Innovation in Behavioral Health (IBH) Model
Notice of Funding Opportunity (NOFO) Office Hours
July 25, 2024

Isaac Devoid: Alright, I think we can go ahead and get started. So, good afternoon everyone. My name is Isaac Devoid. I'm a co-model lead of the IBH Model here at the CMS Innovation Center. I'm joined today by Sarah Grantham, my other co-model lead of the IBH Model, as well as several members of our team.

Before we dig into questions, we did want to start with some housekeeping. So first, this Zoom is being recorded today and if you have any objections, please hang up at this time. The recording slides, as well as the transcript will be made available on the IBH model website after today's event. And we will only be answering questions related to the IBH Notice of Funding Opportunity, or NOFO for short, as well as the application process, requirements for application and participation in the IBH Model.

Today we're gonna start by walking through some commonly asked questions we've heard from stakeholders recently and then afterwards we'll take some live questions and answers.

We'll do this for each section. So, for example, we'll start by answering a few commonly asked questions we've heard relating to eligibility, and then we'll open it up for live questions and answers on model eligibility. We'll then transition into questions on the care delivery framework, quality measurement and evaluation, funding and payment, and finally to existing initiatives.

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

We may not be able to answer every question today, but we really appreciate everyone's patience and if we don't get to your question, we definitely plan to answer additional questions via the IBH Model inbox, future office hour sessions, and through upcoming frequently asked questions documents that we'll publish to our model website. Next slide, please.

So again, before we jump into questions, we just wanted to go over the different sections of our NOFO given that it's a really large and expansive document. So, on Page 2 of the NOFO you can find the table of contents which is incredibly helpful to navigate to different NOFO sections. I think the control F feature, using that in adobe or whatever you're using to look at the NOFO, can really help to find specific sections or keywords that you might be looking for as well. And to really help engage more with the NOFO what we'll do is when we answer questions today, we'll try to cite the specific NOFO section where more information is available.

In addition, our slide here exhibits where you can find some of the key sections that we're gonna refer to throughout the NOFO today. Again, the slides from today's recording will be available as soon as possible after the event concludes. And with that I'm going to pass it over to my co-model lead, Sarah, to answer some commonly asked questions on application and eligibility. Next slide, please.

Sarah Grantham: Thanks so much, Isaac, and I'm very glad to be with you all today. Thank you for joining us. I'm gonna present four commonly asked questions and answers about eligibility for the IBH Model, and we'll start with this one about the eligibility of IBH practices in a range of different settings.

Can a behavioral health hospital, a county hospital, or nonprofit facility be a program participant?

To be eligible for the IBH Model, specialty behavioral health practices must provide mental health and/or substance use disorder treatment services at the outpatient level of care.

Specialty behavioral health practices within the IBH Model state's proposed geographic area will be eligible practice participants, and that is, if at the time of their application they fulfill the criteria that is outlined in Section A4.2.1 in the NOFO. That is the eligibility, the eligible practice participants section.

Practice participants must provide mental health and/or substance use disorder treatment services at the outpatient level of care, as I mentioned. And so, when I think about behavioral health hospitals or county hospitals or nonprofits, I think of them as potentially providing services at many levels of care, and only the services provided at the outpatient level of care can receive IBH Model payment.

You can also find additional information about practice participant eligibility in the IBH Model's frequently asked questions which you can find online and we'll add that link also in chat. Next slide, please.

Here's the next question. My specialty behavioral health practice meets the eligibility requirements in the NOFO. How do I apply?

Well, only state Medicaid agencies are eligible to apply to the IBH Model. Up to eight states will receive a cooperative agreement and those states will be responsible for recruiting eligible practice participants. However nonprofit and for-profit organizations, such as specialty behavioral health practices or managed care organizations can reach out to their state to express their interest in participating during the application and pre-implementation period, and even early in the implementation period.

I'll also add here that states will need to hold meetings with commercial payers, potential practice participants, and other stakeholders to design and implement the IBH Model's Medicaid payment approach and by becoming involved in that convening structure, partners and stakeholders can collaborate with CMS, state agencies, and other interested parties to drive consensus on model design elements and shared priorities. Next slide, please.

Okay, so now we're switching gears. And what we found is that besides states and behavioral health providers, there are others who have questions about potentially participating in the IBH

Model. So here we have this question, are business associates and/or vendors of technology that support behavioral health care welcome to apply to the IBH Model?

And, as mentioned, while only state Medicaid agencies are eligible to apply to the model, these entities, business associates and technology vendors can work with their state Medicaid agencies to support states and practice participants during the application, the pre-implementation, and the implementation period. Next slide, please.

This is my fourth question in this section on eligibility. Moving on to the beneficiary who's at the center of the IBH Model, we often get questions about how the model defines moderate to severe mental health conditions and/or substance use disorders. For example, we got this question. In terms of beneficiary eligibility how are "moderate to severe behavioral health conditions" operationalized? The range of severity is quite wide for most ICD/DSM categories.

And we at CMS work with our own clinical subject matter experts as well as our federal partners at the Substance Abuse and Mental Health Services Administration, or SAMHSA, on this definition, and examples of moderate to severe conditions are opioid use disorder, major depressive disorder, bipolar disorder, and generalized anxiety disorder. You can find a full list of diagnoses in Appendix 14, which is called, "Moderate to Severe Behavioral Health Conditions," in the NOFO. Okay. Next slide, please.

Alright. Now we'll open it up for live questions related to IBH eligibility and you can ask any questions about the NOFO application as well. Please feel free to put your questions in chat or come off mute. Either way, when you ask your questions, please, please, please introduce yourself, and where you are calling from.

Not seeing questions quite yet, though if others are seeing them, please chime in.

Isaac, I might recommend that we continue to move forward with the questions that we received from the registration form. And then if folks have more questions later that they can chime in. Does that sound like a good plan?

Isaac Devoid: Sounds great. Yeah, we'll definitely have more opportunities for live Q&A if you're saving one or just have a question that pops up as we as we go through more of these. So yeah, I can jump in and take some common questions that we've received on care delivery.

So, the first question was, you mentioned that providers were needed to integrate behavioral health and physical health. What is the guidance on required specialty practice services?

So, in the NOFO Section A4.3.3, that includes a wide variety of information in regards to the care delivery framework requirements and these outline the requirements of practice participants, including which services are required.

So, the first core element of the care delivery framework is care integration and that's really where practices will screen, assess, treat, and refer patients as needed for both behavioral and physical health conditions within the provider scope of practice.

That second core element is care management and that's where an interprofessional care team will address the needs of the beneficiary and this includes providing ongoing care management across the beneficiary's behavioral and physical healthcare needs.

And then that third core element is health equity and this is where practice participants will engage in activities that really foster equitable care, such as health-related social needs screenings and a health equity plan. Next slide, please.

Alright, another common question that we received was, what are some strategies that are recommended to integrate behavioral health with physical health and how can programs bill Medicaid and Medicare care coordination and case management?

So, to integrate behavioral health with physical healthcare, the IBH NOFO recommends strategies such as co-locating services, incorporating virtual services, developing integrated care teams, using standardized screening tools, and employing care coordinators or case managers.

I'll note that here we're also open to providing technical assistance and that's something we really look forward to during that pre-implementation period. And additionally, infrastructure funding is available to support the implementation and enhancement of electronic health records and health information exchange systems, which are really critical for facilitating seamless communication and coordination between behavioral health and primary care specialty care providers.

To bill Medicaid and Medicare for care coordination and case management services under the IBH Model, providers would utilize the IBH Model's Medicare integration support payment, or ISP for short, for Medicare and dual eligible patients, and they would use the Medicaid payment approach for Medicaid beneficiaries.

The integration support payment is a prospective per-member-per-month payment that will begin at the start of Model Year 4. And this payment really covers the costs associated with managing care for Medicare and dual eligible patients attributed under the IBH Model, and that's for the services that I just outlined on my last slide. So those care integration, care management, and health equity.

And on the Medicaid side, CMS is really looking forward to working with states in the pre-implementation period to develop a Medicaid payment approach that reaches directional alignment with the integration support payment and works well for the unique state context. And when I say works well, what I'm talking about there is, it aligns with existing value-based payment efforts in the state or it really helps fulfill some of the value-based payment goals or objectives that the state has. So, this payment covers the cost associated with managing care for Medicaid eligible patients attributed under the IBH Model. Next slide, please.

Alright, we'll now open it up for some live questions related to care delivery, so feel free to raise your hand and come off mute. You can also throw your questions in the chat.

Alright, so we got a question about how an organization, a hospital, can advocate to the state to apply for the IBH Model. We certainly encourage any practice or other entity, if they're interested in participating in the IBH Model, to certainly note their interest in in the application process but like we said, the state Medicaid agency will be the applicants for the IBH Model so I think great to be in touch with your states, where you're interested.

Sarah Grantham: Isaac, we had also received an eligibility question about how specialty behavioral health providers can participate in the application process and during that NOFO application period those providers can consult with their state Medicaid agency to inform the state's application to participate, and that's in the model, and that's where they can express their interest as well.

Isaac Devoid: Awesome, I'm just reading and getting through another question. Just one second.

Sarah Grantham: Also, Isaac, I did see that one of our participants raised his hand. Paul, I apologize, I don't know how to pronounce your last name, but maybe you could pronounce it for us and let us know where you're from.

Paul Uncanin: Hi, thank you, Sarah. It's Paul Uncanin from Alera Health. I had a question around attribution for the model and how would that work. I know you mentioned there's specific criteria, but is it just such that where, if a member meets that criteria, they could be attributed to a provider, and if so, just if there's any additional information, if that's prospectively, do they stay on the attribution panel for a set number of months, and I don't know if there's any conflicts if that member is also attributed to like an MSSP provider or some other type of program, if that precludes them from being a part of this also. So, just wasn't sure if there's any more information there.

Sarah Grantham: Yeah, Paul, thank you so much. I appreciate these weedy attribution questions. I will need to take them back and then we can follow up in a future office hour in, you know, via the email or through frequently asked questions, cause I understand the need and interest in kind of in digging in further. Thank you for that one.

Paul Uncanin: Thank you.

Isaac Devoid: We received another question in regards to eligibility from a program at the county level and their eligibility to apply to the model. A county level agency would not be eligible to directly apply to the IBH Model because it's only open to state Medicaid agencies. Again, we do think that those sorts of agencies are great partners throughout the IBH Model application process as well as through the pre-implementation and the implementation periods. And we definitely encourage, if you're interested, to get in touch with your state Medicaid agency to understand if they plan on applying.

Alright, I think we can move on to our next section, which is on data collection and evaluation. And with that I'll pass it back over to Sarah.

Sarah Grantham: Thank you, Isaac, and thank you all for your patience, as we sort of muddle through the live Q&A portion of all of this. Okay, so now we'll jump into some questions on data collection and evaluation, and one common one that we received are, what are the key patient outcomes to be tracked?

And the IBH Model aims to improve the quality of care that patients receive and increase their access to care as well. The model aims to achieve greater equity in patient outcomes and reduce avoidable emergency department and inpatient hospital utilization. CMS will use a set of quality measures to monitor key areas related to the model's desired outcomes and these include the beneficiary's utilization of services, care coordination, health-related social needs, IBH Model targeted health outcomes, patient-reported outcome measures, and physical health screening. Next slide, please.

Terrific. Another quality common quality measurement question that we received was this one. What are the quality metrics to show success and earn value-based payments?

The IBH Model includes incentives for improvements in health outcomes and screenings based on a number of practice-based measures. These are defined in Table A4.7.2 in the NOFO which we can put in the chat. Meanwhile, I'll just briefly walk you through them. They include tobacco, use screening and cessation intervention, emergency department utilization, controlling high blood pressure, screening for social drivers of health, and a patient-reported outcomes measure. Next slide, please.

We also received this related quality measurement question. What are the nine quality measures that states will report quarterly and annually?

Well, the IBH Model's nine state-based quality measures are described in Table A4.7.1 in the NOFO, and these include follow up after emergency department visit for substance use, follow up for emergency department visit for mental illness, plan all-cause readmissions, follow up after hospitalization for mental illness, hemoglobin A1c control for patients with diabetes, diabetes screening for people who are using antipsychotic medications, emergency department utilization, colorectal cancer screening, or breast cancer screening. Next slide, please.

Okay, now we're back to the live QA section. These are related, especially the data collection and evaluation, but if you have other questions that we haven't been able to answer before we are happy to pause for just a moment and prepare to answer these. Thank you.

Isaac Devoid: Yeah, I can start by taking a question Jennifer had that I didn't have time to get to last time. So, sorry about that, Jennifer, and I'm gonna just summarize your question but please feel free to put in the QA box or come off mute if I'm summarizing your question incorrectly. I think you're asking essentially what the requirements are for what treatment looks like for both behavioral and physical health conditions within the IBH practice participants.

What I will say here is that what we note within the NOFO is that practice participants will treat within their scope of practice. So here we're trying to keep it flexible and ensure that the IBH practice participant can participate and aren't going outside the leaps and bounds of what they're

licensed to do. We do plan on providing more information here but generally what we're looking at is at a minimum, you know, really would just be screening, assessing, and then having appropriate referrals to the different whether those are community partners, primary care providers, or other specialty practices.

And please let me know, Jennifer, if you have any follow-up questions there, or if that didn't answer your question.

Awesome, glad that was helpful. We'll just give it another second and we can see if other questions come through and if not, we can move on to questions on funding and payment.

Alright, I think we can keep moving to our slides on funding and payment. So, next slide, please.

Thanks for taking those questions on data and evaluation, Sarah. So, since we've launched the IBH Model, many have been curious to know what the payments going to be for CPT or HCPCS codes under the model for Medicare, as well as the pay-for-performance incentives for Medicare.

So, we'll release more information on the Medicare payment approach over the coming year, but we do anticipate that the integration support payment will be approximately $200 to $220 per-member-per-month and I'd like to reiterate that the integration support payment covers care integration, care management, and health equity, and that this payment would be on top of what specialty behavioral health practices currently receive for delivering behavioral health care.

The pay-for-reporting and performance bonuses will be a percentage of the integration support payment and those increase over time as we transition from pay-for-reporting to pay-for-performance. There's more information about both the Medicare payment approach as well as our pay-for-reporting and performance bonuses that are further detailed in Appendix 11 of the NOFO. Next slide, please

Alright, another common funding and payment question that we got was what amount of funding would be provided directly to providers in the IBH Model for infrastructure funding, including technology enhancements, practice transformation activities, and other tools?

So, infrastructure funding will be determined by a practice needs assessment and CMS will provide up to $200,000 in infrastructure funding directly to practice participants that participate in both the Medicare payment approach as well as the Medicaid payment approach. For practice participants that only participate in the Medicaid payment approach, infrastructure funding will be provided from recipients' cooperative agreement funding. We provide more detail on this policy in Section A4.5 of the NOFO and we can put this information in the chat.

I just want to reiterate this information, as we've received many questions here. If an IBH practice participant voluntarily enrolls to participate in the Medicare payment approach they can receive up to $200,000 in infrastructure funding directly from CMS. However, if a practice only participates in the Medicaid payment approach, their infrastructure funding must come from the state's cooperative agreement funding. Next slide, please.

Another question we received on funding and payment is, can states develop more than one payment approach? Different potential practice participants will be best served by different payment approaches.

So, recipients may only develop one Medicaid payment approach for IBH Model services. However, if a state includes practice participants with different payment methodologies, for example, per-member-per-month versus a practice participant that uses a prospective payment system, then the state would be permitted to develop more than one Medicaid payment approach, pending CMS review and approval.

The CMS Innovation Center and the Center for Medicaid and CHIP services are committed to helping recipients develop a Medicaid payment approach that meets our directional alignment principles but also that enables practice participants to succeed. Next slide, please.

And then our last common question we received on funding and payment is, and it actually relates to our last question, is can states use a prospective payment system for the Medicaid payment approach?

Yes, states can certainly use a prospective payment approach, pending CMS approval, and they do have flexibility to determine if their Medicaid payment approach is grounded in a per-member-per-month, a prospective payment, or traditional fee-for-service. However, please note that each payment must meet the IBH Model payment approach criteria that's listed in Section A4.4 of the NOFO, which includes a performance-based payment component. We can link to that section in the chat. And next slide, please.

Alright, we're now back open for live Q&As.

Sarah Grantham: Isaac, we got an eligibility question that I'm happy to jump in with if you feel that's okay.

Isaac Devoid: Yeah, please, do.

Sarah Grantham: Okay, great. We had a question about whether a practice participant will need to submit an application to participate in the IBH Model, how those applications get submitted.

So, the way that it works is practice participants, all practice participants must participate in the Medicaid aspect of the model, so that that means they see Medicaid patients and there's a series of criteria that they need to meet. So, then they have the option. So, they would talk to their states if they want to participate in that part of the model. That's the way this works. And then if they're accepted by the state, and they provide services for Medicaid beneficiaries in the IBH Model, then they have the option to apply to CMS to participate in the Medicare side of the model, and when they do that, then they can see Medicare patients and patients who are duly eligible for Medicare and Medicaid, and they do that through the request for application, the RFA, which is coming out later in the model and that is because, you know, it's sort of it's a rollout in terms of like first folks enroll in Medicaid and then later they apply to participate in in

the Medicare portion of the model. So, I hope that helps to clarify the way that sort of applications to participate, the way that happens.

Isaac Devoid: I think we can leave the Q&A open for a bit longer for this live Q&A portion. Definitely let us know if you have any other questions, feel free to come off mute, raise your hand, throw a question in the Q&A. And also, just noting if you have a question on a section that we've already answered like a quality and evaluation, or something along those lines, we can certainly circle back to it. We're not closing out on the specific section, so feel free to submit a question for any topic.

Yeah, so I just got a, we just got a follow up question in regards to what we just answered. So, it says, if a state accepts our application for the IBH Model then we'll have to apply at CMS, right?

So, in that first model year after a state is selected for participation in the IBH Model, the state Medicaid agency would be required to work with a variety of partners like their state behavioral health and substance use disorder agencies, managed care organizations, and other state partners to recruit practices into the model, and once practices are recruited into the model, like Sarah said, they would have that option to apply into the Medicare portion of the model. But there, that that application would come at a later date, likely later into the pre-implementation period.

Definitely let us know if we're still confusing your question. We're happy to take any others.

Sarah Grantham: Also, just a quick reminder about sort of the overall timeline for the model. The model is slated to start early next year and then what we are calling the pre-implementation period, that's three years, so three years after that. And then providers actually at the end of that three-year period then providers actually provide care, IBH Model services, through Model Years 4 through 8. And we're doing that very, very long glide path to give all of the interested parties a chance to get ready and prepare. We know that we're seeking some significant care transformation in this model and care integration obviously is a key part of it. So, we know that it takes time to pull all these different pieces together. So that's why we have that long implementation glide path, pre-implementation glide path. Thank you.

Isaac, should we move on to the next slide so we can talk a little bit about existing state initiatives?

Isaac Devoid: That sounds great over to you.

Sarah Grantham: Okay, great. We've been asked by several stakeholders about how the IBH Model would align with a state's existing initiatives. CMCS and SAMHSA have designed the IBH Model to complement the CCBHC efforts and investments that states and federal government have already made and so we were asked by several stakeholders to discuss opportunities and challenges with CCBHC and IBH Model implementation.

So, we wanted to just take this opportunity to underscore that we have worked closely with our partners at the Center for Medicaid and CHIP services, or CMCS, and SAMHSA to assure that

the IBH Model aligns with CCBHCs, which are otherwise known as Certified Community Behavioral Health Clinics.

And for selected states seeking to include their CCBHCs in the IBH Model, we're committed to working with you over that three-year pre-implementation period that I just mentioned a few minutes ago, and that's because CCBHCs are at different points when it comes to care integration. We understand that some CCBHCs are already integrating care and for those CCBHCs the IBH Model provides the opportunity to refine their care integration framework, and for the CCBHCs who haven't begun to integrate care, the IBH Model will be the foundation for them to do this for the first time. And regardless of where your CCBHC is along that continuum, the IBH Model will provide CCBHCs with the opportunity to receive payment for IBH Model services in Medicare. CCBHCs would also be eligible for infrastructure funding to further enhance health information technology or conduct practice transformation activities and states seeking to include their CCBHCs in the IBH Model should understand the extent to which their CCBHCs are currently integrating care. Next slide, please.

We've also been asked for a crosswalk between the CCBHC and IBH Model, and there are three CCBHC programs underway. These include the CCBHC Improvement and Advancement grant, which is called CCBHC-IA, and there's the CCBHC Community Behavioral Health Clinic Planning, Development, and Implementation grant called CCBHC PDI, and then there's the Section 223 Medicaid CCBHC demo, and these programs have different requirements and funding linked to them. In Appendix 10 in the NOFO we have outlined different IBH implementation strategies for CCBHC Improvement and Advancement and Planning and Development grantees, as well as for CCBHC demonstration providers, and that appendix shows how an IBH recipient state could think about aligning their CCBHCs into the IBH Model in key domains, and those include payment and billing, infrastructure funding, and quality measurement. Next slide, please.

Okay, great. Thank you. The next slide relates to existing billing and coding and it is this, how might the innovation and behavioral health model interact with Medicare behavioral health integration services?

And this is a very important question. To avoid the duplication of services and payment, including that Medicare behavioral health integration service that we just talked about, CMS has developed a full list of codes that will be prohibited for a provider to bill when a beneficiary is participating in the IBH Model. This list of codes is in Appendix 11 in the NOFO.

Okay, perfect. So now we'll open it up one again for live questions related to existing state initiatives or from the prior parts of this webinar. So again, feel free to put your questions in chat or come off mute. Either way, when you ask your question again, please introduce us yourself and let us know where you're calling from.

We're doing that pause thing while we wait for folks to gather any other questions they might have.

Isaac, any thoughts here.

Isaac Devoid: No, this is all the questions that we had teed up today from, you know, pre-registration, we had gotten from our mailbox, in our NOFO webinar recently. But we're gonna stay on the line, just noting throughout all the office hour session.

So, we have three more sessions. The next one's planned for August 7th. We'll always stay on the line and be available. So, if you're somebody who's like, oh, I can't get to the next one until a half hour afterwards, like no problem, we'll be here, and if there's no questions we'll just stay on the line and wait to see if anybody has questions. So, if you wait with us, and something pops into your head in fifteen minutes we'll still be here.

Sarah Grantham: Thanks, Isaac, for that clarification. Also wanted to remind folks that these slides will be available online. So, although it might be difficult, impossible actually, to click on the links here, those links will become available when you get access to the slides on the IBH Model website.

And also, we've included a lot of these links in the chat and perhaps actually, while we have a pause, one of our team members could just include them in the chat. Thank you.