CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Innovation in Behavioral Health (IBH) Model Overview Webinar

February 29, 2024

The Center for Medicare & Medicaid Services (CMS) Innovation Center

Housekeeping and Logistics

DIAL IN

It is recommended that you listen via your computer speakers.

Options for audio listening:

Dial-In (US): +1 929 436 2866

or +1 669 900 6833

Webinar ID: 927 0034 3909

ID/Passcode: 059407

PARTICIPATE

If you have questions for the IBH Team, please use the Q&A box at the bottom of your screen.

SHARE FEEDBACK

Please complete a short survey that will be available at the end of the event.

All information provided in the Model Overview Webinar is potentially subject to change. When published, the Notice of Funding Opportunity (NOFO) will be the sole source of information about IBH Model details and the application process.

Agenda

1 CMS Innovation Center Introduction

2 Opening Remarks

3 IBH Model Overview

4 Model Eligibility and Participation

5 Care Delivery Framework

6 Funding and Payment Structure

7 Application Timeline

8 Questions and Answers

9 Closing and Resources

Today's Presenters

Dr. Elizabeth Fowler
Deputy Administrator and Director, CMS Innovation Center

Dr. Anita Everett
Director, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA)

Kirsten Beronio
Senior Policy Advisor, Center for Medicaid and CHIP Services (CMCS)

Isaac Devoid
IBH Model Co-Lead, CMS Innovation Center

Sarah Grantham
IBH Model Co-Lead, CMS Innovation Center

CMS Innovation Center Introduction

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Statutory Authority for CMMI

> The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles.

The CMS Innovation Center was established by section 1115A of the Social Security Act (the "Act") (as added by section 3021 of the Affordable Care Act).

Innovation Center Strategic Refresh

Created for the purpose of developing and testing **innovative health care payment** and **service delivery models** within Medicare, Medicaid, and CHIP programs nationwide.

Innovation Center Priorities and Strategic Refresh

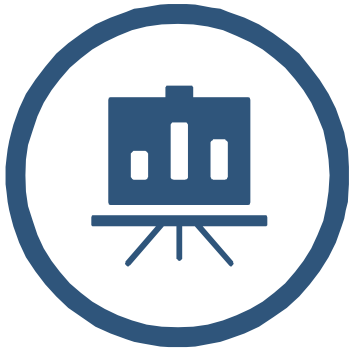
Strategic Refresh *White Paper is available at https://innovation.cms.gov/strategic-direction-whitepaper*

CMS defines health equity as: The attainment of the highest level of health **for all people**, where everyone has a **fair and just opportunity** to **attain their optimal health** regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

Opening Remarks

Audience Poll #1

Please respond to the poll using the Zoom platform.

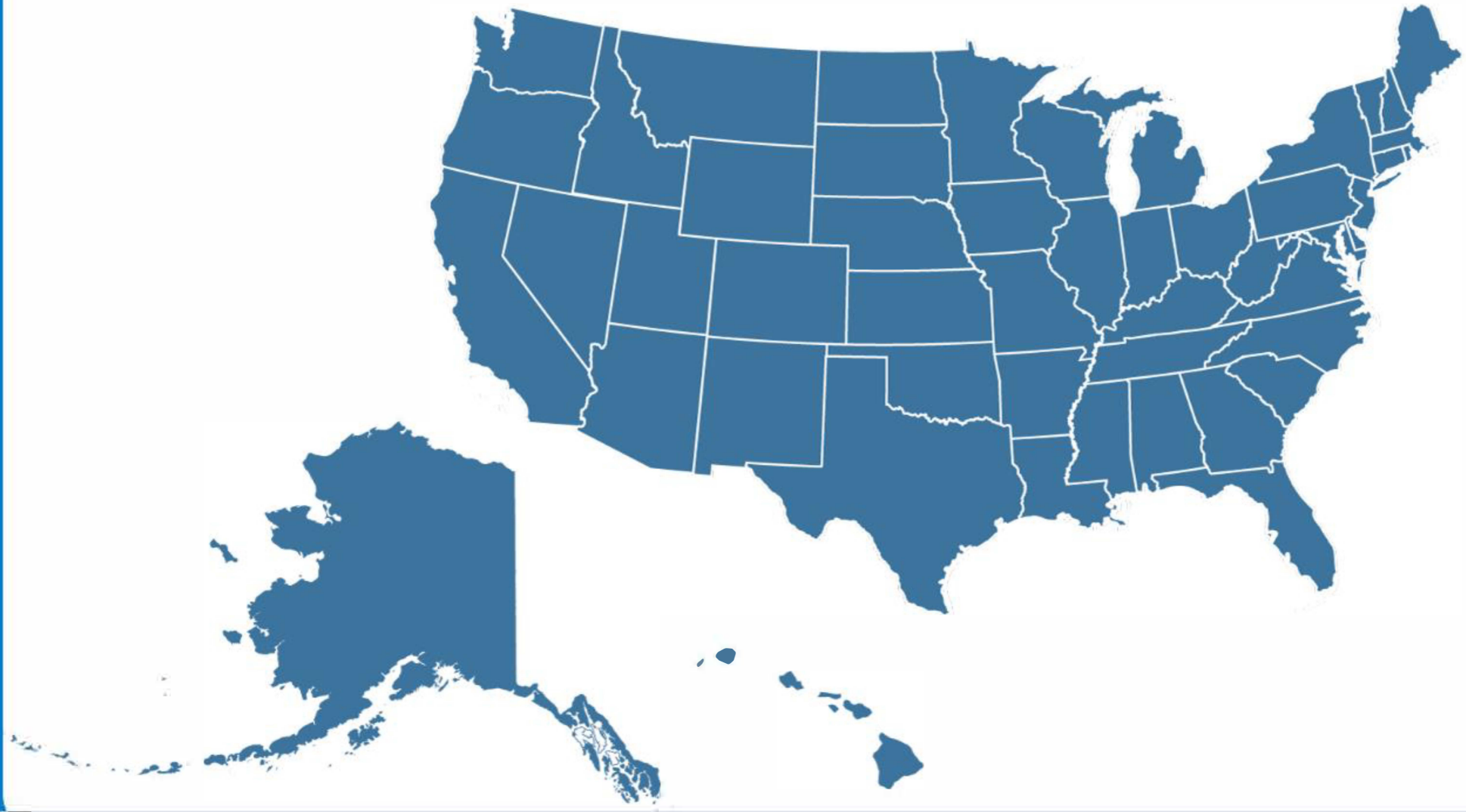


Please select the organization type you represent.

- State Medicaid Agency
- Mental Health Provider
- Substance Use Disorder Provider
- State Public Health or Behavioral Health Agency
- Other State Government Role
- Hospital
- Primary Care Provider
- Community Organization
- Beneficiary or Community Stakeholder Group
- Local Health Department (County or City)
- Tribal Health Center
- Federally Qualified Health Center
- Rural Health Clinic
- Managed Care Organization
- Other Payer Type
- Other Organization Type

Where are you calling from today?

0



IBH Model Overview

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Model Timeline

The IBH Model will run for 8 years total, including a 3-year pre-implementation and 5-year implementation period.

Key Activity	Timing
State recipient pre-implementation period	Q4 2024 - Q3 2027
Practice participant enrollment period	Q4 2025 - Q3 2028
Practice participant pre-implementation period	Q4 2025 - Q3 2027
Implementation period (state recipients and practice participants)	Q4 2027 - Q3 2032

**Timelines are subject to change. The Model Notice of Funding Opportunity will have the final timelines.*

IBH Objectives and Intended Outcomes

The IBH Model aims to test a value-based payment (VBP) approach, aligned across Medicaid and Medicare, that enables behavioral health (BH) practices to integrate BH care with physical health (PH) care and health-related social needs (HRSNs).

OBJECTIVES

Improve care quality and health outcomes for people with moderate to severe BH conditions, including mental health (MH) conditions and/or substance use disorders (SUDs).

Support BH practices to provide integrated, person-centered care in a BH setting, working with other providers as part of an **interprofessional care management team** to address beneficiaries' BH and PH needs as well as HRSNs.

INTENDED OUTCOMES

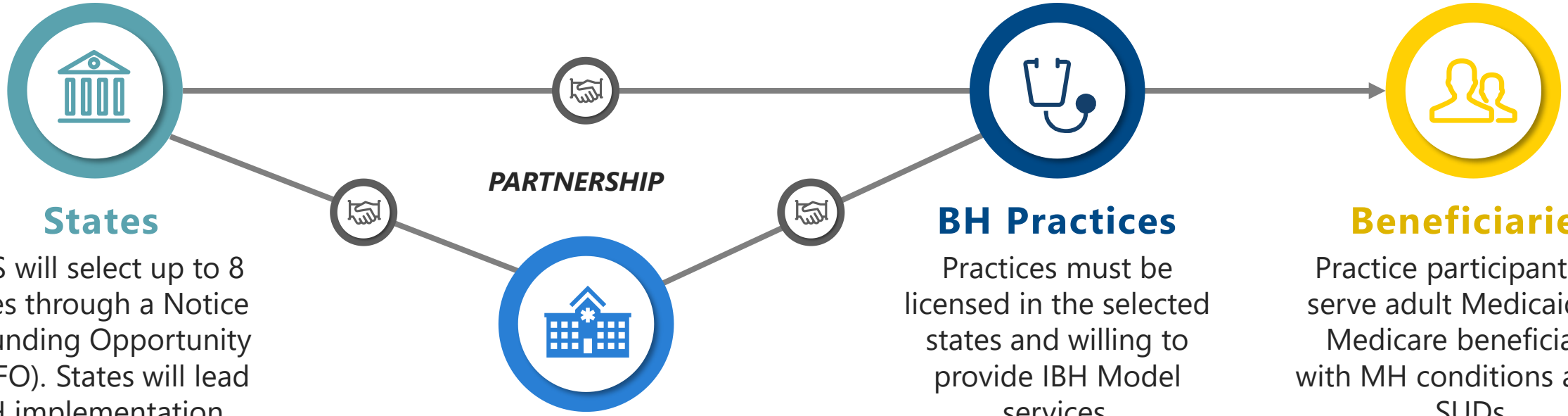
- Enhanced quality and delivery of **whole person care**
- Increased **access to BH, PH, and HRSN services**
- Improved health and equity **outcomes**
- Fewer **avoidable emergency department** and inpatient visits
- Strengthened **health information technology (IT) systems capacity**

Model Eligibility and Participation

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Overview of IBH Partners

State recipients and practice participants, with support from managed care organizations (MCOs) or other intermediaries, will implement the IBH Model.



States

CMS will select up to 8 states through a Notice of Funding Opportunity (NOFO). States will lead IBH implementation.

MCOs or Intermediaries

State recipients may partner with MCOs or other intermediaries, such as a risk-based prepaid inpatient health plan (PIHP) or risk-based prepaid ambulatory health plan (PAHP), to implement the IBH Model (where applicable).

BH Practices

Practices must be licensed in the selected states and willing to provide IBH Model services.

Beneficiaries

Practice participants will serve adult Medicaid and Medicare beneficiaries with MH conditions and/or SUDs.

State recipients can build off existing Medicaid and state-based initiatives to implement IBH.

Model Eligibility and Participation Overview

Model participants are state Medicaid agencies (SMAs) and BH practices that accept Medicaid in the selected states.

STATES: CMS will consider all state applicants. Selected states will:

- Receive a maximum of **$7.5M in cooperative agreement funding**
- Develop and implement the care delivery framework and Medicaid alternative payment approach
- Recruit practice participants
- Invest in statewide and practice level health IT

MCO OR INTERMEDIARY: State recipients that use a managed care structure may partner with MCOs or other fiscal intermediaries to implement IBH. This does not apply for states without managed care.

BH PRACTICES: To be eligible, billing practice participants within selected states must:

- Have at least one BH provider who is an employee, a leased employee, or an independent contractor. That person needs to:
  1) Be licensed by the state to deliver behavioral health services, and
  2) Meet any state-specific Medicaid provider enrollment requirements. They must be eligible for Medicaid reimbursement.
- Serve adult Medicaid beneficiaries (aged 18 or older) with moderate to severe behavioral health conditions.
- Provide MH and/or SUD services at the outpatient level of care.

All practices must participate in Medicaid. Practices have the option to participate in the IBH Medicare payment model if they enroll or are already enrolled in Medicare.

BENEFICIARY ELIGIBILITY

Practices that participate in the IBH Model must serve a certain number of beneficiaries with moderate to severe behavioral health conditions. Beneficiaries with behavioral health needs who are treated by a participating practice are eligible for the model, so long as their services are deemed reasonable and medically necessary.

Benefits of State Participation in IBH

IBH anticipates that state recipients will benefit from expanded value-based care arrangements for BH providers and the beneficiaries they serve, encouraging better care and health outcomes while reducing disparities.

Receive **Cooperative Agreement funding** of up to $7.5 million to enhance state capacity to develop and implement IBH Model requirements

Build on **existing state-based initiatives** to implement IBH

Test a **value-based payment approach** that aims to improve the quality of care

Improve outcomes for beneficiaries with MH conditions and/or SUDs through increased access to integrated care

Promote **equitable care** in their state by addressing HRSNs

State Medicaid Agency Recipient Role

SMA recipients will lead IBH implementation via their responsibilities outlined below.

ROLE OVERVIEW

- Develop and enhance **statewide infrastructure to support BH practice** participants
- **Recruit and select BH practices**, working with managed care partners and/or state fiscal intermediaries as applicable
- **Partner with state MH agencies** to inform and carry out model pre-implementation and implementation activities
- Implement the **care delivery framework**
- **Develop and implement a Medicaid APM** that aligns with the IBH payment approach
- **Convene** relevant stakeholders in model development and implementation
- **Collect, analyze, and share model data** among practice participants and with CMS
- Contribute to **model learning and convening**

The model quality strategy will measure:

Health outcomes targeted by IBH

Care coordination

Physical health screenings

HRSNs

Beneficiary utilization of services

Patient-reported outcome measures

BH Practice Participant Role

BH practice participants within awarded states will deliver the IBH care delivery framework for eligible beneficiaries.

ROLE OVERVIEW

- **Screen, assess, and refer beneficiaries,** as needed, for BH and PH conditions
- **Lead an interprofessional care team** to address the beneficiary's BH and PH conditions and HRSNs, adjusting the care plan as needed
- **Support equitable care** by implementing HRSN screenings, a population needs assessment, and a health equity plan

Examples of potential IBH practice participants:

- Outpatient Opioid Treatment Programs
- Community Mental Health Centers (CMHCs)
- Certified Community Behavioral Health Clinics (CCBHCs)
- Non-affiliated, Independent Providers
- Health Departments
- Tribal Health Organizations and Clinics
- Hospital- or University-Affiliated Outpatient BH Programs or Clinics
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Medicaid Managed Care Role

MCOs, PIHPs, PAHPs and other fiscal intermediaries will support state recipients as outlined below. Details regarding their role will be available in the NOFO.*

ROLE OVERVIEW

- Assist state recipients in **selecting practice participants** for participation and managing provider networks
- Collaborate with state recipients **to operationalize the Medicaid APM (e.g., modify existing managed care contracts, as necessary)**
- Collaborate with state recipients and practice participants to **allocate cooperative agreement funding**
- **Improve data sharing, collection, analysis**, and decision making
- Provide **technical assistance** and coaching to practice participants in support of model goals

*In states that do not follow an MCO structure, MCO collaboration is not required.

*In some states, administrative services organizations (ASOs) or other intermediaries may serve similar functions in place of or in addition to MCOs, PIHPs, or PAHPs.

Pre-Implementation and Implementation Periods

Below is key information regarding funding and processes that are designed to support state recipients and practice participants throughout the pre-implementation and implementation periods.

PRE-IMPLEMENTATION (2024-2027)

- State recipients and practice participants will receive **funding during the pre-implementation period** to support the activities needed to successfully participate in IBH.
- State recipients will develop an **alternative payment model (APM)** and plan for implementing the care delivery framework, working with MCOs and/or other fiscal intermediaries (as applicable).
- Practice participants will begin their pre-implementation period **one year later than state recipients** to allow states to **recruit and onboard practices** into the model.

IMPLEMENTATION (2027-2032)

- State recipients will **operationalize the Medicaid APM.**
- State recipients will continue to receive **Cooperative Agreement funding** to support implementation of IBH.
- **Practice participants who also participate in the Medicare** component of IBH will receive payments for model services through Medicare participation agreements with CMS.

Care Delivery Framework

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Overview of Care Delivery Framework

The IBH Model's care delivery framework aims to improve quality and outcomes by testing a framework for integration of PH needs and HRSNs in BH settings. The care delivery framework focuses on three core elements of the beneficiary experience: care integration, care management, and health equity.

CARE INTEGRATION

- **Screening and assessment** for BH and PH needs as well as HRSNs
- **Person-centered care planning and treatment** of BH and PH conditions and/or close-loop referral to PH care
- **Monitoring of BH conditions** and certain PH conditions
- **Care plan adjustments** if outcomes are not improving, or new needs are identified.

CARE MANAGEMENT

- **Interprofessional team-based care**
  - Develop care team that reflect the needs of the service population, and at a minimum, includes the beneficiary, billing practitioner, PH consultant, clinical staff, and care management team
- **Ongoing care management**
  - Monitor person-centered planning goals, treatment, and outcomes; coordinate beneficiary needs related to BH and PH conditions and HRSNs

HEALTH EQUITY

- **Screen, refer, and follow-up for HRSNs; collaborate** with HRSN partners
- **Complete population needs assessment** and develop a **health equity plan**

Care Delivery Framework: Care Integration

Practice participants will offer screening, referral, and follow up for BH and PH needs as well as HRSNs.

PURPOSE

BH is often **siloed from primary care** and may lack capacity to address HRSNs, which can lead to poor quality and outcomes for beneficiaries. Care integration helps **minimize barriers to quality care** for beneficiaries with co-occurring BH and PH needs, particularly those with moderate to severe BH conditions.

What care do practice participants provide?

Screen and assess for BH and PH needs as well as HRSNs

Conduct person-centered planning and treatment of BH and PH conditions and/or closed-loop PH referrals

Monitor BH conditions and certain PH conditions*

Make care plan adjustments based on outcomes

***A targeted set of health conditions** (diabetes, hypertension, and tobacco use disorder) will be used to measure the impact of care integration. SMAs have the option to include additional conditions.

Care Delivery Framework: Care Management

Practice participants will conduct care management to increase access to PH services, including primary care, and HRSN services.

PURPOSE

Interprofessional care teams are shown to limit adverse events, improve beneficiary outcomes, and add to beneficiary satisfaction.

What does care management include?

Interprofessional care teams* that reflect the needs of the population served

Ongoing monitoring of person-centered care planning goals, treatment, and outcomes

Ongoing coordination of beneficiary BH and PH needs and HRSNs

***The interprofessional team** includes all individuals needed to manage the whole-person care of each IBH Model beneficiary, including:

- Beneficiary, family, or caregiver (at the beneficiary's discretion)
- A combination of the following: BH provider team, care coordinator or care manager, PH consultant (e.g., physician or primary care provider), peer support specialist, community health worker, education and/or employment support, and other staff with lived experience

Care Delivery Framework: Health Equity

Practice participants will establish interprofessional teams that implement individual and population-level interventions to address HRSNs.

PURPOSE

HRSNs are the largest **contributor to health outcomes** and are associated with **health care utilization and costs.** Individuals with serious mental illness and/or SUDs often face poverty and other social needs that can worsen health (e.g., housing instability and/or food insecurity).

How is equitable care supported?

Screen, refer, and follow-up for HRSNs; collaborate with HRSN partners

Complete population needs assessment and develop a **health equity plan**

Expand **data collection, reporting, and analysis**

Foundational Support Activities

During the pre-implementation period, states and practice participants will receive funding to conduct the below activities that will support the care delivery framework.

Health IT infrastructure capacity, such as adoption and upgrading of electronic health records (EHRs); establishment and use of registries; adoption, use, and maintenance of interoperability solutions, etc.

Telehealth tools to support delivery of integrated care (e.g., telehealth needs assessment, tools, and in-practice support capabilities to connect beneficiaries to primary care or specialty providers).

Population management tools to provide data-driven, proactive care to support population needs and address disparities.

Practice transformation activities, such as workflow development, staffing development and retention plans, systematic quality improvement, and strategies for outreach to beneficiaries and caregivers.

Illustrative Sample Beneficiary Experience in the IBH Model

Background

Name: Robert

Age: 65

Health Conditions:
- Bipolar disorder (BPD)
- Alcohol use disorder (AUD)
- Hypertension (HTN)

Emergency Department Visits: 4 times in the past 6 months

Situation

- Recently lost his job
- Under a lot of stress to afford groceries, car repairs, and health care
- Primary care staff are not well informed about how to treat his BPD and AUD
- His BH clinic is the provider that he visits most often, but the clinic is not equipped to assist him in managing his PH needs

Robert's Experience in the IBH Model

Initial Contact

- Visits an IBH-participating BH clinic
- Care team recognizes he could benefit from IBH
- Consents to participate
- Screened for **BH** *and* **PH** conditions *and* HRSNs

Care Integration

- IBH care team contacts Robert's primary care provider (PCP) to discuss the results of his screening
- They discuss how Robert's AUD and BPD make it difficult to manage his HTN

Care Planning

- Robert, his IBH provider, and PCP create a care plan to address his BH and PH conditions and HRSNs
- His care team plans to connect him to AUD and BPD support groups

Integration with Social Needs

- A CHW connects Robert to community organizations that deliver nutritious food and provide transportation to appointments
- Robert begins meeting with his AUD and BPD support groups and a peer support specialist

Care Management

- Robert's IBH care team follows up with him before and after his BH appointments to send reminders and check on his experience

Ongoing Monitoring

- As appropriate, Robert is screened again for BH, PH, and HRSNs by his IBH care team
- His outcomes are improving
- Receives IBH services until no longer medically necessary

Robert's Outcomes

- Supported by his care team and follows his care plan
- Lower stress, improved medication management, reduced hypertension, and improved food security
- Confident enough to start applying for a job

Funding and Payment Structure

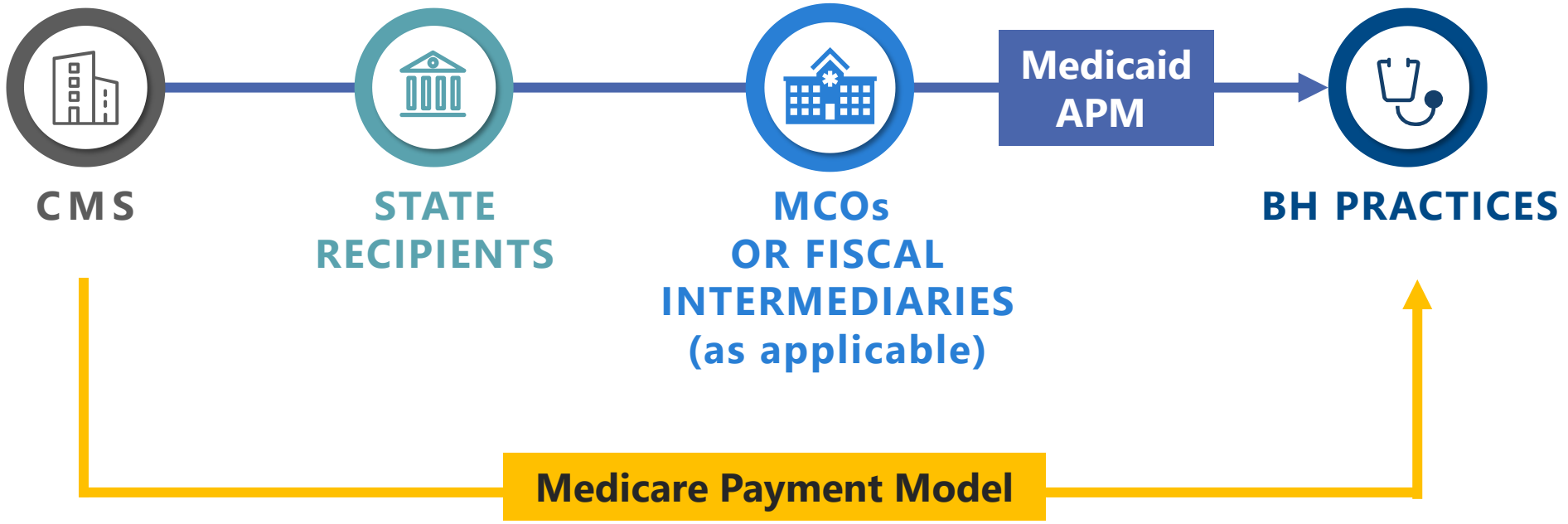
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Payment Model Flow

Below provides an overview the IBH payment model's flow to states and practice participants.

Medicaid APM flows from states/MCOs to Medicaid practice participants.

Medicare payment model and capacity building funds flow directly from CMS to Medicare practice participants.



Funding Types

Below is an overview of the funding types that the model includes.

	FUNDING TYPE		
	Cooperative Agreement Funding	**Infrastructure Funding**	**VBP for IBH Care Delivery Framework**
Recipient	States	Practice participants	Practice participants
Purpose	Enhance state capacity to develop and implement the IBH Model and to support practice participants	Develop the essential infrastructure and practice capacity to implement the model	Provide BH practices with a glidepath to VBP
Distribution	Section 3021* funding issued via Cooperative Agreements with CMS	• CMS distributes to Medicare practice participants • States use Cooperative Agreement funding to administer infrastructure funding to Medicaid-only practices	• Medicaid APM • Medicare risk adjusted integration support payment (ISP) • Medicaid and Medicare performance-based payments (PBP)
Timing	MY1-MY8	MY2-MY5	MY4-MY8 (for both ISP and PBP)

*Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) establishes the Innovation Center to test innovative payment and service delivery models that have the potential to lower Medicare, Medicaid, and Children's Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

Cooperative Agreement Funding for States

State recipients receive Cooperative Agreement funding to increase their capacity to implement the Medicaid payment approach and care delivery framework while ensuring sustainability of the model in the long-run.

FUNDING PURPOSE

State recipients will work with MCOs, PIHPs, or PAHPs (as applicable) on readiness and technical assistance activities, including:

- Identifying and recruiting practice participants
- Building and updating state and provider-level health information technology infrastructure and capacity
- Convening partners to develop the Medicaid APM
- Ensuring the flow and analysis of data needed for monitoring, evaluation, and payment

FUNDING TIMING

State recipients receive Cooperative Agreement funding every year of the model (MY1-MY8). In the implementation period, a small portion of funding will be tied to performance on statewide milestones.

Infrastructure Funding for Practice Participants

Practice participants will receive infrastructure funding during early model years to increase their capacity to implement the Medicaid and Medicare payment approaches and care delivery framework.

FUNDING PURPOSE

Practice participants who opt to participate in the Medicare payment model will receive infrastructure funding directly from CMS, through their participation agreements, for the below foundational support activities.

- Build and refine EHR interoperability
- Connect with existing state health information exchanges
- Hire and train practice staff in new clinical workflows and IT
- Collaborate with PH consultants to establish care protocols
- Establish agreements with primary care providers and social service organizations for enhanced referrals
- Develop communication strategies to notify patients of screening opportunities and clinical changes

For Medicaid-only practice participants, state recipients will use a portion of their Cooperative Agreement funding to increase capacity of practices to implement foundational support activities.

FUNDING TIMING

Practice participants will receive up to **4 years of infrastructure funding** (from MY 2-5).

**The NOFO will include more detail on infrastructure funding.*

Aligned VBP for IBH Care Delivery Framework

The IBH Model aims to test a VBP approach that incentivizes integrated care.

FUNDING PURPOSE

The IBH Model's **aligned Medicaid and Medicare payment approach** aims to introduce BH providers to VBP, connecting payment to performance and establishing accountability for care delivered.

Practices participating in the Medicare payment model will receive value-based payments through the **Medicare integration support payment (ISP) and performance-based payments (PBP).**

- The **risk adjusted ISP** covers the care delivery framework's integrated services for the attributed populations identified via screening and assessment for model services.
- The **PBP** is a quality incentive payment first based on reporting and later based on performance. The PBP is designed to encourage and reward advancement of care quality and accountability. States will be required to design and implement an aligned Medicaid alternative payment model that includes a performance-based payment approach. States will also make determinations for appropriate level of risk (if any).

The **Health Care Payment Learning and Action Network (LAN) APM** framework and definitions will specify the minimum type of APM that aligned payers should develop.

FUNDING TIMING

MY4-MY8 for ISP and PBP

Multi-Payer Alignment

Multi-payer alignment is a critical strategy to reduce practice and state burden and to move payers in a uniform direction on payment that adequately supports the delivery of integrated care in BH settings.

OVERALL APPROACH

Medicaid and Medicare will align on key model design elements, such as payment model and quality measures, which will allow state partners flexibility while designing and implementing a Medicaid APM for their state context.

ALIGNMENT PRINCIPLES

To achieve alignment across payers, IBH has defined minimum requirements below:

Design Element*	Minimum Required Alignment
Care Delivery Framework	**Care Integration:** BH, PH, and HRSN screening; care plan development; and referral to care for PH and HRSN needs
	Care Management: Interprofessional care management team, closed-loop referrals, and follow ups as needed
	Health Equity: HRSN screening and reporting to CMS, use of population needs assessment, and health equity plan
Payment Progression	**Fee-for-Service to VBP:** Payer develops a new or adapts existing APM that complements their state's existing payment approaches
	Attribution: Practices receive list of prospectively attributed members at least quarterly and use health IT data tools
Quality Measurement	**Quality Measures:** SMAs and MCOs, PIHPs, or PAHPs agree to an aligned set of IBH Model quality measures that at the least are tied to payment and reporting at the state or plan level only

*For design elements that payers do not directly control, such as the care delivery framework, the participating payer will ensure that their practice participants are equipped to execute the specific model components and provide compliance oversight.

Medicaid Payment Approach

State recipients will develop new or adapt existing Medicaid APMs that align across key features of the IBH payment approach.*

Guidelines for State Recipients

- **Develop new or adapt existing Medicaid APMs** that align with the IBH Medicare payment approach on key aspects (i.e., the multi-payer alignment principles)
- **Partner with MCOs or relevant fiscal intermediaries** to implement an aligned Medicaid APM
- Jointly engage Center for Medicaid & CHIP Services (CMCS) and the Innovation Center to obtain the **appropriate Medicaid authority** (if needed) to operationalize the IBH Model

**More details about existing Medicaid initiatives are on the next slide.*

Adapting Existing Medicaid Components

Below are examples of how state recipients can build off existing Medicaid and state-based initiatives to implement IBH.

Examples of existing Medicaid and state-based initiatives that states can adapt to implement IBH:

- Medicaid Health Homes, CCBHCs, Primary Care Case Management, and Promoting Integration of Primary and BH Care Program
- As applicable, CMS will work with CCBHC participating states and practices to ensure they are aligned with the IBH Model requirements

CCBHCs

Under the initiative jointly administered by CMS and SAMHSA, a CCBHC provides a comprehensive array of MH and SUD services to individuals regardless of diagnosis or insurance status.

CCBHC demonstration states are eligible to participate in IBH. Model participation can help CCBHCs bolster their existing integration efforts and accelerate uptake of the model among more providers.

If a CCBHC demonstration state participates in IBH, their CCBHCs would be eligible for aligned Medicare payments.

Example of existing Medicaid flexibilities states can adapt for IBH use:

State Health Official Letter #23-001, Coverage and Payment Of Interprofessional Consultation

Medicare Integration Support Payment (ISP)

The ISP is a prospective, risk adjusted Medicare payment for initial and ongoing screening, assessment, and coordination for BH and PH conditions, along with HRSN screening and referral.

FUNDING PURPOSE

ISP is a **care integration and care management fee** that will be **risk adjusted** based on the beneficiary population.

ISP is expected to range **$200-$220 per beneficiary per month.**

IBH will establish a **model-specific billing code** that practice participants will use to submit claims for the ISP.

The value of the ISP will be **adjusted to account for geographic variation** using the geographic practice cost indexes currently used in the Medicare physician fee schedule.

FUNDING TIMING

ISP will be paid to **Medicare practice participants** as a quarterly payment, beginning at the start of MY 4.

Medicare Performance-Based Payment (PBP)

Medicare practice participants will participate in a performance-based payment program where the bonus payments are contingent upon performance against quality measures.

FUNDING PURPOSE

The Medicare PBP is **upside-only** and is designed to **encourage and reward behaviors** such as reporting data and advancing care quality and accountability across multiple dimensions, including care integration, coordination, efficiency, and beneficiary-centered outcomes.

Medicare PBP components:

- **Pay for Reporting:** Incentives for achieving reporting and attainment thresholds (MY4-5)
- **Pay for Performance:** Incentives for improvements in health outcomes and screenings (starts in MY5 for 1-2 specific measures, MY6-8 for all measures)

CALCULATION DETAILS

The Medicare PBP amount will be based on a percentage of the ISP.

As the PBP strategy shifts from pay-for-reporting to pay-for-performance, the total amount of Medicare PBP available will increase as a percentage of the ISP. This gives practice participants additional incentives to achieve quality outcomes and begin to move towards more sophisticated VBP arrangements.

FUNDING TIMING

The Medicare payment structure will include a PBP paid annually for reporting and performance measured from MY4 to MY8.

Application Timeline

Application Timeline

Interested states can prepare to apply to the IBH Model based on the timeline below.

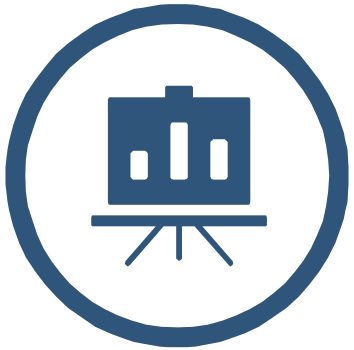
Key Activity	Timing
State NOFO Application Period	Q2 2024 - Q3 2024
State Recipient Announcement Period	Q3 2024 - Q4 2024
State Recipient Pre-Implementation Starts	Q4 2024
Practice Participant Enrollment Period	Q4 2025 - Q3 2028
Practice Participant Pre-Implementation Period	Q4 2025 - Q3 2027

**Timelines are subject to change. The Model Notice of Funding Opportunity will have the final timelines.*

Questions and Answers

Poll Question 3

Please respond to the live poll using the Zoom platform.

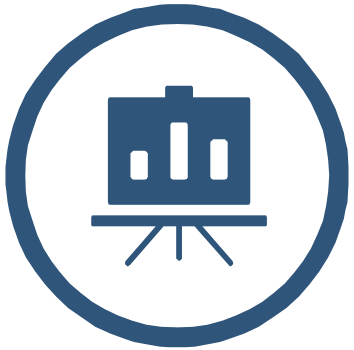


How well does the IBH Model align with your state and practice-level priorities?
a. Aligns very well b. Aligns well c. Neutral/unsure d. Not very well

If you would like to share more, please add to the Q&A box.

Poll Question 4

Please respond to the live poll using the Zoom platform.



How well does the IBH Model align with existing initiatives within your state?

a. Aligns very well
b. Aligns well
c. Neutral/unsure
d. Not very well

If you would like to share more, please add to the Q&A box.

Question 1

Can Medicare Advantage and other commercial health plans participate in the IBH Model?

Question 2

Will technical assistance be provided through the IBH Model?

Question 3

How do mental health and SUD providers apply to participate in the IBH Model?

Question 4

Do mental health and SUD providers have an adequate level of information technology (IT) capacity to engage in the IBH Model?

Question 5

What types of behavioral health providers and care settings are not eligible to participate in the IBH Model?

Question 6

Why does CMS think that the IBH Model will be successful?

Open Q&A

Please **submit questions via the Q&A box** to the right of your screen.

Specific questions about your organization can be submitted to IBHModel@cms.hhs.gov.

Closing and Resources

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Additional Information and Application Support

For more information and to stay updated on IBH announcements and events, please refer to the below resources.

Webpage

go.cms.gov/ibh

Email

IBHModel@cms.hhs.gov

Listserv

Sign up for updates on www.cms.gov

Social Media

@CMSinnovates

Thank you for attending the overview webinar!

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES