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Re: CF Blog: "Making Care Primary: An Important Advance for Integrated Behavioral Health Care, August, 18, 2023

Dear Gentlemen,

Our organizations write to share with you our consensus view that the above-referenced blog on behavioral health integration (BHI) in primary care is inaccurate and misleading, both of which can and should be corrected in future CF blogs and newsletters.

First and most important, the blog on p. 2 and throughout describes just one behavioral health integration approach, the collaborative care model (CC), when in fact there are three evidence-based approaches: CC, PCBH (Primary Care Behavioral Health) and SBIRT (Short Brief intervention and Referral to Treatment). We do not understand why the focus on one sole approach while we are in midst of a national mental health crisis and all evidence-based approaches should be explicitly and strongly supported, leaving to practices which to select that best meets the needs of their unique clinical care ecosystem. Further, we fail to understand why no mention at all of the PCBH model that is consistently being deployed by PC practices across the U.S. over the past 15 years, and most recently by a 70%-30% ratio over the past 5 years of CMS reimbursement utilization data.

Second, the blog (p. 2) describes the behavioral health provider as a "consulting behavioral health specialist." That is misleading as it implies a range of BH professionals could fill that role such as a psychologist, nurse, nurse practitioner, clinical social worker, licensed therapist). When in fact under CMS rules, that role in CC must be filled only by a psychiatrist, hence why CMS consistently calls it "a psychiatric consultant." Having only a psychiatrist as the BH provider in CC model considerably narrows the range of BH professionals to a very small group, 30,000 in the entire country.

Third, the blog states on p. 2, para 1, that 'primary care has been slow.' That statement is indeed accurate *as regards the CC approach alone*. However, it is not accurate as regards all integration approaches. Implementation data of the past 15 years demonstrates that the PCBH approach has been undergoing a rapid and steady increase in adoption. Most recently, Medicare integration code reimbursement data during 2018-2022 shows consistent growth for PCBH uptake. In the most recent year (2022), adoption of the PCBH/99484 code was 171,060, while utilization of all three (99492-4) CC codes combined, was 65,078. The 70:30 uptake ratio between the two approaches has been consistent since 2018 (Source: CY 2021 PFS Final Rule Utilization Data Cross-walked to 2023).

Fourthly, the blog completely omits any discussion at all of the PCBH approach to behavioral integration which the facts on the ground clearly demonstrate has high utilization data. Also omitted is the fact that large health systems like the Veterans Health Administration, the Department of Defense, Kaiser Permanente, and Cheroke Health System have been successfully integrated behavioral health using the PCBH approach over the past 20 years. And, the scientific literature clearly demonstrates improved patient health outcomes under that model.

Fifthly, most telling is that the CMS/CMMI MCP model, which the article purports to be about, does NOT limit practices to just the CC BHI approach, but will support and incentivize participating clinic sites in their adoption of any of the evidence-based approaches. *Res ipso loquitur* (the thing speaks for itself).

It is unclear to us why a 'one model only messaging' approach seems to have taken hold among many in the field when speaking about behavioral health integration. We expect a better, more informed methodology from a respected institution as the Commonwealth Fund. Finally, to ignore the body of scientific evidence and real-world clinical practice surrounding this clinical care innovation, does American patients and families a real disservice as our country works to urgently expand access to quality, effective, evidence-based approach to behavioral health care.

With regards,

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