principles of CoCM include the application of population-based strategies through the use of a patient registry, measurement-based care oriented around capturing progress toward patient-defined health goals, use of evidence-based treatments, and accountability for the providers.²⁹ The CoCM has been

extended to other settings, including specialty medical care and inpatient settings.^{30,31}

Evidence base: The CoCM has been studied extensively in a variety of contexts and for numerous behavioral health issues. The largest, most robust set of evidence exists on the impact of the CoCM on populations with depression. A Cochrane Collaboration systematic

review of 79 randomized controlled trials found evidence that the CoCM significantly improved depression and anxiety relative to usual care.³² Other systematic reviews assessing implementation of at least three or four of the five core components of

The Medical University of South Carolina has partnered with rural health clinics to implement a [telepsychiatry CoCM model](#) to provide better access to behavioral health services in rural parts of the state. Primary care practices screen patients, care managers coordinate treatment, and psychiatrists can provide consultations remotely.

the CoCM across settings beyond the primary care context also found improved mental and physical health outcomes across different care settings.^{33,34} The evidence base for improvements in outcomes among people with SUD is more limited. One systematic review examined the potential of CoCM for populations with comorbid chronic pain and opioid use disorder, a complicated subpopulation.³⁵ Eleven of the 18 reviewed trials included in the analysis found significant improvements in pain outcomes, but the size of the effects was variable.

Implementation considerations: Like many other integrated care models, CoCM requires a staffing arrangement and workflow that is distinct from the way many primary care practices tend to operate. This requires activities, such as communication and coordination with the team, that have not been traditionally covered by insurers, creating financial sustainability challenges.³⁶ Various initiatives have funded CoCM in settings including the Veterans Health Administration and academic medical centers. In 2017, CMS introduced billing codes for CoCM.

Community health centers and Federally Qualified Health Centers with behavioral health components

Overview: Community health centers (CHCs) are the foundation of the nation's safety-net primary care system, serving more than 30 million patients from low-income and other vulnerable communities across the United States.^{37,38} Section 330 of the Public Health Service Act authorized the federal CHC program, which is operated out of the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA).³⁹ Federally qualified health centers (FQHCs) receive funding from HRSA to provide primary care in medically underserved areas or to populations that are medically underserved, including migrants, people experiencing homelessness, and those living in public housing. FQHCs must provide care to patients on a sliding fee scale and include patients and community members on their governing boards.⁴⁰ FQHC look-alikes are CHCs that meet federal requirements but do not receive funding from the HRSA health center program.⁴¹ As of 2026, there were over 1,512 CHCs operating at over 17,000 locations across the country.⁴² Given the complexity of needs among CHC patients, most offer mental health and substance use services.

Model design: Although CHCs were originally designed as community-based PCPs, the comprehensiveness of their services has expanded over time. In a national survey of CHCs fielded in 2024, 76% of CHCs reported screening all patients for mental health or substance use-related needs, up from 71% in 2018.⁴³ The majority of CHCs also reported screening for social and economic needs. Notably, many CHCs also provide mental health and substance use-related services on-site. This includes mental health counseling, offered at over 70% of CHCs, substance use treatment services, reported as available on-site by 66% of CHCs, and medications for treatment of SUD, available at 62% of CHCs, a large jump from 2018, when only 37% of CHCs reported medication availability on-site.⁴⁴ CHCs are financed

through insurance reimbursement from payors including Medicaid, covering half of CHC patients, commercial insurance plans including Affordable Care Act's Health Insurance Marketplace plans, and federal grant funding.

Evidence base: Evidence on the impact of integrating mental health and substance use services into CHC settings is somewhat limited but generally positive. In an analysis of Massachusetts all-payor claims data, individuals with SMI receiving care at FQHCs versus other primary care settings were more likely to have access to outpatient mental health care and psychotropic medication fills.⁴⁵ Findings were mixed with respect to acute care utilization, with a greater likelihood of emergency department use but lower likelihood of inpatient admission than in other primary care settings.⁴⁶ Another study, focused on Massachusetts and children, found that integrating mental health services into the CHC setting was associated with improved access to pediatric mental health services among Medicaid-enrolled children.⁴⁷

Implementation considerations: CHCs face various challenges with respect to integrating mental health and substance use services. The majority of CHCs report workforce shortages of mental health providers (among 77% of CHCs in 2024) and the enabling service providers that address social determinants of health needs among patients (69%).⁴⁸ CHCs report difficulty identifying mental health and substance use treatment providers that can work on-site but also serve as external providers in the community for patients in need of referral.⁴⁹ Securing specialty medical care appointments for patients and two-way communication from external health providers in the community impedes CHCs' ability to support integrated care for a complex population. Additional implementation considerations reported in the literature include state licensure regulations regarding co-location of services, billing for medical and mental health or substance use services in the same day, and altering clinic workflow.⁵⁰ While the 2026 Consolidated Appropriations Act extended CHC funding through the end of 2026, longer-term federal funding has not been secured. Changes to Medicaid and Marketplace plans also creates uncertainty about sustainment of operations.

The Primary Care Behavioral Health model

Overview: Another prominent approach to integrating behavioral health services into primary care settings is the Primary Care Behavioral Health (PCBH) model, which is "a team-based primary care approach to managing behavioral health problems and biopsychosocially influenced health conditions."⁵¹

Model design: The main goal of the PCBH model is to enhance the primary care team's ability to manage and treat behavioral health problems and conditions, with a focus on improving primary care services for the entire clinic population.⁵² A key component of the PCBH model is the role of a behavioral health consultant, who works as a member of the primary care team to support and extend the PCP, nurses, medical assistants, and other delivery team members. Sometimes referred

to as a PCP “extender,” the behavioral health consultant works as a “generalist and an educator who provides high-volume services that are accessible, team-based, and a routine part of primary care.”⁵³ Built on a population health approach, the goal of the behavioral health consultant is to maximize the effectiveness of the primary care team for the *whole* clinic population.

Evidence base: Evidence suggests two primary ways in which the PCBH model contributes to improved population health: (1) by strengthening primary care in general through improved access to PCPs, increased delivery of preventive care and chronic disease management activities, and improved confidence and comfort among PCPs working with biopsychosocial issues in patients,^{54,55,56} and (2) by providing low-intensity interventions to large numbers of patients with an identified problem, such as universal screening and intervention for tobacco use.⁵⁷ Overall, the PCBH model is associated with improved patient outcomes, including high levels of patient satisfaction as well as significant improvements in anxiety and depressive symptoms, PTSD symptoms, tobacco use, and weight change, and is perceived to be highly “acceptable” by providers.⁵⁸ With its emphasis on the whole population, the PCBH model can complement other integration approaches focused on specific populations (e.g., patients with depression, anxiety, or risky substance use patterns); however, more research is needed to understand the optimal scenarios for combining these models.⁵⁹

Implementation considerations: The PCBH model has been successfully implemented and sustained across diverse healthcare settings, including large healthcare systems, community mental health organizations, and various other settings (e.g., family medicine residency programs, university health centers, and homeless clinics).^{60,61,62} Despite these successes, significant implementation challenges persist. Financial barriers represent a primary obstacle, particularly the lack of reimbursement for same-day visits, as some payors do not reimburse for behavioral health visits on the same day as a PCP visit.⁶³ Additionally, key activities performed by the behavioral health consultant, such as curbside consultations and preventive care, often remain unreimbursed.⁶⁴ Workforce challenges further complicate implementation, including difficulty finding providers who possess both the capability and the interest to serve as behavioral health consultants as well as team- and system-level challenges related to using the behavioral health consultant in the ways intended by the model.⁶⁵

Approach integrating physical health into behavioral health settings

Primary and Behavioral Health Care Integration model

Overview: The Primary and Behavioral Health Care Integration (PBHCI) demonstration was a SAMHSA grant program that supported the integration and co-location of primary and physical health care in behavioral health settings.⁶⁶



(SAMHSA no longer financially supports this grant program, but the model continues to be used by some providers.)

Model design: The PBHCI model was designed to improve physical health for those with SMI and SUD and achieve the triple aim of improving care, improving patient experience, and reducing healthcare costs.⁶⁷ PBHCI programs have four core features, involving preventive primary care screenings, primary care needs and outcomes tracking, care management, and wellness support services, as well as six optional components (**Table 2** and **Table 3**).⁶⁸ While not listed as a particular feature of the model, medication reconciliation was an important part of the demonstration program, as most of the patients were taking medications for both their behavioral and physical health.⁶⁹

Table 2: Core features of PBHCI programs

Screening/referral	Basic primary care prevention, including screening and referral for hypertension, obesity, smoking, and substance abuse
Registry/tracking system	Registry of primary care needs and outcomes for patients with SMI
Care management	Person-centered care management and coordination to increase patient engagement and follow-up, including the involvement of family members in planning and implementation, as well as peer support services
Prevention and wellness support	Individualized wellness planning, including nutrition, health education, peer specialists, and self-help programs

Table 3: Optional features of PBHCI programs

Regular Screening	Regular screening at psychiatric visits for all patients prescribed psychiatric medications
Co-location	Co-location of medical nurse practitioner and/or PCP in behavioral health clinic
Primary care physician supervisors	Identification of a supervising PCP to provide consultation to other healthcare providers
Nurse care managers	Employment of nurse care managers to support those with significant physical health challenges
Evidence-based practices	Use of evidence-based practices adapted for use in behavioral health systems
Wellness programming	Creation of wellness programming for engaging individuals in self-management of health conditions, with peers as group leaders



Evidence base: During the SAMHSA demonstration grant program, the PBHCI model was implemented within a wide range of programs, with different program structures, procedures, and levels of integration.⁷⁰ There was wide variation in the levels of integration at various sites. Most organizations partnered with other agencies to provide services; about half of these partner organizations were FQHCs.⁷¹ All organizations offered some primary care services at their physical location (co-location), but this varied from basic screenings to treatment.⁷² Evidence for quality of health care and health outcomes is inconsistent.⁷³ Although access to integrated care was not directly associated with physical health improvements, a small comparative effectiveness study found that patients showed improvement in some physical health factors, including dyslipidemia, hypertension, and diabetes.⁷⁴ Patients did not show improvement in smoking and weight.⁷⁵ An analysis of the first three cohorts of PBHCI grantees indicated a reduction in emergency department visits, a reduction in healthcare costs, and improvement in follow-up after mental illness–related hospitalizations.⁷⁶

Implementation considerations: There are many factors relevant to implementation of the PBHCI model, related to staffing, workflows, structural factors, and patient factors. Staff-related factors include maintaining staffing levels, training staff, and hiring a multidisciplinary team of nurses, doctors, care coordinators, case managers, and peer specialists.⁷⁷ Workflow-related factors include communication between providers, opportunities for medication reconciliation, and shared decision-making between primary care and behavioral health providers and leadership. Structural factors include physical space, transportation, electronic health records (EHRs) and information sharing, as well as billing and insurance.⁷⁸ Patient factors include challenges with recruitment, appointment attendance, follow-up, and engagement.

While the last funding was awarded under the PBHCI program in 2019, SAMHSA continues to support integration through the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) program. The PIPBHC program has two program tracks: The first is aimed at comprehensive integration in community mental health centers or CHCs, while the second focuses on implementing the CoCM, an evidence-based, integrated care approach, in primary care settings.

Under both of these tracks, funding is provided to states, which then work with selected providers to implement integration strategies focused on identified special populations. The selected providers improve integration capacity while acting as pilot sites that states use to explore the implementation of chosen integration models.

Models that advance aspects of integrated care

Certified Community Behavioral Health Clinics

Overview: Certified Community Behavioral Health Clinics (CCBHCs) are a newer community-based model intended to address coordination and comprehensiveness of care across the continuum for mental health and substance use. They are not required to

integrate physical and behavioral health care, but must ensure that the people they serve have a PCP, screen for a set of common physical health conditions, monitor physical health status, and provide care coordination to

Services Offered at Certified Community Behavioral Health Clinics (CCBHCs)

24/7 crisis response services	Outpatient mental health and substance use services	Person- and family-center treatment planning
Community-based mental health care for veterans	Peer family support and counselor services	Targeted case management
Primary care screening and monitoring	Psychiatric rehabilitation services	Screening, diagnosis, and risk assessment

ensure that the people they serve are able to access needed primary and physical health care. Section 223 of the 2014 Protecting Access to Medicare Act established a federal definition and criteria for CCBHCs and authorized the initial CCBHC demonstration.⁷⁹ Of 24 states awarded grants to plan for CCBHC implementation in 2015, 8 were selected to participate in a CMS demonstration that launched in 2017.⁸⁰ In 2022, the Bipartisan Safer Communities Act extended and expanded the CCBHC demonstration, and in 2024, Section 209 of the Consolidated Appropriations Act made the CCBHC program a Medicaid state plan option, creating a mechanism for sustaining the program in the longer term.^{81,82} By 2026, 500 CCBHCs were operating in 46 states and the District of Columbia.⁸³ As of June 2024, about a quarter of counties in the United States had a CCBHC, with geographic reach to about half of the U.S. population, up significantly from 2016, when CCBHCs existed in fewer than 2 percent of counties.⁸⁴

Model design: By statute, CCBHCs are required to provide nine services, including 24/7 crisis response services; outpatient mental health and substance use services; person- and family-centered treatment planning; community-based mental health care for veterans; peer family support and counselor services; targeted case management; primary care screening and monitoring; psychiatric rehabilitation services; and screening, diagnosis, risk assessment.⁸⁵ The primary financing mechanisms for CCBHCs are grants from SAMHSA and payments through Medicaid.

Evidence base: The evidence base on the impact of CCBHCs is nascent. Reports on the implementation and impact of CCBHCs indicate substantial expansion over

the last decade and increased access to timely mental health and substance use-related care.^{86,87,88} While early analyses of the impact of CCBHCs in three states found mixed effects on all-cause acute care utilization,⁸⁹ an analysis of Medicaid enrollees in three states found evidence that CCBHC service engagement was associated with reductions in mental health and substance use-related emergency department visits in two states and all-cause hospitalization in one state.⁹⁰ Several studies have used data from the National Substance Use and Mental Health Services Survey and its predecessor, the National Mental Health Services Survey, to assess differences in service availability among CCBHCs relative to similar outpatient provider settings. Using the 2020 survey, Wishon and Brown found that CCBHCs were more likely than community mental health centers to offer crisis response services, peer support, SUD treatment, co-occurring disorder treatment, assertive community treatment, general medical health screening, tobacco cessation services, psychiatric rehabilitation services, and other outpatient services.⁹¹ Subsequent studies have produced similar findings, indicating that CCBHCs are offering a more comprehensive set of services than other types of providers serving similar populations.^{92,93} Despite Medicaid being an important source of financing for many CCBHCs, these centers may also be supporting patients with other forms of insurance coverage. One study in New York found that Medicare and commercially insured enrollees with SMI treated in CCBHCs used mental health services more and were less likely to have all-cause emergency department visits and nonpsychiatric hospitalizations relative to a matched comparison group treated in other settings.⁹⁴ Thus, the model may have promise in improved outcomes related to physical health conditions along with behavioral health.

Implementation considerations: Many CCBHCs are not de novo organizations but rather evolved from community behavioral health organizations as the CCBHC financing mechanisms became available and CCBHC criteria were established. Implementation research indicates that organizational transformation has been challenging for many of these entities, but organizational staff have perceived the transition to the CCBHC as having improved service access and care coordination. Even though the CCBHC model requires primary care screening and monitoring but not provision of integrated primary care, many CCBHCs have on-site primary care. According to a 2024 survey of CCBHCs, 27.9 percent directly provide primary care services and another 21.9 percent have a co-location agreement with a separate provider organization that delivers primary care services on-site.⁹⁵

Medicaid “behavioral health homes”

Overview: The Affordable Care Act authorized the Medicaid Health Home State Plan Option, which offered states flexibility to establish health homes to address the complex care coordination needs of Medicaid enrollees who meet one of the following eligibility criteria: (1) have two chronic conditions, (2) have one chronic condition and are at risk for a second, or (3) have an SMI. By October 2025, CMS had approved 33 health home models in 19 states and the District of Columbia. Of these, 22 Medicaid health home programs, as of May 2026,⁹⁶ have been used to support what can be termed “behavioral health homes” (BHHs), given their focus on populations with behavioral health conditions.

Though not an official CMS term for services, this term has become commonly used among mental health programs and policymakers. Specifically, utilizing the original medical

health home conceptualization with an application to behavioral health, 18 state health home models target enrollees with SMI or serious emotional disturbance; 13 target individuals with SUD; and 10 target individuals with other mental health conditions.⁹⁷ Health home services include six key types of services: comprehensive care management, care coordination, health promotion, comprehensive transitional or follow-up care, patient and family support, and referral to community and social support services.

Model design: States have significant latitude in the design of health home models. The settings and provider types that states have designated as health homes, and the staffing structures involved, vary. Some state models are “reverse integration” models in the sense that care coordination is managed by the specialty mental health or substance use treatment provider serving as the health home and primary care is integrated into this setting, as opposed to adding behavioral health expertise to the primary care setting. Maryland, for instance, has designed psychiatric rehabilitation programs as BHHs for enrollees with SMI. These programs offer various mental health and social services for people with SMI and, as health homes, are responsible for coordinating primary care needs for their enrollees. Connecticut’s model has designated local mental health authorities, or locally operated entities that provide publicly financed mental health services, as the designated type of provider of BHH services. Several states, including Maryland,

Medicaid Health Home Eligibility & Services	
Eligibility (must meet one)	Services
1. Have two chronic conditions	1. Comprehensive care management
2. Have one chronic condition and at risk for a second	2. Care coordination
3. Have a serious mental illness	3. Health promotion
	4. Comprehensive transitional or follow-up care
	5. Patient and family support
	6. Referral to community and social support services

Michigan, Rhode Island, and Vermont, have deployed BHHs among federally licensed outpatient opioid treatment clinics that dispense methadone and other FDA-approved medications to treat opioid use disorder. In addition to SMI and opioid use disorder, other states have focused on serious emotional disturbance in youth (e.g., Maine, New Jersey, North Carolina), SUD more broadly in addition to opioid use disorder (e.g., Wisconsin), and mental health issues more broadly (e.g., Missouri).⁹⁸

Evidence base: Characterizing the evidence base is challenging in part due to the significant heterogeneity of these models across states. A multistate policy evaluation using national survey data found that Medicaid BHHs were associated with increased service use and improved self-reported health.⁹⁹ A review of 11 studies on BHHs and physical health outcomes found improvements in primary care access and cardiovascular disease screening and monitoring among patients with SMI but no impact on diabetes control or smoking cessation.¹⁰⁰

Several studies have evaluated the impact of the Maryland behavioral health home. These analyses found minimal improvements in delivery of guideline-concordant cardiovascular disease risk factor care among enrollees with SMI. However, the health home was associated with small reductions in acute care utilization, specifically all-cause and somatic-related emergency department visits,¹⁰¹ increased probability of having a follow-up visit after hospitalization,¹⁰² and improved screening for cervical and breast cancer among adults with SMI.¹⁰³ As a model, there is room for the BHH concept to grow in terms of establishing true, meaningful integration.

Implementation considerations: There are multiple considerations regarding implementation of BHHs, including financial, infrastructural, and workforce-related concerns. Financial considerations include issues related to payment asymmetry across providers. BHH implementation may also reduce incentives for providers external to the health home to communicate and coordinate care. Often, health information technology systems are not designed to facilitate coordination across provider types. In addition, BHH-approved providers may not have sufficient population health management capacity.¹⁰⁴

BARRIERS TO IMPLEMENTATION AND POLICY STRATEGIES TO ADVANCE INTEGRATED CARE

Integrating care for individuals with mental health, substance use, and medical service needs and scaling the types of models and services described in this report require significant structural and process reforms to succeed. The specialty behavioral health and medical systems have long been siloed, with distinct histories, systems of development, workforces, and financing streams. To cultivate an environment more conducive to integrated care, it is critical to develop policy strategies at both the public level (i.e., government, or “big P,” policies) and the private level (i.e., insurance company and healthcare system, or “little p,” policies).¹⁰⁵ This includes addressing payment and financing, health information technology, and workforce development.

To cultivate an environment more conducive to integrated care, it is critical to develop policy strategies at both the **public level** (i.e., government, or “big P,” policies”) and the **private level** (i.e., insurance company and health care system, or “little p,” policies). This includes addressing the following barriers:

Payment & financing	Health information technology	Workforce development
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Payment and financing

A key barrier to integrated care has been insufficient mechanisms for insurance coverage of integration activities. To address this ongoing challenge, strategies related to payment and financing for integrated care have taken various forms, including federal grants, CMS demonstrations, and the creation of new options for coverage through key public payors such as Medicaid and Medicare.

In 2017, four new billing codes were introduced in the Medicare Physician Fee Schedule to enable clinicians to bill for services that support behavioral health integration.^{106,107} Three of the four billing codes support billing for care and activities related to the CoCM, described previously. They allow members of CoCM teams to bill for every month in which they have devoted up to a certain amount of time to CoCM services. The fourth code allows billing for other types of behavioral health integration activities and models.¹⁰⁸ To date, research indicates uptake of these new billing codes has been relatively slow and limited.^{109,110} A survey of administrators of 44 primary care practices participating in a pragmatic trial of behavioral health integration found that most received reimbursement through fee-for-service (FFS) codes (albeit only 14 percent of practices reporting using the CoCM billing codes specifically) and pay-for-performance incentives; about a third received grant funding.¹¹¹

Alternative payment models (APMs) have emerged in the face of critiques of traditional FFS billing.¹¹² These APMs may involve a wide variety of approaches, such as FFS billing but with pay-for-reporting or pay-for-performance elements in which providers receive bonuses for achieving certain quality metrics, models involving shared savings (between the provider and payor) or variations of the shared savings approach in which the provider is also at some financial risk for poorer performance, and population-based payment approaches such as per-member per-month arrangements or global budgets. A systematic review of the impact of these APMs found that their implementation was associated with reductions in use of mental health and substance use treatment services and in spending, alongside improvement in process-of-care outcomes.¹¹³ Certain integration models already incorporate some of these APMs. For instance, some states have designed their BHHs to pay participating providers via a per-member per-month arrangement.¹¹⁴ Oregon's Medicaid program's coordinated care organization approach employs a global budget with prospective payments to cover medical care, mental health and substance use treatment, and dental care.¹¹⁵

SAMHSA's report titled [Exploring Value-Based Payment for Substance Use Disorder Services in the United States](#) discusses the role of value-based payment models in improving integrated care delivery for substance use disorder treatment services.

Carve-In

State Medicaid programs include mental health and substance use services in the pool of health services managed by managed care organizations (MCOs).

Carve-Out

State Medicaid contract with organizations with expertise in behavioral health to manage these benefits separately from MCOs managing medical benefits.

As the largest payor of behavioral health services, state Medicaid plays a particularly important role in considering financing mechanisms for integrated care. Various integrated models, such as BHHs and CCBHCs, are financed through Medicaid reimbursement, for instance. In addition, many state Medicaid programs have been restructuring how they manage their mental health, substance use, and medical benefits in recent years, in part in the service of facilitating behavioral health integration. For many years, states carved out mental health and substance use treatment services, contracting with specialized entities to manage these benefits separately from the

managed care organizations (MCOs) managing medical benefits. For instance, in 2004, over 20 states carved out behavioral health benefits (i.e., arranged for behavioral health benefits to be managed by a separate entity from the MCOs managing medical benefits). This idea was born from the notion that behavioral health services required dedicated resources to avoid being utilized by other healthcare system needs, and the carve-out model also allowed and required specialized oversight. By 2019, only seven states and the District of Columbia were

carving out behavioral health benefits for at least enrollees with SMI.¹¹⁶ The rationale for carving in behavioral health benefits was that financial integration might facilitate integration at the service delivery system level. However, research on state Medicaid carve-in efforts has not indicated that these hopes have been realized.^{117,118}

Further innovation is needed to address persisting barriers related to the implementation and financial sustainability of integration. Practices delivering integrated services continue to face complex documentation requirements related to billing for care management and care coordination activities—a challenge compounded by varying requirements across physical and behavioral health payors and regulators. In addition to these administrative costs, reimbursement challenges continue to undermine the financial sustainability of integration. A large portion of psychiatrists and psychologists opt out of insurance plans, citing low reimbursement rates.^{119,120} This then requires the patient to submit evidence of payment out of pocket to the insurance company for direct reimbursement. Providers can charge what they feel is reasonable, but reimbursement for behavioral health is generally only at market rate at best, leaving the patient financially obligated to pay the difference. Other mental health and substance use treatment providers have historically faced coverage limitations due to inadequate benefit parity and inadequate inclusion in insurance plan provider networks, limiting patient access to receiving integrated care.^{121,122} Current financing models also may exclude nonlicensed staff—such as certified peer specialists and community health workers—despite the essential roles they play on many integrated care teams.¹²³

Looking ahead, improved payment methods can be a powerful force for achieving greater advances in integration and the sustainability of integrated services. To achieve this potential, it will be important for payors to be able to connect financing models to measurable improvements in the delivery of integrated services and population health. Historically, it has been difficult for implementing practices to estimate the specific effects of integration on total medical expenses, hindering their ability to calculate return on investment.¹²⁴ In turn, with limited evidence of value creation, it has been difficult for practices to make a business case for investing in the infrastructure needed to first implement, and then sustain, the delivery of integrated services. To address this barrier, the CHI framework offers a road map for demonstrating the value produced through integrated services by connecting each integration stage to measurable demonstrations of value.

Health information technology

Health information technology plays a critical role in enabling effective communication and collaboration among providers working to deliver integrated care. A range of technologies, such as EHR systems, automated referral systems, and patient portals, have been found to facilitate communication between providers¹²⁵ as well as between patients and providers.¹²⁶



Despite efforts at medical record integration, sharing clinical information between behavioral health and medical providers remains a significant challenge. At the system level, there are well-documented gaps between general medical and behavioral health technologies,¹²⁷ which have severely undermined interoperability efforts. There are also meaningful gaps between large health systems, which may have more resources and capacity to implement and maintain new technologies, and smaller, rural, and independent provider groups. For example, in a recent qualitative study of physician practices in adopting behavioral health integration, several practices reported that their EHRs were “not designed for behavioral health integration,” citing difficulties with information sharing and platform interoperability when behavioral clinicians used different recordkeeping systems.¹²⁸ In this study, larger practices were able to devote substantial time and resources to developing customized behavioral health integration capabilities within their EHRs, while smaller practices often lacked the resources needed for such changes. Since gaps in technology infrastructure and workforce capacity for data management and analytics directly impacts practices’ ability to participate in federal and state grants and clinical improvement efforts,^{129,130} it is imperative for policymakers to address technology inequities at the system level. As highlighted by Simoun and others, this could be achieved through the strategic allocation of resources to support practices in meeting foundational requirements for integration, as well as increased use of implementation science to guide practices in adopting and using technology.¹³¹

Another impediment to information flow highlighted by Malâtre-Lansac and colleagues’ study of physician practices’ adoption of behavioral health integration is that even when providers were in the same organization, behavioral health records were infrequently shared with medical providers or were accessible only with special permission.¹³² Some respondents attributed these barriers to organizational leaders’ overly restrictive interpretations of federal regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Confidentiality of Substance Use Disorder Patient Records (42 C.F.R. Part 2). However, while sharing patient information is crucial for care coordination, there are valid concerns about data sharing among providers, given the detailed nature of behavioral health assessments.¹³³ For example, technologies increasingly analyze patient information to perform clinical functions (e.g., predicting risks, matching treatments), yet patients may not fully understand how their data is being used.¹³⁴ Given the growing complexity and scope of data shared to support integrated care, patients should be better informed about these practices and provided opportunities to consent to sharing through their health records.¹³⁵

Workforce development

Several workforce challenges impede integrated care. Medical practices frequently cite the shortage of behavioral health providers who have specialized training in primary care as a major barrier to integration.¹³⁶ Common policy levers such as loan repayment programs and scholarships for integrated care specializations can help



recruit and retrain behavioral health providers for integrated settings. However, scaling integrated services more widely likely requires reforming insurance reimbursement rates for behavioral health services to levels that enable organizations to offer competitive compensation.¹³⁷

Siloed training programs for medical and mental health professionals represent another barrier to integration.¹³⁸ Developing standardized competency frameworks and offering accessible continuing education focused on the core competencies required by many of the integration models (e.g., team-based care, care coordination, brief behavioral interventions)¹³⁹ can upskill the existing workforce and create clear career pathways. Moreover, expanding interprofessional education programs at the undergraduate and graduate levels can prepare future medical and behavioral health providers to work collaboratively from the outset of their careers.

Policies to facilitate expanded telehealth options for behavioral health are another strategy for easing workforce shortages and addressing uneven geographic distribution of providers and/or the mismatch between where behavioral health providers are located and where their services are needed.¹⁴⁰ Policies that facilitate access to telemental health services may facilitate integrated care by ensuring that patients have opportunities to access behavioral health services regardless of geographic location. A survey of specialty mental health treatment facilities in 2022–2023 found that 80% reported offering telemental health services.¹⁴¹ Telemental health may not align with models relying on physically co-located services yet can ensure that patients have opportunities to connect with specialists in mental health and substance use. Policies to facilitate telemental health provision must address payment equivalency between in-person and telehealth-delivered services as well as authorization for clinicians to practice in states beyond those in which they are licensed.¹⁴²

CONCLUSION

Integration initiatives recognize that the long history of segregating the financing and delivery of mental health and substance use treatment services from other medical services has not served patients or providers well. Frameworks for conceptualizing integration and its key elements, and integration models deployed in a variety of settings demonstrate that moving toward a more integrated approach for populations with complex health needs is feasible and achievable. However, structural constraints have impeded the more comprehensive transformations to the health system needed to ensure that mental health, substance use, and other medical conditions are identified and treated in an intentional and coordinated approach. There are exciting potential improvements to realize true integration. Changes to financing, health information technologies, and workforce development can facilitate broader uptake of proven strategies and models for integrating care.

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