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Supplemental Materials A. Description of National Programs

Integration Continuum	PC into BH ←→ Multi-targeted/Comprehensive ←→ BH into PC					
Model	Primary and Behavioral Health Care Integration (PBHCI)	Certified Community Behavioral Health Clinic (CCBHC)	Medicaid Health Homes (MHH)	Patient-Centered Medical Home (PCMH)		IMPACT/ Collaborative Care Model
				Standard PCMH 2017	PCMH with Distinction in Behavioral Health Integration	
Origin	SAMHSA grant program	Demonstration program authorized by PAMA; Extension grants	State Medicaid option authorized by ACA	NCQA Recognition Programs		Research Developed
Payment Model	Grant	Prospective daily or monthly Medicaid payment	Medicaid case rate	Enhanced fee-for-service payments, care management fees, and VBP		Medicare Case Rate
Target Population	SMI plus risk/diagnosis of comorbid physical health condition	Full-spectrum BH care, including CMD, SMI and SUD	Complex conditions (SMI, HIV, etc.)	Mostly primary care with CMD		Primary Care
Implementation Status	9 cohorts from 2009-2016; 213 grants in 38 states + DC	8 states began in 2017, with 67 sites	32 approved models in 21 states + DC as of March 2019; potential for SMI focus	New requirements published in 2017, with BH distinction updated in 2019		Multiple trials and disseminated by AIMS

Figure. Features of Programs that Integrate Behavioral Health and General Medical Care.

Notes: Abbreviations: ACA – Patient Protection and Affordable Care Act of 2010; AIMS – Advancing Integrated Mental Health Solutions Center; BH – Behavioral Health; CMD – Common Mental Disorders; DC – District of Columbia; NCQA – National Committee for Quality Assurance; PAMA – Protecting Access to Medicare Act of 2014; PC – Primary Care; SAMHSA – Substance Abuse and Mental Health Services Administration; SMI – Serious Mental Illness; SUD – Substance Use Disorder; VBP – value-based payment

Primary and Behavioral Health Care Integration Program

From 2009 to 2018, the Primary and Behavioral Health Care Integration (PBHCI) grant program, sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), awarded over $162 million in grant funds to 213 community mental health centers (CMHCs) located in 38 states and the District of Columbia to integrate primary care and improve the health status of individuals with SMI who have comorbid physical health conditions and chronic diseases or who are at risk for developing them.[1] Grantees in nine cohorts requested up to $400,000-$500,000 per year for up to four years to support their integrated care efforts.[2,3] The scope and specificity of PBHCI grantee requirements has evolved with each round of funding, based on the learnings from prior cohorts of grantees. Grantees that began from 2009-2011 were required to provide screening and referral for primary care conditions and substance use disorders (SUDs) and offer comprehensive care management and preventive and health promotion services, among other requirements. Starting in 2012, grantees were required to co-locate primary care services within the behavioral health clinic and serve as consumers' health home. PBHCI requirements for the final two cohorts of grantees further emphasized the use of evidence-based interventions to target tobacco use, diet/nutrition, and chronic disease self-management.[3]

Initial PBHCI evaluations completed by the RAND Corporation found mixed results with regard to the impact of integrated care on healthcare spending and physical health outcomes, though these evaluations were limited by methodological constraints and focused on earlier cohorts of grantees.[1,4,5] At the time of this writing, SAMHSA is conducting a larger evaluation that includes all cohorts. Additionally, SAMHSA has developed the Promoting Integration of

Primary and Behavioral Health Care (PIPBHC) program, which supports a range of different integration models overseen by state-wide agencies and partner organizations, in distinction from the PBHCI program's focus on individual clinics.[6] PIPBHC state grantees receive technical, clinical, social, and organizational supports to increase integrated care services related to screening, diagnosis, prevention, and treatment of mental and substance use disorders, as well as co-occurring physical health conditions.

Certified Community Behavioral Health Clinic

The Certified Community Behavioral Health Clinic (CCBHC) demonstration, authorized under Section 223 of the Protecting Access to Medicare Act (PAMA), allows states to test new strategies for delivering and reimbursing services provided in CMHCs. The demonstration aims to improve the availability, quality, and outcomes of ambulatory services provided in CMHCs and other providers by establishing a standard definition and criteria for CCBHCs and developing new Medicaid prospective payment systems that account for the total cost of providing comprehensive services to all individuals who seek care. The demonstration also aims to provide coordinated care that addresses both behavioral and physical health conditions.[7] In 2017, the Department of Health and Human Services (HHS) selected eight states to participate in the demonstration, which began in mid-2017 and includes 67 clinics.

These eight states certified that the participating clinics met the CCBHC criteria developed by HHS, which include, among other requirements, that clinics provide "primary care screening and monitoring" and care coordination service for primary care conditions. In addition, the CCBHC criteria require that treatment planning incorporates attention to primary care conditions and that treatment teams coordinate with primary care providers as needed. However,

the criteria do not explicitly require that CCBHCs provide on-site primary care services, and primary care services may be provided by a partner organization.[19] The demonstration requires that participating states and CCBHCs submit annual performance on quality measures, including measures that assess screening and delivery of preventive care for body mass index and tobacco use. An evaluation of the CCBHC program is ongoing.[9] In 2018, SAMHSA developed the CCBHC Expansion Grant program to provide grants directly to clinics to implement the CCBHC criteria but without any corresponding changes in the state's Medicaid reimbursement system to support the CCBHC model.[10]

Medicaid Health Home

Medicaid Health Homes (MHH) were established by the Affordable Care Act (ACA) in 2010 to incentivize state Medicaid programs to support flexible services for specific populations with complex care needs.[11] States receive a 90% enhanced Federal Medical Assistance Percentage (FMAP) for the first eight quarters of the program for qualifying services such as health promotion, care coordination, comprehensive care management and transitional care, patient and family support, and referral to community and social support services.[11] The enhanced match does not apply to the underlying Medicaid services also provided to people enrolled in a health home. In order to be eligible for Health Home services, an individual must be enrolled in Medicaid and have two chronic conditions, one chronic condition and risk for a second, or a SMI. Health home providers include primary care practices, hospitals, care management networks, and specialized providers such as CMHCs.[11]

States develop their own MHH models to meet general guidelines and submit state plan amendments to their Medicaid plan for approval by the Centers for Medicare & Medicaid

Services (CMS). As of March 2019, 23 states and the District of Columbia had a total of 38 approved MHH models, many of which focus specifically on populations with SMI.[12] In general, MHHs emphasize comprehensive needs assessment, person-centered care planning, and care management to support ongoing integration and coordination of primary, behavioral and specialty health care, as well as community support services for each enrollee.[13] An Urban Institute evaluation of the administrative data from the first 13 MHHs on behalf of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) showed large and significant reductions in overall Medicaid spending for consumers with longer and consistent enrollment in MHHs, though Medicaid program spending increased significantly for Medicaid-only CMHC enrollees as a group.[14]

Patient-Centered Medical Home

The Patient-Centered Medical Home (PCMH), rooted in the work of Ed Wagner and his chronic illness model [15] and featured in the Institute of Medicine's "Crossing the Quality Chasm" report,[16] has become a central feature of primary care redesign in both federal and non-federal efforts.[17,18] The National Committee for Quality Assurance (NCQA) PCMH recognition program is the largest program nationally; nearly 20% of practicing primary care clinicians work in NCQA-recognized PCMH practices. To achieve recognition under the PCMH 2020 requirements, practices must meet all 40 core criteria and earn 25 credits in elective criteria across 5 of 6 domains.[19] PCMH's far-reaching set of standards covers most domains in the framework, though many features apply to the general aspects of primary care, with a subset of criteria describing specifications for behavioral health integration. NCQA released an additional module, PCMH with Distinction in Behavioral Health Integration (PCMH-BHI), which

recognizes practices that meet all eleven core criteria and two of seven elective criteria across four competencies related to behavioral health: (1) behavioral health workforce, (2) integrated information sharing, (3) evidence-based care, and (4) measuring and monitoring.[20] While evidence-based integration models such as the collaborative care model may allow for an important psychiatric consultative role in medical home settings,[21,22] an evaluation of the effect of PCMH on overall behavioral health outcomes has not yet been conducted.

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Supplemental Materials B. Components of national initiatives integrating behavioral health and general medical care, as described in application requirements for the Primary and Behavioral Health Care Integration (PBHCI) grant program, Certified Community Behavioral Health Clinic (CCBHC) demonstration program, Medicaid Health Homes (MHH), and the National Committee for Quality Assurance's Patient-Centered Medical Home (PCMH) and PCMH with Distinction in Behavioral Health Integration recognition programs.

Components	Subcomponents	PBHCI	CCBHC	MHH	PCMH
Population Health Management	Systematic population needs assessment	Monitors population health status and service use to determine impact on consumer health status (11, 18, 43)	Uses health IT for population health management (3.b.2)	None	Monitoring social determinants of health for patients and, at the population level, and implements care interventions accordingly (KM6-12c/e*); evaluates and adjusts panel from access and performance measurement and comprehensive risk-stratification (AC13-14c*) and directs resources appropriately (CM3e*)
	Outreach to health disparities populations	Identifies, recruits and retains consumers in highest-need of on site primary care services and specialty referrals by using appropriate language, norms, and values (28)	Uses health IT to identify disparities and guide outreach (3.b.2)	Encourages health care providers and hospitals to refer eligible individuals to the participating providers (III.1)	No specific outreach requirement, though several strategies encourage engagement of health disparities populations: Monitor/ adjust care interventions (KM7e); uses health disparities to tailor population health management (AC9e); evaluate health disparities to assess access (QI5e, QI13-14e)
	Screening and initial assessment with follow-up	Assesses preliminary service needs (43), screening and treatment planning for MH/SUD (12)	Screens and assesses risk at first contact, then evaluation and treatment planning (4D)	Defines eligibility for Medicaid beneficiaries by chronic or MH conditions, with comprehensive person-centered care plan (II.1.2)	Assesses MH/SUD history (KM2c) and standardized screens for depression (KM3c/BH11c), anxiety, SUD, and development (KM4e/BH12c); reviews controlled substance database when relevant (KM18e/BH10e)
Access to routine and urgent care	Systems for prompt access to routine care	Provides access to PC 5 days per week during routine operating hours; option to include evenings, weekends, and by phone or email (10-11)	Includes some night and weekend hours (2.a.2) and has standards for timely access to services (2.B)	Provides access to timely health care 24/7 for immediate care needs (V.2.5)	Assesses access needs, provides same-day appointments, clinical advice by telephone, and routine or urgent care appointments outside regular business hours, including with an interactive electronic system (AC2-9c/e*); has BH clinician located in the practice who can directly provide brief interventions on an urgent basis (BH3c)
	Arrangements for BH services on site or remotely	Grantees are community-based BH settings (6, 22-23)	Makes locations accessible to consumers (2.a.3) and utilizes in-home, telehealth, telemedicine, and on-line treatment services (2.a.5)	Coordinates and provides access to BH services (IV.1.4)	Integrates BH providers within the practice site or remotely (CC10e); has BH care manager to coordinate needs (TC8e/BH1c); has BH clinician on site to provide MAT and behavior therapy for SUD (BH4e)

	Formal policy and established relationships for crisis response	None	Provides 24-hour mobile crisis teams, intervention, and stabilization, unless there is an existing state system (2.C, 4.C); local EDs have policies to address consumer needs (2.c.4)	None	None
Decision support for measurement-based, stepped care	Preventive care	Grantees must implement tobacco cessation, nutrition/exercise interventions to prevent obesity, and other health promotion programs (11)	None	Promotes wellness and prevention programs that address exercise, nutrition, stress management, substance use reduction and cessation, smoking cessation, self-help recovery resources (II.1.3), and provides access to preventive and health promotion services, including prevention of MH/SUD (IV.1.3)	Proactively reminds patients of preventive care services (KM12c*)
	Evidence-based guidelines and treatment protocols	Selects and implements evidence-based and promising intervention protocols for tobacco cessation, obesity reduction, and chronic disease management (14, 17, 27, Appendix I)	Uses health IT that includes clinical decision support (3.b.1) and ensures continual integration of new evidence-based practices (4.f.1)	High-quality health care services informed by evidence-based clinical practice guidelines (IV.1.2, V.2.1)	Implements clinical decision support following evidence-based guidelines for MH (KM20Ac/BH13c) and SUD (KM20Bc/BH14c).
	Evidence-based psychotherapy	None	Directly provides evidence-based and/or best practice outpatient MH and SUD services (4.F)	None	Provides behavior therapy for SUD on site or via referral (BH4e)
Self-management support	Tools for consumer activation and recovery	Follows SAMHSA's principles of recovery (health, home, purpose, community), provides chronic disease self-management (13, 44)	Follows SAMHSA's and VHA's principles of recovery (4.k.5) and provides evidence-based and other psychiatric rehabilitation services (4.i.1)	Creates a comprehensive person-centered care plan (II.1.1); promotes enrollee's education of their chronic condition and teaches self-management skills (II.1.3)	Incorporates patient preferences, functional and lifestyle goals in individual care plans, provides access to self-management support, educational materials, online support programs, shared decision-making aids (TC9c, KM22e, CM8e*)
	Peer support	Includes peers as part of the integrated treatment team (10) and involves peers in development and implementation of wellness programs (12)	Provides peer specialists and allows states to specify their scope of service (4.j.1)	Provides information and assistance in accessing peer support services (II.1.5)	Offers or refers patients to structured health education programs such as group classes and peer support (KM22e*)
	Involvement of families, caregivers, and support members	Provide individual and family support, including authorized representatives (7, 44)	If consumers agree, families or caregivers receive information (3.a.2) and are included in the treatment team (3.d.1; 4.d.4)	Provides family support with counseling or training on caregiver skills, self-advocacy, acquiring resources and respite services (II.1.5)	Involves families and caregivers throughout multiple components, including informing them of key care coordination activities (TC9c, KM12c, CM5c*)

Multi-disciplinary team	Care team (including consumers)	PCP, nurse care coordinator, integrated care manager, peer wellness coach, SUD counselor, and others (10)	Medical BH provider, SUD specialist, trauma specialist, and others (1.A); providers are licensed and accredited as required by state (1.B)	PCP, nurse, BH care provider, social worker, and others (V.1)	Designates clinician lead and defines practice organizational structure and staff responsibilities/skills to support key PCMH functions (TC1-TC2c*) with regular patient care team meetings or a structured communication process focused on individual patient care (TC6c*)
	Synchronous contact between PCP and BH specialist	Integrated teams meet at least weekly (8-10)	None	Not specifically between PCP and BH, though schedules team meetings to review care plans and assess progress through face-to-face and collateral contacts with enrollee, PCP and specialty care providers (II.1.2)	Integrates BH clinician into the practice workflow either in person or with telehealth capabilities (BH3c)
	Cultural competence training	Provides as needed to meet CLAS standards (9, Part II, Appendix G)	Trains staff culturally and linguistically to serve the needs of the clinic's patient population (1.C, 1.D)	Provides culturally appropriate and person- and family-centered services (IV.1.1)	Assesses the diversity and the language needs of its population (KM9-10c*) and provides training and education on cultural competence accordingly (KM11e*)
Ongoing care management	Systematic team-based caseload review	Discusses cases weekly and oversees integrated person-centered treatment plans for each client (10)	Completes diagnostic and treatment planning evaluation within 60 days by BH professional, consumers, and treatment team (4.d.4)	Regularly reviews person-centered care plans and monitoring service delivery and progress toward goals (II.1.2)	Considers the BH conditions in establishing a systematic process and criteria for identifying patients who may benefit from care management (CM1c); has regular team meetings on individual patient care (TC6c*); care plan integrated and accessible by PCP and BH providers (BH9e)
	Targeted case management, longitudinal assessment and treatment planning	Monitors outcomes according to guidelines/grant requirements (15-16) and develops treatment plan with client goals, preferences, and optimal outcomes (43)	Directly provides screening, assessment and diagnosis for BH, general medical, and social service needs, with referrals to specialists as needed (4.D); directly provides person-centered treatment planning (4.E)	Initial and ongoing assessment and care management for integration of PC, BH, and specialty care (II.1.1)	Establishes a person-centered care plan and provides written document with patient preference, goals, barriers, and self-management plan (CM4-8c/e*); monitors and assesses MH/SUD symptoms over time and adjusts treatment plan if no demonstrated improvement (BH15c, BH16e)
Seamless referral process	Formal agreements between BH and PCP	Grantees provide evidence of collaborative agreements with PC agencies (9-10, 25)	Formal agreements for services provided by DCO (4.a.1); referrals to specialists made through formal arrangements or telehealth services (4.d.1)	Demonstrates effectively coordinating medical and BH care, as well as long-term and social services (V.2.2), though does not specify formal agreements	Establishes formal agreement or consultative relationship with a licensed BH provider or practice group for advice or consultations (BH6c)
	Sharing of treatment information	Data sharing protocols between BH and PC providers (10) including e-prescribing, lab results, shared continuity of care record, and regional extension center program (7-8)	Providers know and share ahead of time patient preferences, including crisis plan (3.a.4)	Facilitates sharing of centralized information to coordinate integrated care by multiple providers through use of EMR (II.1.2)	Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care (CC9e/BH5c); has a single integrated EMR for physical and BH, or protocol for exchanging information (BH8e).

Mechanisms to facilitate coordination of care	Clinical registries and health IT for measurement-based care and referral tracking	Aims to achieve health IT meaningful use standards, including clinical registry functions (7)	Uses health IT to improve care coordination between CCBHC and DCOs (3.b.1; 3.b.5)	Uses data for population health management, tracking tests, referrals and follow-up, and medication management (V.2.9)	Coordinates information and tracking of specialist referral (CC4c*) and monitors timeliness and quality or response, documents co-management, and considers cost (CC11-13e*); tracks referrals to BH with process to monitor quality and timeliness of response (BH7c)
	Communication and transition management between episodes of care	Comprehensive transitional care from inpatient to other settings, including appropriate follow-up (44)	Provides care coordination for transitions between all levels of service (3.b.5)	Supports transition to a non-hospital setting (II.1.2); establishes a written care transition protocol with hospitals with real-time information sharing and notification of admission and discharge (II.1.4, V.2.6)	Identifies unplanned ED or hospital admissions, shares clinical information, contacts family, shares clinical information with admitting hospitals and EDs, and obtains discharge summaries (C14-19c/e*)
Linkages with community and social services	Partnerships with housing, transportation, entitlement, legal, criminal justice, and other social support services	Care manager and administrative support staff provide referrals to community and social support services, including appropriate follow-up (45)	Collaborates, by statute, with multiple service types (3.c.3-4), and has agreements with others, as needed for the population served (3.c.3); also provides transportation or transportation vouchers (2.a.4)	Provides referral and information assistance for community based resources and social support services, with identified resources, monitoring and follow-up (II.1.6)	Engages with schools or intervention agencies in the community and maintains active list (KM25-26e), and follows up on community referrals to determine impact on individual patients (KM27e*)
Systematic quality improvement	Quality metrics for program improvement, including consumer self-report	Collects and reports on infrastructure, prevention, performance, and SAMHSA's uniform data collection tool (consumer self-report measure of health and behavioral health status, functioning, quality of life, and perceptions of care (15-18)	Clinic collects 9 required quality measures; state agency reports 12 required quality measures, including patient and family experience of care surveys (5.A; Appendices 1-2)	Continuous quality improvement program using clinical outcomes, experience of care outcomes, and quality of care outcomes (IV.1.11)	Measures clinical quality of BH (QI1c), overall resources, cost, performance, and patient experience (QI2-6c/e*), and sets goals and acts to improve upon BH measures (QI8c); monitors performance using ≥2 BH clinical quality measures (BH17c) and sets goals and acts to improve upon them (BH18e)
	Oversight by stakeholders (e.g. advisory boards, with consumer participation)	Assembles a grant coordination team (CEO, CFO, medical director, PC lead, project director, consumers) (9)	Participating agencies are subject to annual audits (6.A) and are governed by boards including 51% consumers and families (6.B)	State Medicaid oversight, but no advisory board	Expects leadership commitment to model, with patient involvement in the practice's governance structure or on stakeholder committees (TC4e*)
Strategy for sustainable practice	Identified primary payment source and diversification of funding	Structured sustainability plan as part of application (12-14, Appendix V)	Submits an annual cost report to CMS and receives prospective Medicaid payments (5.a.5)	Medicaid payment structure to be proposed by each state and approved by CMS (VII.1); no payments for start-up costs, though CMS provides states with 90% match for first 8 quarters (VII.3)	The practice is engaged in Value-Based Contract agreement with either an up-side or two-sided risk contract (QI19e). PCMH recognition by NCQA results in greater compensation, e.g. MIPS.
	Affordable care, available to all	Grant funds pay for services to the uninsured (12)	Sliding fee schedule, with no refusal/limiting services because of ability to pay or residence in clinic catchment area (2.D, 2.E)	State plan rates must be economic and efficient and provide for quality care (VII.1)	Engages with patients regarding cost implications of treatment options (CC13e*)

	Workforce development	Provides as needed to help staff identify PC, MH or SUD issues, accessing and enrolling in insurance, and support to attend professional meetings (20)	Training plan for all staff, including training in risk assessment, families and peers, cultural competency and more (1.C)	None	Defines practice organizational structure and staff responsibilities and skills to support key PCMH functions (TC2c*); provides resources and training for the care team to develop skills on when to screen and refer (BH2e).
	Engagement with policy change	Facilitates policy development to support needed collaborative service systems improvement (e.g., change in standards of practice, data sharing) (19)	Grantees are restricted from using federal funds for activities designed to influence the enactment of legislation, appropriations, regulations, administrative actions, or Executive Orders proposed or pending before federal, state, or local governments.	No direct provision for MHHs to engage in policy change; ASPE will independently evaluate the Health Homes provision in select states (VI.4)	Gets involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges) (TC3e*)

Notes:
PCMH recognition criteria are divided into 6 concepts: TC – Team-based care and practice organization, KM – Knowing and managing your patients, AC – Patient-centered access and continuity, CM – Care management and support, CC – Care coordination and care transitions, QI – Performance measurement and quality improvement. Additionally, PCMH with Distinction in Behavioral Health Integration is a module denoted by BH; some criteria are included in both the general PCMH recognition and BH integration module. Each component above includes reference to the concept, element number, and whether the component is a core ("c") or elective ("e") criterion for recognition. Components that apply to PCMH in general but not specific to BH are noted with *.

Abbreviations:
Assistant Secretary for Planning and Evaluation – ASPE; BH – behavioral health; CLAS – Culturally and Linguistically Appropriate Services; DCO – Designated Collaborating Organization; ED – emergency department; EMR – electronic medical record; IT – information technology; MAT – medication-assisted treatment; MH – mental health; MIPS – Merit-Based Incentive Payment System; PC – primary care; NCQA – National Committee for Quality Assurance; PCP – primary care provider; SAMHSA – Substance Abuse and Mental Health Services Administration; SUD – substance use disorder; VHA – Veterans' Health Administration.

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