Innovation in Behavioral Health (IBH) Model
Notice of Funding Opportunity (NOFO) Office Hours
August 7, 2024

Isaac Devoid: Alright, I think we can go ahead and get started. For those of you who didn't attend last time, my name's Isaac Devoid. I'm a co-model lead for the IBH Model, and I'm joined by our other co-model lead, Sarah Grantham, on the line today, as well as several members of our team.

Just want to say thanks again for taking the opportunity to join into the IBH Model Notice of Funding Opportunity Office Hours. Like last time, before we dig into questions, we just wanted to share a couple of housekeeping items.

You could turn to the next slide please, Hayli.

I just wanted to let people know that the zoom is being recorded. So, if you have any objections, feel free to hang up now. The recording slides and a transcript from today's session will be made available on the IBH Model website after today's event.

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So, for today's session, we're only going to be answering questions related to the IBH Model Notice of Funding Opportunity. You'll hear us call that the NOFO for short throughout this webinar. We'll also talk about the NOFO application and application process as well.

We have received a wide range of questions that our team used to identify some common topic areas for today's call. And for each identified topic, we'll address a few pre-identified questions before opening the floor for live questions and answers.

So, for instance, we're [going to] start by answering application timeline questions that we've received and then we'll open it up to receive live questions on that topic. So, we will use that same process for each topic that we will cover today.

We also welcome questions outside of the topics covered, again as long as they're related to the NOFO application process.

And if you do have a question to ask during any of the live Q&A portion of today's session, we just ask that you please type your question in the chat box or use the raise hand feature. Also, please introduce yourself and where you are from before asking your question.

We sincerely appreciate your engagement and patience today, so we can best understand how to support your state and partners to participate in the IBH Model, and if we run out of time, or we are unable to address your question, we will respond to any outstanding questions through our IBH Model mailbox, future office hours, and updated frequently asked questions on our IBH Model website.

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And before we start off with questions, we wanted to provide some really brief guidance on navigating the NOFO itself, given the size and complexity of the document.

So, on Page 2 of the NOFO you can find the table of contents, which is incredibly helpful to navigate to key sections within the NOFO. We also recommend utilizing the control F feature of your keyboard to search for key terms within the document. This slide also provides information on where you can find some key topics within the document.

When it's applicable today, we will cite the relevant NOFO section where you can find additional information on the topics discussed.

I'm now [going to] pass it over to Sarah to answer some commonly received questions on application and selection timelines. Sarah, over to you.

Sarah Grantham: Hi, everybody. Thanks a lot to Isaac and all of you on the call. As Isaac mentioned, we're going to kick off today's session with a few questions about the application timeline.

So, we'll start with this one. What is the timeline for future NOFOs?

And there is only one planned funding opportunity for the IBH Model at this time. That NOFO is currently open, and the applications are due on September 9th of this year by 11:59, Eastern Standard Time, and that is described in Section D4 of the NOFO. We do recognize that some other CMS Innovation Center models will have multiple cohorts, but that's not planned for the IBH Model. Considering this, if you're interested in applying to the IBH Model, please be sure to do so under the current NOFO.

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Here's our next question. Is there a timeline for selecting the eight states that will participate in the model?

The answer to that question is, yes. CMS intends to issue Notices of Award by December of this year, and the IBH Model's launch and performance period are expected to begin on January 1st, 2025.

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After states have applied through the IBH Model's NOFO and CMS selects participating states, we've gotten this [question] about the next phase involving funding. When will funding begin?

That's probably one of the most important questions everybody wants to have answered. The model will have an eight-year performance period. This includes a three-year pre-

implementation period that goes from 2025 through 2027, and after that is a five-year implementation period, and that runs from 2028 through 2032. Up to $7.5M in cooperative agreement award funding will be available to each selected state recipient over the course of those eight years, and states will receive funding in both the pre-implementation and implementation period.

These funds support the development of key model activities. This includes, but is not limited to, developing the Medicaid Payment Approach, the care delivery framework, and also supporting key data sharing and infrastructure activities.

Section B of the NOFO details the funding available for each of the eight budget periods, and we'll put that up in chat.

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At this point we would like to open it up for live questions related to the application timeline. As Isaac mentioned, please put your questions in chat, or use the raise hand feature, and we will ask you to unmute yourself to ask a question. Either way, please let us know who you are and where you're from.

I think Isaac and I are just taking a moment to read this through. Okay.

Isaac Devoid: We did receive a question through the chat about how Medicaid-only MCOs would be able to receive funding for handling IBH Medicaid-only enrolled members. And then the question submitted also noted about the Medicare integration support payment, or ISP, and that ranging between $200 to $220 per-member-per-month. That'll come directly from CMS.

So that's a great question. Here, what is really [going to] happen is that the state is going to develop a Medicaid Payment Approach that is directly aligned with the Medicare Payment Approach, or the ISP, like I just mentioned, like we like to call it. So that Medicaid Payment Approach that they're going to develop, like I mentioned, needs to reach directional alignment, and that means that the Medicaid Payment Approach really should align with the Medicare Payment Approach on a few key details like quality measures, the services that are included, and so on. We provide more specifics on that in Section A4.4 of the of the NOFO, but the state in the pre-implementation period will work very closely with CMS and other partners, especially those within their convening structure, to develop a Medicaid Payment Approach that includes all the IBH Model services. So those are care integration, care management, and health equity, and one that also really fits the state's unique context. So, it'd be great if that one is, you know, adapting from an existing approach the state's using, or really is in alignment with some of the state's goals around, perhaps value-based care. And that funding, or the Medicaid Payment Approach, would use an existing or new authority, either a state or a federal authority. So, thinking about authorities like state plan amendments, Medicaid managed care contracts, or other potential waiver authorities.

Definitely let me know if that doesn't answer the question. I'm happy to try and massage that a little bit more.

Sarah Grantham: Yeah, Isaac, if you wouldn't mind, I'd just like to chime in, because I think part of the question involves sort of how the payment would flow for Medicaid beneficiaries. So, in that case, the payment would go from the state to the managed care entity, [because] I know that the person who asked the question asked about managed care, and then on to the provider. So that's the way that the flow would go, from the state, to the MCO, to the provider.

And then I see that Robert Myers raised your hand. Thank you very much. Please unmute yourself and let us know where you're from.

Robert Myers: Okay. Can you hear me now?

Sarah Grantham: Yep.

Isaac Devoid: Yep.

Robert Myers: I'm Robert Myers. I'm from the New York State Office of Mental Health, and I actually had a three-part question related to Medicare. The first question is, it appears from the application that CMS will have three different funding streams coming to Medicare fee-for-service recipients in the participating providers, if you could describe those three streams?

The second one is, CMS in general has a goal to try to move as many Medicare people into managed care as possible by 2030, in their strategic plan. So, is there any possibility or option going forward that eventually the dollars you would make available through Medicare fee-for-service could also be made available if somebody's in a dual plan?

And then the third question is, will any of the money that you're moving through Medicare to the participating providers be available after the eight years?

Isaac Devoid: All great questions, Robert. Thank you, and appreciate you coming off mute and asking some questions.

So, the first question I can start with, and that was in regards to the funding streams that are available to Medicare providers. So, the first one, like I just mentioned, is the Medicare integration support payment. So that payment is a prospective per-member-per-month payment for providing IBH Model services. Like I just mentioned, those are care integration, care management, and health equity. And the payment is expected to range between $200 to $220 dollars per-member-per-month for that payment, for beneficiaries that are engaged in IBH. So, that would be what I'd say the first funding stream is.

And then the other funding stream that's part of the model for practices that participate in both Medicaid and Medicare, so those practices would be serving again, both Medicaid and Medicare beneficiaries, is called Medicare infrastructure funding. And that's funding that's provided directly from CMS to practice participants for any sort of infrastructure that practice needs to deliver integrated care. So, some examples of that would be health information technology

funding, like electronic health records. We'd also think about things like population health management tools. And then we might even think about practice transformation activity, so things like improving workflows within offices, staff retention and improvement, things of that nature.

So those are really the two funding flows that we have on the Medicare portion of the model. Before I jump into question number two, does that answer that portion of it, Robert?

Robert Myers: Oh, can you still hear me?

Isaac Devoid: Yeah, yeah.

Robert Myers: Yes. Well, is that funding time limited? Does it end in part of the eight-year period?

Isaac Devoid: For the infrastructure funding?

Robert Myers: Yes.

Isaac Devoid: Good question. Yeah, so that will start in the pre-implementation period, and it's really based on a practice needs assessment. So, each practice would do a needs assessment, and that would determine the amount of funding that a practice would get. And we would distribute that annually through Model Year 5.

Robert Myers: Thank you.

Isaac Devoid: Yep, absolutely.

Sarah Grantham: And then sorry, just chiming in. The ISP, that support payment is delivered during the period of time when providers are actually providing care in IBH, from Model Year 4 through Model Year 8.

Robert Myers: Okay, and then the I had the other question related to, will any of this continue after the eight years?

Isaac Devoid: Definitely a great question. So, our charge is, CMS, at the Innovation Center, is to test these innovative payment and service delivery models. So, it, you know, certainly could be something that, if our office of the actuary determines it to be, you know, effective, that it could be scaled up across the nation. However, there's certainly, there's no guarantee of that. So, it really depends on the determined effectiveness of the model throughout the five-year implementation period.

Robert Myers: Isn't that actually, I was focused on isn't there also part of the model, in the alternative payment model that you have laid out in the Appendix that you want the state

Medicaid authority to mirror, that eventually you'll be revising reimbursement for pay-for-reporting, and then to pay-for-performance? So, my question would be, after the eight years, would that reimbursement methodology continue? Would you still be participating on the Medicare side for pay-for-reporting, and then pay-for-performance?

Isaac Devoid: Yeah, it's great question. So, on the on the Medicaid side, absolutely one of the goals in developing the Medicaid Payment Approaches alongside state partners is to really develop a payment approach that is sustainable. And that's why really thinking about, you know, adapting or developing payment approaches that are in line with the states' existing objectives in regards to value-based payment. So, we certainly hope that, after the model—and that'll be a really key goal of technical assistance—that both the Innovation Center, different contractors, as well as our Center for Medicaid and CHIP Services will be providing, just to ensure that this is a sustainable payment approach into the future.

Robert Myers: And so, you, the Medicare side, would potentially still participate in the value-based model for a shared savings?

Isaac Devoid: That would really depend on the results of the evaluations and, like I mentioned, how our office of the actuary determines the model to meet the model test. And if successful, yeah, there definitely can be some sort of scale and spread of the of the payment model.

Robert Myers: And then my third question was related to, as people move into Medicare manage care products or dual products over the eight-year period, with CMS' encouragement more and more Medicare fee-for-service people will probably be moving into these insurance products. Is there any possibility that CMS could provide the Medicare component of your assistance to these participating providers, if a portion of their Medicare and dual people are in managed care products? Is my question clear?

Isaac Devoid: Yeah, totally. It's a great question. At this point, the model will be limited to Medicare fee-for-service. What I can say at the moment is that we're [going to] continue to be as transparent as possible in the ways that we're developing payments and we are aligned, like the different approaches that we're taking. And we really hope that states take the convening structure opportunity to take pre-existing relationships with payers, including those commercial payers, to really try to, you know, align into the model. A lot of the payers could voluntarily align into the model and develop an approach that's similar to IBH, so that it really creates a synergy and a multi-payer alignment across those different payers within a state.

Robert Myers: So, in other words, you're saying for the dual products and the Medicare managed care products, it would probably be up to the collaboration between the state, CMS, and the convening structure, and the particular insurance company, about whether they would redesign their reimbursement to align.

Isaac Devoid: Yeah, it'd certainly be an option for payers to voluntarily align into the model.

Robert Myers: Thank you. This has been very helpful.

Isaac Devoid: Yeah, absolutely appreciate the questions and definitely let us know if we can answer any more.

Yeah, I see that we have another person raising their hand, please feel free to jump in.

Vinayak Sharma: Hi, good afternoon, everyone. So, I apologize if my question is kind of redundant because I couldn't join at the start of the webinar. But my question is, when is CMS [going to] announce the mandatory states for this particular program?

Isaac Devoid: We anticipate announcing the selected states sometime in December of 2024.

Vinayak Sharma: Okay, thank you very much.

Isaac Devoid: And no problem at all. We hadn't announced that yet, or we hadn't noted that yet on this call, so.

Vinayak Sharma: Okay. Thank you.

Isaac Devoid: Awesome, then I think we might have another couple of people with questions, yeah, absolutely jump in.

Neelam Brar: Hi, thanks for this webinar, my name is Neelam Brar. I run a company called totallife.com. We focus on teletherapy for seniors nationwide, working predominantly with Medicare patients, and it's very accessible, because rural seniors [that] work [and] live in rural areas, have trouble accessing therapists in person. So, my question is, with this program, do provider networks have to be enrolled in Medicare or could they act as a vendor to the state, powering the solution? And the second part is, is telehealth only or teletherapy okay, or is a physical in-person requirement needed for every partner to the state?

Isaac Devoid: Those are great questions, and I might just need to take those back and work with our telehealth SME on those, if that's alright. And we can certainly follow up if you wouldn't mind sending an email to our model inbox. We also have the message that you sent through the Q&A here but just want to ensure that I'm not missing any portion of your question, and we can follow up there, if that sounds alright.

Neelam Brar: Yeah, I've been emailing since January, and I never heard back. So, I can send another.

Isaac Devoid: Oh, sorry to hear that. Yeah, sorry, we can definitely follow up with you and definitely let us know, but feel free to bump up the prior emails if we had missed those. And yeah, sorry about that.

Neelam Brar: No, we've been, as a company, we've been really excited about this because we see the true impact that we're having on seniors nationwide and we would love to also work with the Medicaid, Medicare, dual eligible patient population.

Isaac Devoid: Yeah, absolutely. Awesome, well thank you so much for the question. Michael, it looks like you have a question.

Michael Ghods: Yes, thank you so much. Hi, Isaac, thank you for your time. My name is Michael Ghods. We have a stand-alone brick and mortar clinic in Los Angeles, and my question is, do we have specifics as to, I've read through the material that you guys, you know, put out. It sounds like, you know, we're trying to do a lot of good things in terms of improving the care. Do we have specifics as to like, what we would need to do differently, what investment we would need to make from a financial standpoint? And then how you guys would support us financially? Like, do we have specific numbers on how it will all work out, if we're selected?

Isaac Devoid: Yeah, and just want to clarify, Michael, you're coming from a behavioral health practice. Is that right?

Michael Ghods: Correct.

Isaac Devoid: Awesome. Yeah, definitely a lot of different streams for us, for, you know, CMS support for behavioral health practices. Like we mentioned beforehand, there's infrastructure funding that's provided to behavioral health practices participating in the model. The infrastructure funding will be for activities to help behavioral health practices deliver person-centered integrated care, so those could include things such as health IT upgrades, so upgrading or maybe adopting an electronic health record, practice transformation activities, so, improving workflows. It could also be things like population health management tools. And, if you're participating in IBH as a practice participant, you'd also receive a Medicaid payment from your state Medicaid agency. That would be for providing care management, care integration, and health equity services to beneficiaries to really provide, like I just mentioned, that person-centered, integrated care.

Michael Ghods: Okay, so that would be, and that would be both sides of it, both CMS and both Medicaid and Medicare would both through this program.

If we apply, and we are selected, we would be able to get funding through both of those branches. And then it sounds like we're not yet in the stage where things are specific. We're like, you're not telling me like, there's, you know, an X dollar amount that we will pay towards X, an X dollar amount towards X, it's just like in general, you guys, the point is that there's [going to] be, you guys are [going to] support the practice to achieve these goals and there's [going to] be, it's a little bit like it's open ended as to what, how we will be able to achieve those ends right?

Meaning like you mentioned, like you know, if it's IT like, we know we can go through like a certain vendor to pick the IT that will, you know, that will help in with the specific improvement, and then that would be subsidized or paid for through either Medicare or Medicaid. Am I understanding it correctly?

Sarah Grantham: Yeah, let me kind of help understand a little bit better, help you understand a little better. In terms of the model, the model serves Medicaid beneficiaries first. So, from what I understand, it sounds like you provide care for Medicaid beneficiaries, which is great.

Michael Ghods: So, we do both. We do traditional Medicare, we do a lot of Medicare HMO, and then we also do Medicaid. Medicaid tends to be, you know where we are in Southern California, Medicaid almost exclusively is either [going to] be in a health plan or an IPA. It's [going to] be in an HMO model, you know.

Sarah Grantham: Okay. So, the model, the IBH Model, is designed to serve Medicaid, in whichever capacity, you know, whether it's fee-for-service or managed care, so that makes complete sense. So, providers first participate through their Medicaid beneficiaries. So, the state would identify you as eligible to participate, because states are required to recruit. States would identify you as eligible, based on their own recruitment strategy and their own eligibility criteria. And on the top of that list was, do you serve Medicaid beneficiaries? So that's great, check. Glad to hear that.

The state is given cooperative agreement funding, and they are asked to set aside $100,000 for each participating provider to provide the kind of infrastructure support that you're talking about. So, that $100,000, that amount is sort of a, they're asked to set that amount aside, and then there's a state provider needs assessment that the state will ask providers to complete. And based on that, they would award the amount of money. It could be 100,000, it could be less, it could be more. We don't know. It's just a set aside that we ask states to make.

And then, after you've gotten into the Medicaid side of the model, I also hear that you serve some Medicare beneficiaries. If you serve Medicare beneficiaries in fee-for-service, not in MA, but in fee-for-service, then you, as a provider, can apply to participate in the Medicare side of the model.

If you participate in the Medicare side of a model, you will also be asked to complete a provider needs assessment. That will be for CMS purposes, and CMS could award you up to $200,000 for that infrastructure support that you were just talking about. So, we are trying to encourage Medicare fee-for-service beneficiaries to get greater access to these behavioral health services. And so that's why you'll see that there is an incentive on both on the Medicare side of the model as well as the Medicaid side of the model. Does that make sense to you? We're trying to kind of fill in some of the details you asked about the dollar figures.

Michael Ghods: That was that was perfect, yeah. Thank you so much. So, my only remaining question is just to get access to this, to initially the Medicaid, state, and then the Medicare, CMS, you know, potential 100K, potential 200K, in order to get access to that, that goes through an application? And that's just that's all this same application? Is that correct?

Sarah Grantham: Kind of sort of. So, the key piece for providers to be aware of is that the state applies to participate in the model. I understand you're in California, so California would need to apply and be accepted to participate in the model. And then California would be recruiting

providers to participate. And we have eight states that that could apply, and eight states could be accepted to participate.

Michael Ghods: Got it, okay. So, that's all out of my control. So, whether California gets accepted or whether they choose me, there's nothing I could do to influence that. So, the only thing that's in my control is to just apply before the September date to this program, and then the wheels will roll and things will happen, and I will get accepted or I won't get accepted, right?

Sarah Grantham: So, no, sorry. So, the state of California needs to apply by September 9th. So, your role would be, you could let the state know, if you want to, that you're interested in this model, and you'd love to be a participant. So, that's what you can do. That's what's within your control. The state gets to, it's the state's job to apply if they wish, if they feel like it works for the state-specific context. With that I will–

Michael Ghods: So, the application, so the actual application that's on the website, at this point, there's nothing that we would, the application that are due September 9th, that's for the state. So, there's nothing that as the individual practice, at this point, this is just informational, and there's nothing I need to do until further notice.

If I find out that California does get accepted, then I would need to then make an application, is that right?

Sarah Grantham: Correct, September 9th, yes, it's a state deadline.

With that, I do see, thank you, I do see we do have another raised hand. If we don't mind, let's just kind of go through a few more of the questions and answers that we have sort of prepared [because] it might answer some more of the audience questions, and then we get back into the live Q&A. So, with that in mind, let's move it on to the next slide, and back to Isaac.

Isaac Devoid: Yeah, I just want to say a thanks, a huge thanks, a lot of good questions coming in and we definitely appreciate it. Thanks for your patience as we answer some of those and might need to get back to folks.

So, kicking us off on our first question on the application and selection process topic is, does the grant application have to be submitted by the state entity or can individual providers, practices, and care settings apply?

So, great question. Only state Medicaid agencies from U.S. states, territories, and the District of Columbia are eligible to apply to the IBH Model. However, individual providers, practices, and care settings can reach out to their states to note their interest in the model and to inform a state's potential application.

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So now that we've covered which entities are eligible to apply, we want to expand on the selection process further with this question, so that is, are there any states or groups that are particularly positioned for success in the model?

So, the IBH Model will use a competitive application process that includes a merit review of all applications using a detailed rubric. And the scoring criteria is detailed in Section E1 of the NOFO, and it includes the following factors, so those are characteristics of the proposed model service area and model population, organizational capacity of the applicant organization, model intervention, Medicaid Payment Approach, behavioral health practice recruitment strategy, health IT implementation plan, sustainability plan, budget impact analysis, and budget narrative.

CMS will definitely consider the geographic diversity and scale of all applications, as well as the quality of applications, in making final award determinations. We'll also consider states' participation in other CMS models, to diversify entities receiving awards.

And we know that states are definitely at varying points as they develop their approaches to behavioral health integration and value-based payments. The IBH Model is well suited to states with varying levels of capacity and experience and we're thinking of states with limited or no experience in designing and implementing integrated care approaches, as well as states with lots of experience.

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So, the last application and selection question we identified for today's session is, will the Innovation Center move forward with the IBH Model if less than eight states apply for the model?

And so, as we touched on earlier, we intend to issue cooperative agreement funding through the NOFO that is currently open, regardless of the number of applications received. So, in other words, this is a great opportunity you definitely don't want to miss out on to receive financial, technical, and learning support to innovate in this important field.

Next slide, please.

Alright, so we're now [going to] open it back up for some live Q&A. Please put your questions in the chat or use the raise hand feature like everyone has been. And either way, when you ask a question, please be sure to introduce yourself, and where you are from.

Robert, I see you have your hand raised. Feel free to jump in.

Robert, if you're talking, you might be on mute.

Robert Myers: Yes, I'm so sorry.

Isaac Devoid: No worries, I do that all the time.

Robert Myers: Again, I'm from the Office of Mental Health with New York state. We're working collaboratively with our single state agency and our substance use agency, and we're actively working on the application. So, we have several questions related specifically to the application. I just didn't want to dominate the first time I was on. But we have, I have, like four other questions I could just lay out real quickly. If you want me to do one at a time, just let me know.

But in it, you have the three metrics, you know, diabetes, hypertension and tobacco, and that's how you're [going to] evaluate progress towards integration. But you say the states are open to adding additional metrics. So, the question would be, if a state added additional metrics, would that be factored into your scoring? Would you get enhanced scoring if you had additional metrics?

Isaac Devoid: It's a good question. And when you say the three metrics, do you mean like the priority health conditions, [because] you noted diabetes?

Robert Myers: Yeah, so, that's what I meant. And then you actually listed some other suggestions, you mentioned HIV and you mentioned some other things. So, the question was, if this is in the application, the state indicated that they would be interested in adding an additional health condition, I know you wouldn't be evaluating it. Would that, would it be factored into the scoring that the state was adding an additional health condition?

Isaac Devoid: Yeah, it wouldn't necessarily be factored into the scoring. But I will say, the application scoring is definitely holistic and it's, I think that there's a lot in the application that exhibits when applicants are showing how, you know, data, and that they're making data informed decisions based on some of the characteristics of their proposed model service area and model population, and how they're using some of the data identified throughout the application process to really inform their application. Does that make sense, Robert?

Robert Myers: Yes, it does, it does [because] it sounds like you're [going to] do scoring but then you're [going to] also look at the response from a broader perspective.

The physical health consultant that you're requiring either be embedded in the behavioral health participants or be virtually connected, how is that paid for? You talked about some billing codes, is your thinking that that individual's participation would be paid for by that individual being able to bill for consultation or not? It wasn't clear about how that was paid for.

Isaac Devoid: Yeah, definitely. And I think it will often depend on the type of approach that states are taking to integrating behavioral and physical health. So, we definitely know that there's a wide variety of approaches to do that, you know. There's telehealth, there's co-location, and all these different bits and pieces. We definitely think this is an area that states have an opportunity to innovate on in their Medicaid Payment Approach as they develop those payment approaches and there's also a lot of different ways that states can do that via existing flexibility documents like, if you look at the Interprofessional Consultation State Health Official letter, that's definitely an area that I think states can utilize to make those payments to physical health consultants

easier, but I think at the bottom line those physical health consultants, at least on the Medicare side, would be paid as regular for physical health services being provided.

Robert Myers: So, what you're really saying is that if you're selected, in the front-end design phase, we could work with our convening structure and the CMS consultant to determine how it would work in the particular, in say, in our case, New York.

Isaac Devoid: Yeah, definitely think so. I think it's an area where, as you design the, as an applicant or a recipient designs their Medicaid Payment Approach, they can definitely work with CMS to design those various aspects.

Robert Myers: Two more quick ones.

Sarah Grantham: Wait. Sorry, Robert, so, Robert, can I chime in, please, on this particular question before we go on? Thanks. I just [want to] reiterate what Isaac had said about how the Medicaid Payment Approach that the state is designing aligns with the Medicare approach, that's part of the IBH Model.

And so that includes the ISP, that on the Medicare side the integration support payment covers care integration, care management, and health equity, and that is payment on top of what specialty behavioral health practices currently receive for delivering behavioral health care. And so, we do, it's not a global payment at all. It is a very narrow band of services. So, CMS anticipates that Medicare providers will continue to get payment the way they have ordinarily gotten payment in terms of like, the physical health provider, they would bill on the physical health side and then on the Medicare side, they'd get this PMPM payment on top of what is ordinarily provided. So, I just wanted to clarify that so you can understand, it's not a global payment.

Robert Myers: We, we understand that, and I think the thing that we were struggling with is, this is a consultant, if we're understanding the role properly. You're having a physical health consultant prescriber collaborating with the team in the behavioral health provider participating agency and they're not actually providing care, they're advising on the physical health side and facilitating connections to the affiliated primary care practices. So, we would have to come up with billing codes that you could bill for that. It's not billing directly for treatment. It would be more like participating in screening and referral. So, you know, I don't think we need to talk about it more. I'm just kind of saying it. That's what we were confused with, how would we bill for that role versus direct care.

You understand what I'm asking?

Isaac Devoid: We can dig into this a little bit more too, Robert, and follow up on our next office hours, or send an email for sure? Yeah.

Robert Myers: Right, [because] obviously that would be, if we're selected and we're recruiting providers and they know that this is requirement, they'll [want to] understand how it's paid for. That's the way we're thinking about it.

In the Medicare piece, you talk about as people are attributed, there's a consenting process, and I guess the question is, on the Medicaid side, will you require a consenting process? And if so, could it be a opt in with the ability to opt out, you know, do you have any direction on how you would work with the state on a consenting approach for the Medicaid population?

Sarah Grantham: We're still working that piece through. We don't have an answer to that question right now, sorry.

Robert Myers: That's helpful. And then just the last part is you do talk about CHIP, is the state, as we're doing our analyses of the– In the application, you're asking for us to project the number of participants that would be in the demonstration over time. Would, or, is the state, if we choose to, are we allowed to exclude CHIP, or if we apply, would CHIP automatically be part of it?

Isaac Devoid: I can jump in, Robert. So, the model is only for adults, age 18 years or older, with moderate to severe behavioral health conditions. So, CHIP wouldn't be an eligible population if a state was participating.

Robert Myers: Okay, okay, when we were working with our fiscal people, there was a reference to CHIP in the document and that's what confused us. So that's helpful, thank you.

Isaac Devoid: Yeah, absolutely, absolutely. And you know, to some of the prior questions you mentioned about developing payment approaches or even on consent, one thing I definitely just flag is we have a three-year pre-implementation period to really work with state recipients, so a lot of these questions, you know, definitely a good on ramp to work through some of those pieces in that pre-implementation period, very intentionally designed so that there's a plenty of time to develop approaches and have an on ramp for practices.

Robert Myers: Oh, okay, maybe this is really a follow up question to somebody else that asked in terms of the funding, and one thing that was a little unclear to us. You indicated that the $100,000 set aside to each participant. We assume that's a one-time $100,000, and not 100,000 each of the eight years. But it also said, for Medicaid-only participants. So, the question would be, if a provider is a Medicare, you know, enrolled in the Medicare program, and they're [going to] do an agreement with you to get the Medicare funding, and they're also a Medicaid provider, would that would the state have to allocate the $100,000 necessarily to that provider if they were getting the $200,000 that you talked about. Then the follow up would be, if they had to do that, depending on how many participating providers the state had at $100,000 a pop given the $7.5M, it could start to add up.

So, depending on what your answer is to the first question, that other question would be relevant. But, do you see what I'm asking? If it's a provider that's Medicare, Medicaid, they participate, they do the agreement with you to get the direct payment of the 200, is the state obligated to also give them the 100?

Isaac Devoid: Yeah, I can definitely jump in. Sarah, is it alright? I think we have a question on infrastructure funding that we teed up for later, and I can walk through that because I think it's definitely an important distinction here.

So, infrastructure funding is funding that's provided directly to practice participants to enable the delivery of integrated care for activities, including but not limited to health IT upgrades. So, thinking about those pieces, population health management tools, practice transformation activities, and so on, and with that grounding can definitely provide a little bit more information on like the operations of it.

So, state recipients will implement a standardized needs assessment process to determine the amount of infrastructure funding provided to each Medicaid-only practice participant, since those practice participants will receive infrastructure funding from the state recipients. So, this amount will vary between practices based on the results of the needs assessment. So, I just really want to reiterate that part, that no matter if you participate in just Medicaid or Medicaid and Medicare, there will be a standardized practice needs assessment process and the results of that needs assessment process will really guide the funding that a practice would be receiving for infrastructure funding.

We estimate that states should budget about a $100,000 per Medicaid-only practice participant, as those practices would receive that funding directly from the state. The states wouldn't have to budget if they know that a practice is intending on participating in both Medicare and Medicaid, because those practices would be receiving that funding directly from CMS.

There's a bunch more detail on this in Section A4.5 of the NOFO, so I'll just note that.

Practice participants that do participate in, like I just mentioned, Medicare and Medicaid Payment Approaches, they'll receive their infrastructure funding directly from CMS and they'll receive it up to $200,000 in infrastructure funding. And again, that'll be determined through that standardized needs assessment process.

And we anticipate providing that funding annually, and that is not $200,000 annually. This will be a certain amount of it based on the practice needs assessment. So, for example, it could be $50,000 a year over a period of years, for that infrastructure funding.

And with that, Robert, I've been talking a lot. Does that answer your question?

Robert Myers: Oh, okay, I was muted, but now I'm unmuted. I was just saying, yeah that was that was very helpful. Thank you.

Isaac Devoid: Yeah, absolutely.

Sarah Grantham: Isaac, I wonder if this might be a good time for us to move into the provider and practice involvement questions.

Isaac Devoid: Yeah, absolutely, you want to jump in there Sarah?

Sarah Grantham: Okay. Yeah, please. One common question we received is, how can interested providers and practices find out if their states have applied?

As I sort of touched on earlier, now is an important opportunity for these entities who are interested in their state's participation in the model to reach out directly to your state Medicaid agency to find out if your state plans to apply. Reaching out to your state Medicaid agency directly will also inform them of your interests and give them the opportunity to engage with you in the process. For CMS though, unfortunately, I'm not able to provide this information until, none of us are, until a formal public announcement is made on that.

We have another question, thank you for forwarding the slides, which is based on questions that we've received from the audience over the last few weeks. It's clear, as we've heard from others on this very call, that providers and practices are very eager to participate in IBH, and we're really excited about that. When and how can providers get involved?

So, I sort of spoke about this earlier, but I'll just kind of for clarity. So, after CMS awards the cooperative agreements to states, those selected states, up to eight of them, will recruit the specialty behavioral health providers and practices to participate in the model, and we refer to those entities as practice [participants] in the NOFO.

States can recruit practice participants on a continuous basis for Model Years 1 through 4. That's from 2025 through 2028. So, if you're a provider and you're interested in participating, you know you can do, you can, you know, engage with your state from that time period, from Model Year 1 through 4. Once states select practice participants, those providers will establish infrastructure improvements from Model Years 1 through 3, during the pre-implementation period. That's from 2025 through 2027. And then, during Model Years 4 through 8, in the implementation period, practice participants will provide IBH Model services to beneficiaries. That is from 2028 through 2032.

Next slide, please.

Now that we've covered how practice participants can get involved in the state's IBH Model, we'll get to our next question, which is, how are states reaching out to practice participants to engage in IBH Model and design?

So, each state will have an opportunity to develop a practice participant recruitment approach that fits their own state specific context and needs. While that recruitment strategy is in the hands of the state, the NOFO requires states to describe how they will engage a number of different types of providers in their recruitment strategy. Specifically, CMS wants to understand how states will engage with rural providers, safety net specialty behavioral health providers, under resourced providers, tribal providers, and private providers serving vulnerable populations. And participating states should also consider including state mental health authorities, single state agencies for substance use disorders, managed care organizations, and risk-based prepaid inpatient health plans and other intermediaries when they're developing their recruitment strategy.

Okie doke, next slide, please.

The next question that we had is about how, what practices can participate in delivering IBH Model services, and we kind of touched on this a little bit earlier. But let's just kind of dig it back in a little bit more. So, can practices that serve Medicaid, Medicare, and private insurance be included?

The answer is, yes, those practices can participate, though I need to share some important clarifications. First, practices must be recruited and selected by their states to participate in the Medicaid Payment Approach, and that's described in our NOFO. And second, for practices that serve a variety of patients with different types of insurance, payment for IBH Model services will be provided for patients who are attributed to the IBH Model. Those include attributed Medicare, Medicaid, and dually eligible patients. In other words, for the practice that serves Medicaid, Medicare, and private insurance, payment for IBH Model services is not for [beneficiaries] with private insurance. This includes [beneficiaries] who are enrolled in Medicare Advantage Plans.

Drilling down into this question a little bit further, states recruit practices that serve Medicaid beneficiaries. Those practices have the option to participate in the Medicare Payment Approach, if they already serve Medicare [beneficiaries] or they want to serve Medicare [beneficiaries]. And those who are interested in starting to serve those Medicare [beneficiaries] must participate, must respond, to the CMS Medicare Request for Application, or RFA for short. That has not been released yet. We expect to release the RFA sometime in 2025.

And as for our commercial payers, CMS will continue to be transparent about IBH Model design elements, and that way those interested commercial payers can voluntarily align with the IBH Model. Just wanted to remind folks on the call that for a complete list of those practice provider eligibility criteria, please see Section A4.2.1 in the NOFO.

Next slide, please.

Okay, so this is a good time for us to open it up again, so we could answer any further audience questions on provider and practice involvement. Just please raise your hand, and we can also look in the Q&As for your question in chat.

Isaac, I'm just kind of reading through as we speak, so feel free to jump in if you wish.

Isaac Devoid: Yeah, I don’t think we currently have any open questions and answers. Yeah, feel free to type any more, and feel free to raise your hand and come off mute as well.

Sarah Grantham: As we are waiting for folks, if they have any other questions, we just want to say this is, we consider this very good, if folks don't have a million questions at this moment. But we'll just pause. You know, we're [going to], [for] just a couple of more minutes give folks a chance to answer any questions before we close up for today.

Everybody, I think we're [going to] start turning to our closing. Hayli, if you could, please move to Slide 26. We just wanted to share some additional resources for folks on the call. Wanted to let you all know that we are routinely updating our model website with different resources to support states and their efforts to submit a strong and robust application.

That our mailbox is also always available, if you have additional questions after today's session, and we will certainly do our best to answer timely. We appreciate everybody's patience on that.

These additional resources that are on the slide can also be found on the IBH Model website, which is linked in the chat box, and they will also be available to link on directly, once we've added the deck to the model's website in the coming week. For additional updates, you can also sign up to the listserv for IBH Model and find us on X, formerly known as Twitter.

Last slide, please.

Thanks again to everybody for attending today, and we hope you join us for our next office hour session. It's scheduled to be August 22nd from three to four o'clock p.m. Eastern Standard Time.

Again, thank you, thank you, thank you for participating. This is really helpful for all of us when we're trying to be responsive and to meet everybody's needs. I know a lot of people have a lot of different interests, and we really appreciate not only, you know, states, but also providers and others who are interested in the model. We feel like it's [going to] take a lot of partners here to do this important work in this space, so we really, really appreciate everybody's engagement in this call, and even outside this call.

Okie doke. With that, thank you very much, everybody. Really, really appreciate the time today.