**Innovation in Behavioral Health (IBH) Model Overview Webinar**
**February 29, 2024**

**>>Sarah Grantham, CMS:** Good afternoon, everyone, and thank you for joining us. My name is Sarah Grantham, and I am a Co-Lead for the Innovation in Behavioral Health Model, or IBH for short. My colleagues and I are excited to share more about this groundbreaking model.

Before we get started, let's do some housekeeping. During today's presentation, all participants will be in listen-only mode. We recommend that you listen via your computer screen speakers, but we also have the option to dial-in from your phone. The dial-in information is available on your screen.

Please feel free to submit any questions you have throughout today's presentation in the Q&A pod that is displayed on the right side of the zoom window. Given today's time constraints, we might not get to every question, but we will collect all the questions for future events and FAQs, that we will post on our webpage. You can also reach our help desk at IBHModel@cms.hhs.gov, which you'll find in the chat. We'll also share a brief survey at the end of the webinar and would welcome your feedback there.

You should know that today's presentation is being recorded. If you have any objections, please hang up now. This slide deck, along with the recording, and a transcript of today's webinar, will be available on the IBH Model in the coming days. Please note that all information provided in this model overview webinar is potentially subject to change. When published, the Notice of Funding Opportunity, or NOFO, will be the sole source of information about IBH Model details and the application process. Next slide, please.

Here's our agenda for today. First, we will begin with an overview of the CMS Innovation Center and some opening remarks. Then we'll have a chance to get to know all of you in the audience a bit better, through a couple of brief polls. We will then share an overview of the IBH Model, and after that we will share more information about model eligibility and participation. Then we will talk about the IBH Model's care delivery framework, and about the funding and payment structure. Next, we'll spend a few minutes talking about the application process and timeline.

At the end of the webinar, we'll finish with a question and answer session, where our team will answer audience questions. As a reminder, you can use, you can submit questions using the Q&A function at the bottom right corner of your Zoom window. Finally, we'll wrap up by sharing some brief, closing remarks and resources. Now, I have the pleasure to introduce today's speakers. Next slide, please.

Dr. Liz Fowler comes first. She is Deputy Administrator and Director of the CMS Innovation Center. She has joined us to share an overview of the CMS Innovation Center. We are also joined by Dr. Anita Everett, Director of the Center for Mental Health Services, within the Substance Abuse and Mental Health Services Administration, or SAMHSA for short. We also have Kirsten Beronio, Senior Policy Advisor for Medicaid and CHIP Services, or CMCS. Our SAMHSA and CMS, CMCS colleagues have been essential partners in developing the IBH Model, so we are very happy to have them here with us today. We also have Isaac Devoid, my IBH Model Co-Lead from the CMS Innovation Center. Now let's welcome Dr. Liz Fowler.

**>>Liz Fowler, CMS:** Thanks so much, Sarah. Good afternoon, and thanks to everyone for joining us today to learn about the groundbreaking IBH Model. And, as Sarah said, a warm welcome and hearty thanks to our colleagues at SAMHSA and the CMS Center for Medicaid and CHIP Services, who've been critical

partners in developing the IBH Model. Just as importantly, we're looking forward to their continued partnership as we implement that model

CMS is dedicated to doing our part to address the nation's behavioral health crisis alongside our federal partners. Before I hand it over to my colleagues at SAMHSA and CMCS to share more about the importance of the IBH Model, I want to provide context and share a brief overview of the CMS Innovation Center and how it supports beneficiaries in Medicare and Medicaid. Next slide, please.

The CMS Innovation Center was established in 2010 as part of the Affordable Care Act to test new payment and care delivery models that have the potential to improve quality for Medicare and Medicaid beneficiaries or lower program spending. Models that meet a stringent test for cost savings and impact can be expanded in duration and scope through rulemaking. We are essentially the R&D component of CMS. Our models focus on certain conditions or diseases like end-stage renal disease, cancer, dementia, and of course, behavioral health, specific health care providers like primary care practitioners, and now behavioral health providers, state-specific models like the Maryland Total Cost of Care Model. And we also test models in Medicare Advantage and Part D prescription drug plans.

Since our inception, the Center has tested over 50 models and demonstrations. In 2023 alone, our models reached more than 7.1 million traditional Medicare beneficiaries and 1.1 million Medicaid beneficiaries through nearly 110,000 providers delivering care through one of our models. Next slide, please.

In 2021, the Innovation Center released a Strategy Refresh with five strategic objectives that charted a path forward in working on our vision towards our vision for a health system that achieves equitable outcomes through high quality, affordable, person-centered care. The first objective is to drive accountable care by increasing the number of beneficiaries in a care relationship with an accountability for quality and total cost of care. The second is to advance health equity by embedding equity in every aspect of our models and increasing focus on underserved populations. The third objective is to support care innovation to enable integrated, person-centered care. This objective connects to knowledge sharing and peer-to-peer learning collaboration and will include closing care gaps and delivering whole-person care. The fourth objective is focused on affordability by addressing health care prices and reducing duplicative or unnecessary care. And this means out-of-pocket costs, not just program costs. And the final objective is to partner to achieve health system transformation to change the way people experience care. We have to get all payers, Medicare, Medicaid, and commercial payers on the same page and moving in the same direction.

The IBH Model incorporates these strategic objectives and the Center's priorities in many ways. For example, we've been partnering with components across CMS and HHS to design the IBH Model so that it facilitates a holistic approach to behavioral health that is aligned with the HHS Behavioral Health Roadmap. As Sara mentioned, we've worked closely with CMCS and SAMHSA in designing the IBH Model. Our colleagues at CMCS have provided insights to help us design a model that takes into account the many different priorities of state Medicaid agencies and support states in building capacity to innovate in behavioral health. And SAMHSA shared their clinical and policy expertise as well as lessons learned from other initiatives, which provided valuable feedback in areas such as care delivery, provider participants, and beneficiary eligibility.

So again, we're so grateful for your continued support and your interest in our model. With that, I'm going to welcome Dr. Anita Everett, Director of the Center for Mental Health Services at SAMHSA, to share some additional opening remarks. Next slide, please.

**>>Dr. Anita Everett, SAMHSA:** Wonderful. So thank you so much, Director Fowler. I can't tell you what a privilege it is, and how excited I am to be here to participate in the more or less public announcement of this model.

We've been in, and as you referenced, we've been involved with CMS all along the way, and have been grateful for the partnership there. The IBH Model has, it will have a great potential to improve how we approach the treatment of mental illness and substance use disorder and improve the lives of so many individuals around our country. This model recognizes that individuals with behavioral health conditions need better access to physical health care, particularly for those illnesses that are longstanding, or sometimes called chronic illnesses, or chronic conditions. And in addition, it will reduce barriers by bringing together clinicians to treat whole-person, the whole person, supporting the mind, body, and health-related social needs of individuals, which we know so often contribute to the overall, the overall outcomes of individuals with long-lasting or chronic conditions.

At SAMHSA, we have participated in the innovation all along the way, as I said, and we've been very grateful to be a part of this. We see this model is something that will be a very welcomed potential addition to some of the programs that we had, longstanding programs that we have. As many of you may be familiar with, we've been working for a long time on an integrated care model that we call the PIPBHC, the Promoting Integration of Primary Care and Behavioral Health Care program. We also are currently working very aggressively on a program together with CMS called CCBHC, the Certified Community Behavioral Health Clinics program. And we see this model, the IBH Model as being very well able to facilitate some of the goals that the overall CCBHC Model has and supports.

Ultimately, this model brings us closer to achieving our priorities; to improve access to quality care, particularly for those with long-term and disabling health and mental health conditions. We look forward at SAMHSA to continuously working with CMS, across HHS and also the states, to support model design and implementation. So, thank you very much for your remarks, and thank you for inviting me to participate today to represent SAMHSA.

**>>Kirsten Beronio, CMCS**: Thanks, Dr. Everett. I'm Kirsten Beronio with the CMS Center for Medicaid and CHIP Services. And thank you to my colleagues at CMMI for inviting me to join you today to talk about this exciting new model. As you may know, Medicaid is the largest single source of funding for mental health and substance use disorder treatment in the US. And so, it provides critical support for millions of people with these conditions, and really underpins the delivery system across the country, particularly for those with more serious conditions.

We at the center for Medicaid and CHIP Services at CMS work with states through many different initiatives and authorities, to help improve access to mental health and substance use disorders treatment and support, including care coordination for co-occurring physical health conditions. In particular, one Medicaid initiative we've been working on with states, that aligns really well with the IBH Model, is the Certified Community Behavioral Health Clinic demonstration, which we administer in partnership with SAMHSA. And through the CCBHC demonstration, as it's known, we're providing states with increased federal Medicaid reimbursement for comprehensive care for mental health and

substance use disorders at community-based clinics that receive enhanced, more flexible federal reimbursement that can really support more of the evidence-based programs that we know are so effective. The CCBHC demonstration also includes screening for physical health conditions as part of the model, the care delivery model, as well as referral and follow up services for those conditions to help ensure people are receiving treatment from the appropriate healthcare professionals.

Another Medicaid authority that aligns closely with this new IBH Model is the Health Home benefit in Medicaid that supports improved care coordination with a focus on people who need mental health and substance use disorder treatment who are enrolled in the Medicaid program. Given the complementary nature of these existing Medicaid authorities, states can use these, as well as other Medicaid program authorities, to support and sustain many of the improvements in care delivery that the CMMI IBH Model will help put in place.

The IBH Model will support participating providers with financial resources and technical assistance to help them prepare for participating in value-based arrangements. Ultimately, the model will help enable states to build on their existing or planned innovations while bringing Medicare importantly to the table with the goal of payment alignment between Medicaid and Medicare. We've worked together to ensure that states have options in how they operationalize the IBH Model so they can use existing Medicaid authorities and initiatives that they already have in place. For example, the CCBHC demonstration, if they're participating in that, or the Health Home benefit, or they can work with us to explore additional authorities and opportunities in their Medicaid program to align with the IBH Model. We look forward to continuing to work with our colleagues at CMMI to support implementation of this critical new program.

Thanks again for joining, and I will turn it back over to Sarah.

**>>Sarah Grantham, CMS:** Thanks to all of our speakers.

Now we will launch a couple of brief polls to learn more about all of you in the audience. For the first question, please answer the Zoom poll about the type of organization that you represent. The question should pop up on your screen and I will give you a few moments to respond. Thank you, everyone. We will now close the poll.

I hope that you can see the results just as I can. It looks like we have a number of mental health providers in our midst. Welcome, welcome! We are very glad to see you and many others here, including some, a lot of also mental health providers, some state Medicaid agencies. Welcome to you all. Thank you for participating, and your responses will help inform our outreach efforts for future IBH Model events. Please advance to the next slide for this second poll.

We are going to use a more interactive platform where you can participate using your phone or computer browser. Please let us know where you are joining us from today by selecting the corresponding state on the map. And your responses will be anonymous. You can join this activity by scanning the QR code on the screen with your phone or mobile device. The link to the poll is also in the chat, so if you prefer, you can participate from your computer by clicking that link. Again, I'll give you a few moments to respond.

Wow! It is really cool to see how many people are coming from all over the place. Thank you so much for joining us and for participating. It is very, very exciting. Let's go to the next slide, please.

Now we will share overview information about IBH. Next slide, please.

Before we dive too deep, we want to first start by sharing some information about the model timeline. Please note that timelines are subject to change, and the models Notice of Funding Opportunity will include additional details about timelines. Turning back to this slide, we'll start with a high-level timeline. The model is expected to run for eight years total. This includes a three-year pre-implementation period and five-year implementation period.

State award recipients, which we'll refer to as states from here on out, have a pre-implementation period that runs from the fourth quarter of 2024, through the third quarter of 2027. The practice enrollment period will take place from the fourth quarter of 2025 to the third quarter of 2028. And the practice participant pre-implementation period will occur from Quarter 4 of 2025 to Quarter 3 of 2027. The implementation period for both states and practice participants will run from Quarter 4 of 2027 to Quarter 3 of 2032. Next slide, please.

Behavioral health practices have not had the same opportunities as other specialties to participate in value-based payment approaches. The IBH Model aims to change that. It is designed as a glide path to value-based payments for behavioral health providers that is aligned across Medicaid and Medicare. It enables behavioral health practices to integrate behavioral health with physical health and health-related social needs.

The model's objectives include improving care quality and health outcomes for people with moderate to severe behavioral health conditions. This includes mental health conditions and or substance use disorder. Another key model goal is supporting behavioral health practices as they provide integrated, person-centered care. Behavioral health practices will work with other providers as part of an interprofessional care team to address beneficiary behavioral health needs and physical health needs as well as health-related social needs.

IBH's intended outcomes are many. They include enhanced quality and the delivery of whole-person care, increased access to services that meet beneficiary’s behavioral health and physical health needs as well as their health-related social needs. Other model goals include improved health and equity outcomes, fewer avoidable emergency department and inpatient visits, and strengthened capacity in health information technology systems that support care integration. Next slide, please.

In this section we will discuss model eligibility and participation details. Next slide.

This slide shows some of the key parties who will be working together to design and implement the IBH Model. As you can see, states, practice participants, and other partners will implement the model. State Medicaid agencies are eligible to apply to the IBH Model through the Notice of Funding Opportunity, or NOFO. States will select up to, sorry CMS will select up to eight states through the NOFO application process. These selected states will receive Cooperative Agreement funding and lead IBH implementation. State Medicaid agencies will partner with their state agencies focused on mental health and or substance use disorders to ensure state alignment in programming and policy. Other partners may include managed care organizations, risk-based prepaid inpatient health plans, prepaid ambulatory health plans and other fiscal intermediaries were applicable. States without managed care are also eligible to participate and may identify other partners to fulfill similar roles.

States will work with behavioral health practices and states will recruit behavior health practices into the model, working with their managed care partners as applicable. Behavioral health practices will serve adult Medicaid and Medicare beneficiaries and dually eligible beneficiaries with mental health conditions and or substance use disorders. An extensive list of eligible providers will be discussed later on in the webinar.

The model allows state Medicaid agencies and their partners to build off existing Medicaid and state-based initiatives to implement IBH. This design aims to reduce the burden for our state partners and to improve the likelihood of sustainability after the IBH Model ends. Next slide, please.

Now we will provide an overview of the eligibility and participation requirements for each partner discussed on the prior slide. As noted, our model participants include selected states and behavioral health practices that accept Medicaid, at a minimum, in those selected states. We are encouraging all states and territories to apply to participate in the IBH Model. If selected, each state will receive a maximum of 7.5 million dollars in Cooperative Agreement funding over the eight years of the model.

States will use this funding to develop necessary infrastructure and capacity to implement the IBH care delivery framework and the Medicaid alternative payment model. States will also use these funds to recruit and select practice participants. And they will use the funds to invest in statewide and practice level health information technology. As previously noted, states may partner with managed care organizations, and or other intermediaries, such as risk-based prepaid inpatient health plans or risk-based prepaid ambulatory health plans.

Now moving on to practice eligibility. To be eligible to participate in the IBH Model, billing practice participants must have at least one behavioral health provider who is an employee, at least an employee or an independent contractor. That person needs to be licensed by the state to deliver behavioral health services and meet the state-specific Medicaid provider enrollment requirements. They must be eligible for Medicaid reimbursement billing. Practice participants must also serve adult Medicaid beneficiaries, age 18 or older with moderate to severe behavioral health conditions. They must also provide mental health and or substance use disorder services at the outpatient level of care.

We just want to pause here for a moment to talk about IBH's definition of moderate to severe behavioral health conditions. We've been working with CMS's clinical subject matter experts and our federal partners at SAMHSA on that definition. Examples of these moderate to severe conditions are opioid use disorder, major depressive disorder, bipolar disorder and generalized anxiety disorder. We are looking forward to sharing a detailed definition in the Notice of Funding Opportunity which we expect to release in the late spring or early summer.

Another important note here is that all IBH practices must participate in Medicaid. These practices will also have the option to participate in the IBH Medicare payment as well if they, if they enroll and are already enrolled in Medicare. Behavioral health practices that serve only Medicare beneficiaries are not eligible to participate in IBH.

Practice participants, practices that participate in the IBH Model, must serve a minimum number of Medicaid beneficiaries with moderate to severe behavioral health conditions. These criteria will be specified in the Notice of Funding Opportunity. 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. Next slide, please.

CMS sought input from a variety of stakeholders, including state agencies, to design a model that has many benefits to states and can be adapted to meet the needs of different states' behavioral health goals. As mentioned earlier, states will receive Cooperative Agreement funding of up to 7.5 million dollars over the model's eight-year period to enhance state capacity to develop and implement the IBH Model requirements. States will also use a portion of the funding to help practice participants deliver integrated care to improve beneficiaries' care experience and their outcomes. We will share more details about the funding later in the presentation.

IBH aims to allow states the flexibility that they need to adapt or build upon their existing innovations. As we will detail further in the Notice of Funding Opportunity, states can adapt several existing initiatives like Certified Community Behavioral Health Clinics, or Medicaid Health Homes to meet IBH Model requirements. We aim to reduce state burdens and support state efforts to sustain the IBH Model long after the implementation period is over. By participating in IBH, states will also be able to move forward along a glide path toward value-based payments that aim to improve the quality of care. States that use IBH Model funding will be able to use that to develop the Medicaid alternative payment model and support practices and other partners in implementing it.

Specifically, IBH aims to improve outcomes for people with mental health and/or substance use disorders by increasing their access to integrated care. IBH will also promote equitable care by screening for beneficiaries' health-related social needs. This is expected to reduce health disparities in states. Next slide, please.

Now, I'll provide some more detail about the role of different participants and providers in implementing the IBH Model. Let's start with state Medicaid agencies. They will apply IBH Model funding to develop and enhance their statewide infrastructure to support their behavioral health practice participants. They will work with managed care partners and/or any other fiscal intermediaries to recruit and select those practices. They will also partner with their state mental health agencies to inform and carry out IBH Model activities.

State Medicaid agencies will implement the care delivery framework and we'll talk some more about that later. They will also develop and implement a Medicaid alternative payment model that aligns with the IBH payment approach. As previously noted, this could be a new Medicaid alternative payment model, or it could adapt an existing Medicaid alternative payment model or initiative.

State Medicaid agencies will convene relevant stakeholders in model development and implementation. Stakeholders might include beneficiaries with lived experience, federally recognized tribes, and others. States will also collect, analyze, and share model data amongst their practice participants, and with CMS. Additionally, states will contribute to model learning and convening. CMS will support states as states develop their Medicaid alternative payment models. CMS will also provide technical assistance to practice participants, and CMS will streamline the use of data collection templates at the state and practice level.

To help ensure states' success, the CMS Innovation Center will monitor state performance in the IBH Model. The quality improvement strategy will be mindful of state and provider participant burden.

Through this quality improvement effort, IBH aims to achieve the desired outcomes, while reaching greater alignment among payers. IBH's quality strategy will include a parsimonious set of quality measures focused on targeted health outcomes, care coordination, screening for physical health needs, screening for health-related social needs, service utilization, and patient-reported outcome measures. Next slide, please.

In this slide, we will cover the important role of practice participants. Of course, they carry out the care delivery framework, and they support eligible beneficiaries in a number of important ways. As beneficiaries with moderate to severe behavioral health conditions tend to have significant behavioral health and physical health needs, IBH practice participants will screen, assess, and refer beneficiaries to better manage their behavioral health and physical health outcomes. Practice participants will also lead and facilitate an interprofessional care team to address beneficiary behavioral health and physical health conditions along with health-related social needs. We'll talk more about this interprofessional care team in a few minutes.

Practice participants will also conduct health-related social needs screening, and they will connect beneficiaries to needed social services and community agencies to improve their health outcomes. This work also entails health equity planning to better serve beneficiaries. The bottom panel of this slide includes numerous examples of potential IBH practices, such as outpatient opioid treatment programs, community mental health services, and Certified Community Behavioral Health Clinics, to name a few. Next slide, please.

Switching gears, this slide covers the role of managed care in the IBH Model for states that use this health care delivery system for their Medicaid programs. This slide also applies to states that use other fiscal intermediaries for their Medicaid programs, such as Prepaid Inpatient Health Plans and Prepaid Ambulatory Health Plans. All these entities have an important role to play in IBH. They will help states to recruit practice participants to join the model. They will work with their states to operationalize their Medicaid alternative payment model. For example, managed care contracts might be modified to support the alternative payment model, if needed. And these entities will facilitate data sharing, data collection, data analysis, and data-driven decision-making.

To support practice participants who were working to achieve model goals, managed care plans will provide technical assistance and practice transformation coaching. Of course, states need not collaborate with managed care companies in states where managed care organizations are not used to manage behavioral health services. You'll get additional details regarding the role of Medicaid managed care in the Notice of Funding Opportunity. Now let's, okay, let's go to the next slide. Great.

Now, let's talk about the technical assistance funding and processes that are involved with the pre-implementation and implementation periods. During pre-implementation, both states and practice participants will have time, in the first three years of the model, to engage in activities that will help them to be prepared to be successful in implementing the care delivery framework and the payment model. Both states and practice participants will receive funding to support the activities required to successfully carry out the IBH care delivery framework.

States receive Cooperative Agreement funding to support activities to successfully participate in IBH. States can use this funding to improve state health information technology infrastructure, and state capacity building, such as staffing. Practice participants will receive infrastructure funding to support

health information technology, certified electronic health records, practice transformation support and staffing.

Now, we'll review what happens during the implementation period. By this point, states must have the appropriate authority in place for their Medicaid alternative payment model. They will begin to operationalize their new or adapted, payment model for practice. Participant states will continue to receive Cooperative Agreement funds during this period to implement the alternative payment model and other elements of IBH.

Practice participants enrolled in the Medicare payment model will receive payments from CMS for the IBH Model services that those practices provide to Medicare beneficiaries. They will do this through Medicare Participation Agreements with CMS. We will discuss the Medicare payment model later in this webinar.

Now I will hand it over to my colleague, Isaac Devoid, to share more information about the model's care delivery framework. Next slide, please.

**>>Isaac Devoid, CMS:** Thanks, Sarah, and good afternoon everyone. In this next section we will share more information about the IBH Model's care delivery framework. Next slide please.

The IBH Model's care delivery framework aims to improve quality and outcomes by testing a framework for the integration of physical health needs and health-related social needs in behavioral health settings. The care delivery framework focuses on three core elements of the beneficiary experience. Those are care integration, care management, and health equity. These elements align closely with the IBH Model's quality strategy and payment approach and will build practice participants' capacity to provide integrated care and coordinate with an interprofessional care team.

The first element is care integration, since beneficiaries will receive integrated care from IBH practice participants. There are several ways that integration can happen, and integration does not require the co-location of physical health and behavioral health services.

The second element is care management. This is where practice participants will develop interprofessional care teams that reflect the needs of the service population. We'll discuss this in more detail later. Care teams will coordinate beneficiary needs related to behavioral health and physical health conditions along with health-related social needs.

The third element of the care delivery framework is health equity. This is where practice participants will screen, refer, and follow-up with beneficiaries for health-related social needs. But also, complete a population needs assessment and develop a health equity plan to address health disparities within the populations they serve. We'll now go into more detail on each of these elements over the next few slides. Next slide, please.

So as we just noted, that first core element of the care delivery framework is care integration. And the purpose of this element is to help address the challenge that behavioral health is often siloed from primary care and may lack capacity to address health-related social needs, which can often lead to poor quality and outcomes for beneficiaries. Care integration helps minimize barriers to quality care for beneficiaries with co-occurring behavioral health and physical health needs, particularly those with moderate to severe behavioral health conditions.

The IBH Model will help behavioral health practices address beneficiaries' behavioral health, physical health, and health-related social needs in the following ways. Practice participants will screen and assess beneficiaries for behavioral health needs, physical health needs and health-related social needs. They will also conduct person-centered planning and treatment of behavioral health and physical health conditions. This can include closed-loop referrals, where a verbal or written report is provided to the provider who requested that referral to the patient, or treating beneficiaries as needed, based on the practice scope.

In addition, practice participants will continuously monitor behavioral health and physical health as well as make care plan adjustments based on the beneficiaries' health outcomes. A targeted set of physical health conditions — diabetes, hypertension, and tobacco use disorder — will be used to measure the impact of care integration. State Medicaid agencies also have the option to include additional physical health conditions that may be prioritized in their state. This person-centered approach aims to embody whole-person health. The approach prioritizes close collaboration with primary care and other physical health providers to support all aspects of a beneficiary's health. Next slide, please.

That second core element of the care delivery framework is care management. Interprofessional care teams are shown to limit adverse events, improve beneficiary outcomes, and add to beneficiary satisfaction. Within IBH, the care team should reflect the needs of the population based on the population needs assessment and should be trained to provide trauma-informed care. The care team will continuously monitor beneficiary treatment and outcomes and provide ongoing coordination of behavioral health, physical health, and health-related social needs, as appropriate.

The bottom part of this slide shows interprofessional care team members which are all the individuals and expertise needed to manage the whole-person care of each beneficiary. This includes the beneficiary, and at their discretion, their family or caregiver. In addition, it could include the following, though this is not an exhaustive list: A behavioral health provider team, a care coordinator or a care manager, a physical health consultant, such as a physician or a primary care provider, a peer support specialist, a community health worker, education and/or employment support, and other staff with lived experience. Next slide, please.

The third core element of the care delivery framework is health equity. I'm sure many are familiar with the association between health-related social needs and health care utilization and costs. Individuals with serious mental illness and/or substance use disorders often face poverty and other social needs that can negatively impact health, such as housing instability and food insecurity.

Within IBH, practice participants in the aforementioned interprofessional care teams will implement individual and population-level interventions to address health-related social needs. Given that behavioral health practices often lack capacity to adequately address health-related social needs, IBH practice participants will receive support to improve health equity by providing beneficiary screenings, referrals, and follow-ups for health-related social needs. Practices will then collaborate with community partners to address health-related social needs as well.

In addition, participating practices will also be required to complete a population needs assessment and develop a health equity plan. Participants can use existing needs assessment processes that may already be in place in their state. The population needs assessment will inform practices about prevalent physical health and behavioral health conditions, as well as cultural and linguistic needs, and geographic

and technological needs. This ultimately provides a basic understanding of beneficiary population diagnoses, needs, and disparities. The population needs assessment will inform the health equity plan, which will stipulate how the practice participant will address disparities that impact the populations they serve. Practice participants will also expand data collection, reporting, and analysis to better understand and expand leading practices to serve their beneficiary populations. Next slide, please.

Ultimately, what really underlies the key elements of the care delivery framework are the foundational support activities. These activities are an essential piece in helping practices implement the care delivery framework. In the early years of the model, states and practice participants will receive funding to build capacity and infrastructure to implement the care delivery framework that we just discussed. This may include building health information technology capacity, such as adopting and upgrading electronic health records, establishing and using registries, and adopting, using, and maintaining interoperability solutions.

Telehealth tools are another foundational support area. These will support the delivery of integrated care, such as in practice support capabilities to connect beneficiaries to primary care or specialty providers. Another foundational support area includes population management tools, which will provide data-driven proactive care to individuals to support population needs and address disparities. States and practices can also apply the infrastructure funding towards practice transformation activities. These include things like developing new information technology and staffing workflows, conducting systemic quality improvement, and creating strategies for outreach to beneficiaries and caregivers.

States will also receive technical assistance from CMS in an array of different areas. This will be especially helpful for states in developing their own alternative payment model. For example, CMS can provide troubleshooting support for states when developing their Medicaid performance-based payment strategy. Next slide, please.

This slide shows an illustrative sample beneficiary's experience under the IBH Model. This example aims to show the model's intended impact on the beneficiary care, experience, and outcomes. In our example here, Robert is 65 years old and has bipolar disorder, alcohol use disorder, and hypertension. He has visited the emergency department four times in the last six months. Robert recently lost his job, which has caused stress and financial challenges, and he can no longer afford groceries, car repairs, or health care costs. Robert's primary care staff are not well informed about how to treat his bipolar disorder or alcohol use disorder. His behavioral health clinic is the provider that he visits most often, and prefers, but the clinic is not equipped to assist him in managing his physical health needs. Robert's care is disjointed, with different members of his care team not always aware of the whole picture of Robert's behavioral health, physical health, and social needs. Robert has difficulty navigating the health care system, and this contributes to higher stress and poorer health.

Now I will walk us through Robert's experience in the IBH Model, and how IBH can improve Robert's outcomes and experience of care. First, when Robert visits an IBH participating behavioral health clinic, the care team recognizes he can benefit from IBH, and he consents to participate. Next, he is screened for behavioral health and physical health conditions along with health-related social needs. The care team flags his bipolar disorder, alcohol use disorder, and hypertension. In addition, the care team identifies that he experiences food, transportation, and financial barriers. Not only does the care team simply identify his needs, they also engage in active follow-up and closed-loop referral activities. The

care team then calls Robert's primary care office to discuss the results of his screening. They discuss how Robert's bipolar and alcohol use disorders make it difficult to manage his hypertension.

Next, Robert, his IBH provider, and primary care provider collaborate to create a comprehensive care plan for Robert's behavioral, physical, and social needs. During this stage, Robert's care team connects him to support groups for alcohol use disorder and bipolar disorder. After the care planning step, a community health worker helps address Robert's social needs by connecting him to community organizations that deliver nutritious food to his home and provide transportation to and from appointments. Robert also begins to meet with his alcohol use disorder and bipolar disorder support groups, as well as a peer support specialist.

The IBH care team follows up with Robert before and after care appointments to send reminders and check on his experience. As appropriate, Robert's care team screens him for his physical, behavioral, and health-related social needs. Also, they adjust his care plan based on the outcomes which ultimately start to improve. Robert continues to receive IBH services until his care team determines they are no longer medically necessary.

By participating in the IBH Model, Robert feels supported by his care team and the different providers engaged in his care actively share information and collaborate to develop and implement his care plan. His input to the care plan gives him confidence to follow it. Robert experiences low stress, improved medication management, reduced hypertension, and improved food security. He is confident enough to start applying for a job. This is just one example of how a beneficiary may experience the IBH Model, although the model is suited to address a range of beneficiary behavioral health, and physical health conditions, as well as health-related social needs. Next slide, please.

Next we'll provide an overview of the model funding and payment structure. Next slide, please.

To start off, this slide shows an overview of how IBH Model funding flows to states and practice participants. Medicaid payment flows from states and MCOs to Medicaid practice participants, as shown by the blue line in the middle of this graphic. Medicare payments and capacity building funds flow directly from CMS to Medicare practice participants, as shown by the orange line here on my screen. Next slide, please.

Now we will provide an overview of the three funding types that the model includes. The first is Cooperative Agreement funding. From Model Years 1 through 8, states will receive Cooperative Agreement funding. Cooperative Agreement funding will support states in enhancing statewide capacity and infrastructure to develop and implement the IBH Model. In addition, it will also help states in supporting their practice participants, for example, through practice-level infrastructure, or technical assistance.

The next two funding types are for practice participants. During Model Years 2 through 5, practice participants receive infrastructure funding to develop the essential infrastructure and practice capacity to implement the IBH Model. There are two ways practices can receive funding to support health IT infrastructure and capacity during Model Years 2 through 5. The first is that CMS distributes infrastructure funding directly to the practices that opt to participate in the Medicare payment model through a Participation Agreement with CMS, also known as Medicare practice participants. Since not all practices may opt to participate in the Medicare payment model, the second way for practices to

receive this funding is through states using Cooperative Agreement funding to administer infrastructure funding to Medicaid-only practices.

During Model Years 4 through 8, practice participants will receive payments for IBH Model services from the Medicaid alternative payment model. Practices who opt to participate in the Medicare payment model will also receive the Medicare integration support payment, or ISP for short. The ISP will be risk-adjusted. Meanwhile, both Medicaid and Medicare practice participants will receive performance-based payments as part of the Medicaid APM and the Medicare ISP. We will go into more detail about these funding types next. Next slide, please.

So first, we're going to go into more detail about the Cooperative Agreement funding. And, as I mentioned earlier, states will 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. Examples of readiness and technical assistance activities that states and their partners can undertake include but are not limited to: Identifying and recruiting practice participants, building and updating state and provider-level health information technology infrastructure and capacity, convening partners to develop the Medicaid alternative payment model, and ensuring the flow and analysis of data needed for monitoring evaluation and payment. States receive Cooperative Agreement funding every year of the model. And in the implementation period, a small portion of funding will be tied to performance on statewide milestones. Next slide, please.

Next, we'll go into more detail about infrastructure funding for practice participants. Practice participants who opt to participate in the Medicare payment model will receive infrastructure funding directly from CMS through their Participation Agreements for foundational support activities. These practice participants will receive up to four years of infrastructure funding during Model Years 2 through 5 to support: Building and refining electronic health record interoperability, connecting with existing state health information exchanges, hiring and training practice staff for new clinical workflows and IT, collaborating with physical health consultants to establish care protocols, establishing agreements with primary care providers and social service organizations for enhanced referrals, and developing communication strategies to notify patients of screening opportunities and clinical changes.

For Medicaid-only practice participants, states will use a portion of their Cooperative Agreement funding to increase capacity of practices so they can implement foundational support activities. The IBH NOFO will include more details about infrastructure funding. Next slide, please.

I'll now go into more detail about the model's aligned, value-based payment model in more detail. The IBH Model's aligned Medicaid and Medicare payment approach aims to introduce behavioral health providers to value-based care, connecting payment to performance and ultimately establishing accountability for care delivered. Practices participating in the Medicare payment model will receive value-based payments through the Medicare integration support payment and performance-based payment. The risk-adjusted integration support payment covers the care delivery framework's integrated services for the attributed populations identified via screening and assessment for model services. The performance-based payment is a quality incentive payment that will first be based on reporting and later based on performance. Ultimately, the performance-based payment 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 the appropriate level of risk for their APMs, while aligning with the Medicare payment model. We will use the Health Care Payment Learning and Action Network Alternative Payment Model Framework and definitions to set the minimum type of alternative payment model that an aligned payer should develop. All three value-based payment components, including the Medicare integration support payment, the Medicaid alternative payment model, and a performance-based payment will take place from Model Years 4 through 8. Next slide, please.

Here we will discuss multi-payer alignment for the model. Multi-payer alignment is a crucial strategy to reduce practice and state burden and move payers in a uniform direction on payment that adequately supports the delivery of integrated care in behavioral health settings. Overall, Medicaid and Medicare will align on key model design elements. Those are things like the payment model and quality measures, and those will ultimately offer state partners flexibility while designing and implementing the Medicaid alternative payment model for their unique state context.

This table shows the minimum alignment, minimum level of alignment required between Medicaid and Medicare across three key model design elements. To achieve alignment between Medicaid and Medicare, and eventually across other payers, IBH has defined minimum requirements to support the model's design elements in the blue table at the bottom half of this slide. These requirements are aligned to the care delivery framework, payment progression, and quality measures and incentives.

To meet the care delivery framework requirements, practice participants are required to integrate care through behavioral health, physical health, and health-related social needs screening, including care plan development and referral to care for physical health and health-related social needs. Practice participants will also support care management by facilitating an interprofessional care team and providing closed-loop referrals and follow-ups as needed. They will also conduct a health-related social needs screening, a population needs assessment, and health equity plan to meet the care delivery framework's health equity requirements.

States will also meet minimum requirements to support payment progression by developing the new Medicaid alternative payment model that complements the state's existing payment approaches or adapts an existing alternative payment model already available in the state. For attribution requirements, practice participants will receive a list of prospectively attributed Medicare members from CMS, at least quarterly, and states will attribute Medicaid beneficiaries using the state's own attribution methodology. State Medicaid agencies and managed care organizations will agree to a set of measures aligned with the 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. This may look like providing technical assistance or funding to support building out the necessary health IT infrastructure and practice capacity. CMS will share lessons learned on implementation about the model so other health plans can voluntarily take similar approaches. Next slide, please.

Now we will review the Medicaid payment approach. As mentioned earlier, states will develop a new alternative payment model or adapt an existing Medicaid alternative payment model that aligns across key features of the IBH Medicare payment approach. This includes partnering with managed care

organizations or relevant fiscal intermediaries to design and implement this aligned Medicaid alternative payment model. These key features include the model's multi-payer alignment principles that we mentioned on our last slide. Additionally, states will jointly engage the Center for Medicaid and CHIP Services and the Innovation Center to obtain the appropriate Medicaid authority, if needed, to operationalize the IBH Model. Next slide please.

Examples of existing Medicaid and state-based initiatives that can be adapted to implement IBH include Medicaid Health Homes, Certified Community Behavioral Health Clinics, Primary Care Case Management, and the Promoting Integration of Primary and Behavioral Health Care program. For the examples I just listed, CMS will work closely with selected states to ensure these initiatives are aligned with IBH Model requirements.

For example, CMS will work with CCBHC participating states and practices to ensure they are aligned with the IBH Model requirements if selected. Under this initiative, jointly administered by CMS and SAMHSA, a CCBHC provides a comprehensive array of mental health and substance use disorder services to individuals regardless of diagnosis or insurance status. We note on this slide that CCBHC demonstration states are eligible to participate in IBH. Model participants, model participation can help CCBHC build on 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.

States can also adapt existing Medicaid flexibilities for use in the IBH Model. An example of a flexibility is the State Health Official letter #23-001: Coverage and Payment of Interprofessional Consultation. Next slide, please.

Now we will go into more detail about the Medicare integration support payment, or ISP. The ISP is a prospective, risk-adjusted Medicare payment for initial and ongoing screening, assessment, and coordination for behavioral health and physical health conditions, along with health-related social needs screening and referral. The ISP is expected to range between $200 to $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. The ISP will be paid to Medicare practice participants as a quarterly payment, beginning at the start of Model Year 4. Next slide, please.

This slide provides more detail about the Medicare performance-based payment, or PBP. Medicare practice participants will participate in a performance-based payment program where the bonus payments are contingent upon performance against quality measures. The Medicare PBP is upside only, and is designed to encourage and reward behavior, such as reporting data and advancing care quality and accountability across multiple dimensions, including care integration, coordination, efficiency and beneficiary-centered outcomes.

The Medicare performance-based payment has two components. The first component is pay-for-reporting, which incentivizes achieving reporting and attainment thresholds. Pay-for-reporting occurs in Model Years 4 to 5. The second component is pay-for-performance, which incentivizes improvements in health outcomes and screenings. Pay-for-performance starts in Model Years 5 for one to two measures and occurs in Model Years 6 through 8 for all measures.

Now turning to a couple of calculation details, the PBP will be based on a percentage of the integration support payment. As the performance-based payment strategy shifts from pay-for-reporting to pay-for-performance, the total amount of Medicare performance-based payment available will increase as a percentage of the integration support payment. This gives practice participants additional incentives to achieve quality outcomes and begin to move towards more sophisticated value-based care arrangements. The Medicare payment structure will include the PBP paid annually for reporting and performance measured from Model Years 4 to 8. Next slide, please.

Next we will share an overview of the application timeline. Next slide, please.

The state Notice of Funding Application is expected to open from Quarter 2 to Quarter 3 of 2024, and the state recipient announcement period will occur from Quarter 3 of 2024 to Quarter 4 of 2024. State recipients' pre-implementation period will start in Quarter 4 of 2024, and the practice participant enrollment period takes place from Quarter 4 of 2025 to Quarter 3 of 2028. The practice participants' pre-implementation period will take place from Quarter 4 of 2025 to Quarter 3 of 2027. Again, please note that the timelines are subject to change, and our Model Notice of Funding Opportunity will have the final timelines included. Next slide, please.

Now we will start on the Q&A portion of today's webinar. Before we dive into questions, we would like to invite you to complete the post-event survey, to share your feedback on this webinar. Next slide, please.

To start off, we would like to understand how well the IBH Model aligns with your state and practice-level priorities. If you would like to share more, please add to the Q&A box. I'll just give folks 30 seconds or so to respond to this one. Alright, I think we can go ahead and close the poll. It's really great to see that the model aligns really well, or well, with initiatives and different programs happening across states. You know, where it doesn't, we really hope that you provide feedback so that that can continue to inform our model design activities. Next slide, please.

Similarly, we'd like to understand how well the IBH Model aligns with existing initiatives in your state. And like the last poll, if you would like to share more, we welcome you to share via the Q&A box. Give you another 30 seconds or so to finalize that. Alright, I think we can go ahead and close the poll. Alright again, it's great to see that you know 35% of participants note that this aligns well. Where there were neutral or unsure response, we really hope that you provided a bit more information so that we can continue to answer those questions ahead of the Notice of Funding Opportunity period.

Thanks again for your participation there. Alright, I'm now going to hand it back to Sarah to take us through a few common, common registration form questions that came in. Thanks, Sarah.

**>>Sarah Grantham, CMS:** Thanks, Isaac. We will now answer some frequently asked questions that we collected from the webinar's registration form, and then, if time permits, we will answer live questions submitted during this webinar.

A common question that we received was: Can Medicare Advantage and other commercial health plans participate in the IBH Model? Multi-payer alignment is an essential component of the IBH Model and aligning payers will make it easier for behavioral health providers and manage administrative burden, which is important when we think about opportunities to optimize resources in the behavioral health space.

The IBH Model focuses on aligning Medicare fee-for-service and Medicaid, since we know that the beneficiaries enrolled in those two programs are at high risk of poor outcomes. That said, as we begin to work with state Medicaid agencies, we think that there's a great opportunity to share our learnings, so that other providers, payers such as Medicare Advantage and commercial payers, can align their efforts with the IBH Model. Although Medicare Advantage payers are not eligible to participate in IBH, we will share the IBH Model's care delivery framework, quality measures, and payment model details with them, that way these payers can leverage the IBH framework and align into the model. Next slide, please.

And next question, please. Thank you, here we go. Will technical assistance be provided through the IBH systems to both state Medicaid agencies and practice participants? The CMS Innovation Center intentionally designed the IBH Model with a three-year pre-implementation period to support all areas like payment, care delivery, data, and quality. Technical assistance will come from multiple resources like CMS, and its contractors, through peer-to-peer learning. That latter approach allows states and practice participants to learn from each other via the Innovation Center's learning system.

I'm now going to turn it over to Isaac Devoid, as I hear, my internet connection is unstable.

**>>Isaac Devoid, CMS:** Thanks, Sarah.

Alright, the next common question we'll answer is: How do mental health and substance use disorder providers apply to participate in the IBH Model? So practices interested in participating may want to reach out to their state to express interest or collaborate with their state-based behavioral health associations, to advocate for state participation in the IBH Model. This is because, first, the state Medicaid agency must apply and be accepted to participate in the IBH Model. After that, state Medicaid agencies then identify and select mental health providers, substance use disorder providers, or both, for participation in IBH. For practices that want to participate in IBH's, IBH's Medicare payment model, CMS will provide further information with details of the Medicare application process in late spring 2024. Alright, please turn on to the next slide.

The next common registration question that we received was: Do mental health and substance use disorder providers have an adequate level of information technology capacity to engage in the model? So historically, community-based behavioral health practices have not had the same level of investment opportunities in health IT, compared with primary care providers and specialists. The IBH Model is designed to address the disparity, such as by including infrastructure funding, a long pre-implementation period, and technical assistance. These model elements were intentionally designed to ensure that participating practices have the necessary resources and tools needed to successfully participate in the IBH Model. Next slide, please.

Another question that we commonly got was: What types of behavioral health providers and care settings are not eligible to participate in the IBH Model? Inpatient and post-acute care providers in settings like home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals, are not eligible to participate in the IBH Model. The IBH Model adopted this policy to assure program integrity and avoid duplicative services and payments with inpatient and post-acute care prospective payment systems and value-based purchasing programs. Next slide, please.

Alright, now we are on the last registration form question we'll answer today. After this we will answer live questions submitted during the session. Why does CMS think that the IBH Model will be successful as value-based care transformation has historically been difficult in behavioral health settings? One reason is that physical and behavioral health systems have historically been siloed which can lead to fragmented care for beneficiaries. The IBH Model is designed to establish a path to value-based care for behavioral health providers. The model expands investments and incentives in the behavioral health space to improve the quality of care and support behavioral health providers on the path to accountable care. By the end of the model, we expect that practice participants will be equipped to engage in more alternative payment models in the future.

We will now transition for an open question and answer session. Please submit your questions to the Q&A box on the right side of your screen. Next slide, please.

Alright, a common question that we received was, that we've received a question in the chat, about whether and how states could build on the CCBHC or Health Home initiatives to implement the IBH Model? This is a really great, great question. And the first thing that I want to note, is that our NOFO will include many more details on how states can participate in the model via existing state programs, as well as ones that are already underway. But I can share that, we have designed the IBH Model to be flexibly, flexibly implemented across multiple diverse states with different programs, including pathways to build off either CCBHC or Health Homes to implement the IBH Model.

The next common question that we received was: Whether states can implement a model in a portion of their state, or if the model must be implemented statewide? Again, our NOFO will provide more detail here. But yes, we do want to confirm states will have the flexibility to implement either statewide or in a sub-state region.

Another question that we received was: As a behavioral health practice, does my state have to be a participant if we want to participate? The answer is that yes, only practices with states selected to participate in the model will be able to participate in this model test.

Another common question that we've received through the chat is: Whether the IBH Model will deliver and pay for specific behavioral or physical health services? The IBH Model is strategically focused on coordinating and integrating providers in behavioral health and physical health settings. For this reason, the model is focused on care integration, management, and coordination. The model does not independently cover separate physical or behavioral health procedures, tests, or other services.

Similarly, another question we received is: How the IBH Model will affect those dually eligible for Medicare and Medicaid? Duals with moderate-to-severe behavioral health needs are eligible for IBH.

Alright, another question that we've received through the chat is: Are children eligible to participate in the IBH Model as beneficiaries? We understand that feelings of persistent sadness and hopelessness are on the rise among young people, and since 2020, we've been implementing the CMS Integrated Care for Kids, or InCK Model, in seven state Medicaid programs. The InCK Model is a child-centered local service delivery and state payment model for children under 21 years of age that integrates care coordination and case management across physical health, behavioral health, and other local service providers. CMS also recently announced 50 million dollars in grants for 20 states to implement or expand school-based health services for children enrolled in Medicaid and CHIP, including services for mental health.

The IBH Model is designed for adults. This decision was based on research showing that a number of other existing programs support adolescents with behavioral health conditions. In contrast, existing targeted investments to coordinate and manage care for adults with moderate-to-severe behavioral health conditions are few. This is despite research indicating that for a high number of such individuals, a lack of integrated care can result in poor outcomes. In response, the IBH Model includes a care delivery framework that integrates care, increases access for patients, and achieves greater equity and outcomes by focusing on identifying and making referrals related to health-related social needs.

Alright, one second while I see what other questions we have in the chat box. If we are an outpatient provider, would, would you recommend we reach out to our state Medicaid Agency or our legislator to encourage them to respond to this Notice of Funding Opportunity? Yes, we certainly encourage folks to reach out to state Medicaid agencies or legislators if you're interested in the model. That's great.

Alright, another question is: Has CMS outlined specific technical requirements for health IT supporting IBH participants? If so, please advise where to find it, thank you. This has not been released yet and will be fully detailed in our Notice of Funding Opportunity. So be sure to be on the lookout for that.

And another question that we received is: When will selected states be confirmed? And similar, when will we know which states are chosen to participate in the IBH Model? And as of now, our timeline is for the eight selected states to be notified by the fall of 2024.

Just looking at our chat box for another question. Another question that we commonly received was: Does a beneficiary need to consent to participate? And the answer is, yes.

Alright, I think with that we can start moving towards our closeout. Not sure if Sarah's internet is back up, so think I can start to close and wrap us out. So, as we wrap up our session today, please remember to complete the post-event survey, to share your feedback on this webinar. We just sent the link for that in the chat. So thank you. We will now highlight some ways that you can stay connected. Next slide, please.

To learn more about the IBH Model, visit the IBH webpage or contact the model team via email, both of which are in the chat. For additional updates from CMS, sign up for the CMS listserv and follow us on X, or Twitter. Next slide, please.

This concludes today's webinar. Thank you so much for joining us today. We hope that the information was helpful. As always, we look forward to continuing to connect with you all and please stay tuned for a follow-up email.

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