Centers for Medicare & Medicaid Services
Behavioral Health Stakeholder Call
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Eden Tesfaye: Good afternoon, and welcome to the U.S. Department of Health and Human Services call on the Centers for Medicare and Medicaid Services' recently announced Innovation and Behavioral Health Model, also referred to in shorthand as the IBH model. My name is Eden Tesfaye, and I'm a Senior Advisor to the Administrators at the Centers for Medicare and Medicaid Services. On behalf of the Biden-Harris Administration, HHS, and the CMS Administrator Chiquita Brooks-LaSure, thank you all for joining us today.

Today I'm joined by several dynamic leaders, Secretary Xavier Becerra, the Secretary for the U.S. Department of Health and Human Services, who will share remarks on the department's behavioral health strategy; Dr. Liz Fowler, Deputy Administrator and Director of the Center for Medicare and Medicaid Innovation Centers (CMMI), who will provide an update on the new Innovation and Behavioral Health Model; Dr. Miriam Delphin-Rittmon, Assistant Secretary for the Substance Abuse and Mental Health Services Administration (SAMHSA), who will provide information about SAMHSA's work on behavioral health and how it complements the new Innovation Center model. Finally, I will moderate a Q&A and then close out the call.

But before we begin, we have a couple of housekeeping items. This session is being recorded. The recording and transcript will be posted on cms.gov following the webinar. Also, while members of the press are always welcome to attend this call, please note that all press and media questions should be submitted using the CMS media inquiries form at www.cms.gov/newsroom/media-inquiries. All participants will be muted. Closed captioning is available via the link shared in the chat by the Zoom moderator. We will have time for Q&A towards the end of the call. Please submit questions using the Q&A function at the bottom of your screen, and we will do our very best to get to as many questions as possible. With that, it is my absolute honor and privilege to introduce our leader and the 25th U.S. Department of Health and Human Services Secretary, Secretary Xavier Becerra. Secretary Becerra, over to you, sir.

Xavier Becerra: Eden, thank you very much, and to everyone who is on, appreciate it very much, and I hope you find this as thrilling as we do—the work that's being done. As I get ready to hand this over to Dr. Liz Fowler, I just simply want to say to her and her team at the Innovation Center, thank you very much for the work that you've done to help us have not just an innovative model, but a novel way of doing business in an area where so many Americans are crying out desperately for help when it comes to behavioral health. And CMS has been active through Medicaid and through Medicare on issues involving mental health substance use disorders for a long time, but we've never been able to say that we're going to bring together in an integrated, an inclusive, comprehensive model, a way of dealing with health care for those

who have behavioral health challenges in such a defined way that we've never seen before. And so, a big thanks to Liz—to you and your team at the Innovation Center for coming up with this new model. I'll simply say this, when a quarter of all your Medicare beneficiaries and four out of every 10 of your Medicaid beneficiaries need behavioral health services, you better be doing something. And so, CMS has an obligation to try to make sure that we're tackling this issue of behavioral health in the right way for Americans, period, but certainly, for our Medicaid and Medicare beneficiaries, the fact that we have the support of SAMHSA, our Substance Use and Mental Health Services Administration that has been working these issues for the longest of times, means that it truly is an inclusive and integrated model. This is the way things should be done. This is a great model for health care, period, and we hope to continue to show that we recognize that health care doesn't mean just physical—it has to include mental, and certainly, for many of us, it has to include spiritual health. And as we go through the process of trying to show how we can try to prevent illness so that we turn our current health care system from one that treats illness to one that promotes wellness, we hope that you'll be with us. And we believe that this innovative model that helps us address behavioral health is a step in that right direction. So, I'm thrilled. I'm proud that HHS at this time is launching this particular model that will help all of us feel as Americans that we're listening, that our government is listening, that President Biden has heard us, and that we're going to do the best we can. So, with all of that said, let me turn it over now to the person who's making this happen, Liz Fowler, and her team at our Innovation Center, Liz.

Dr. Elizabeth Fowler: Thank you, Secretary Becerra, and thank you for your leadership and thanks to all who are joining us today to talk about this important issue and the groundbreaking work happening across HHS. You can see that the CMS and HHS behavioral health strategy is an indication that we're dedicated to addressing our nation's behavioral health crisis. As part of that strategy, the CMS Innovation Center is using its unique statutory authority to design and test innovative payment and care delivery models to advance these priorities. I'm excited to announce that our first CMMI model of 2024 is the Innovation and Behavioral Health Model, or IBH for short. The impetus for this model was the data we were just seeing, we've all been seeing, on the unprecedented behavioral health emergency in the U.S., and as the Secretary noted, the data shows that the impact of the behavioral health crisis, both on mental health conditions and substance use disorders is even more significant in Medicare and Medicaid populations.

Through the IBH model, we aim to improve the quality of care and health outcomes for Medicaid and Medicare beneficiaries with moderate to severe behavioral health conditions, both mental health and substance use disorders. State Medicaid agencies will be able to participate in the IBH model and will select up to eight states to participate through a cooperative agreement. Under the IBH model, community-based behavioral health practices will provide person-centered care in the behavioral health setting. Participating behavioral health practices will facilitate interprofessional care teams in close collaboration with primary care, other physical health providers, and health-related social need partners. IBH will also test the impact of a value-based payment model aligned in Medicaid and Medicare. The aligned payment model will support community-based behavioral health providers to deliver integrated whole-person care. Components across CMS and HHS have been working together to design the IBH model in a way that will facilitate a holistic approach to behavioral health that is aligned with the HHS Behavioral Health Roadmap.

More specifically, we've collaborated and worked particularly closely with our partners at SAMHSA in designing the IBH model, and we're really grateful for their expertise and guidance. In designing the IBH model, SAMHSA shared their valuable clinical and policy expertise as well as lessons learned from other initiatives to provide valuable feedback in areas such as care delivery, provider participants, and beneficiary eligibility. We look forward to this opportunity to test important innovations for behavioral health in Medicare and Medicaid and hope that you'll consider participating in the model in some way.

Before I turn it over to Dr. Miriam Delphin-Rittmon, Assistant Secretary for Mental Health and Substance Use and leader of the Substance Abuse and Mental Health Services Administration or SAMHSA, I want to take a moment to introduce Tequila Terry, who leads the State and Population Health Group at the Innovation Center. She and members of her team are on the line, and they'll be available to help answer questions about the new model. With that, I'm going to turn it over. Dr. Delphin-Rittmon from SAMHSA. Thank you very much.

Dr. Miriam Delphin-Rittmon: Thank you so much, Dr. Fowler, Secretary Becerra. I just have to say I so appreciate the opportunity to join you in this really exciting initiative. The Innovation and Behavioral Health Model, or the IBH model, has the potential to revolutionize how we approach behavioral health and improve the lives of so many individuals around the country. It recognizes that individuals with behavioral health conditions need better access to physical health care. It removes barriers by bringing together clinicians to treat the whole person, supporting their minds, their bodies, and health-related social needs. And for SAMHSA, this innovative model brings us closer to achieving our priority to integrate behavioral health and physical health care. We know that this is an incredibly complex path forward, and we will continuously work with CMS, with HHS, and with the eight demonstration states to support this implementation. As the last speaker for this event, I'd like to mention that when we say the IBH model supports a no-wrong-door approach to care, we mean that when our family members or a friend, or even when we go to be a behavioral health provider, the model opens doors to all types of care. An individual being treated for a substance use disorder can go to their provider to get screening and assessed for hepatitis. An individual who goes to their mental health appointment can now also go and get ongoing access and care for their diabetes. And an individual continuing behavioral health treatment while on their recovery journey can be connected to other resources for their health-related social needs. These include housing, transportation, vocational or employment opportunities, and food security. At SAMHSA, we are so pleased to have collaborated with colleagues at the Center for Medicare and Medicaid Services on the development of this program, and we are so excited about the future, bringing innovation, hope, health, and healing to all those who need it. At this time, I'll go ahead and I'll turn the floor back over to Eden Tesfaye from the CMS Office of the Administrator. Eden.

Eden Tesfaye: Thank you so much, Dr. Delphin-Rittmon, Dr. Fowler, and Secretary Becerra. We'll now turn it over to our Q&A portion of the call, and our first question is for our colleagues over at SAMHSA. Trina, I'm going to ask you this one. What, if anything, is being done to integrate primary medical care into mental health practices, and where can we find more resources on how mental health agencies and independent health providers, social workers, etc., psychiatrists, can do that?

Trina Dutta: Sure. Thanks so much, Eden, and thank you for the question. Sorry, I hope I'm not freezing. So that's a great question. And actually, SAMHSA starting back, I think, in maybe 2010, if not earlier, launched an entire grant program focused on the integration of primary care and behavioral health, and it was really looking at the integration of primary care into behavioral health settings. Given what we knew that people with more serious behavioral health issues had traditionally had their physical health issues going unaddressed and were dying earlier not because of their behavioral health issues but because of their chronic illness like diabetes or any number of major chronic illnesses that you could think of. So, at that point, SAMHSA was funding community-based providers around this integration and looking at different models of care around how best to do this integration. We partnered with ASPE (Assistant Secretary for Planning and Evaluation) at that time to do a pretty in-depth evaluation of what elements, what features of the different models of integration, really worked and sort of building up really a repository of knowledge base around that integration. Sometimes, people call that reverse integration, but we just like to call it bi-directional integration.

At that time, we also started, we started a partnership with HRSA (Health Resources and Services Administration) to launch the Center for Integrated Health Solutions, which was really focused on providing technical assistance support to the field, so to providers, etc., around integration. And really, the primary focus there was around integrating primary care into behavioral health, but also looking at bringing behavioral health and mental health and substance use capacity into primary care settings. Now that technical assistance center has now evolved into being sort of a center of excellence that SAMHSA is funding independently, but that really is a source to understand, to get more information at the provider level, at the practitioner level, around how best to engage around the integration of primary care into behavioral health.

Now, the grant program that SAMHSA had originally started over 10 years ago has now evolved into more of a state-centric grant program. So, this is now an award that goes to states to really help them look at, from a systems level, what are the different changes that have to occur to really support providers around doing that type of integration. And then, resources then move to providers to actually embark on the integration of primary care into behavioral health. So I think it's a really interesting question because I think a lot of the more well-known models of integration do really speak to how to bring behavioral health into primary care settings because that’s where a lot of us are more comfortable getting our care, but if we are looking at people with moderate to severe mental illness or substance use disorder, we know that those communities and those populations are really most comfortable getting their care in a specialty behavioral health setting. And that, quite frankly, oftentimes primary care providers don't have the training and the time and really the capacity that's necessary to serve this population. So, centering this work in sort of especially behavioral health setting, I think, will really allow for the outcomes that CMS is looking for in regard to people with moderate to severe mental illness. So just to loop back, I think folks can learn a lot by visiting our center of excellence on integration, integrated health solutions, and I can put that URL in the chat for folks, but then also looking at the evaluation results of the work that SAMHSA has been doing around this. So hopefully that helps.

Eden Tesfaye: Thank you so much, Trina. Our next question is for our CMMI team. Tequila, who exactly will constitute these interprofessional teams mentioned in the model?

Tequila Terry: That's a great question. Before answering that, I do want to just add on to what my colleague Trina just talked about. When it comes to really thinking about the CCBHC (Certified Community Behavioral Health Clinics) approach, we see these as being complementary. And so I hope that one of the messages that becomes really clear from this conversation is that the CMS Innovation Center and SAMHSA are working very closely to ensure that we are using our respective strengths to really address the crisis that we all know exists across the country. And so it is really important to us to make sure that these programs are complementary and that we have participants who are CCBHCs who can participate in the IBH model alongside with providers who are not CCBHCs. So, I want to just acknowledge again the partnership and tremendous work of the SAMHSA team to help us think through opportunities and make sure this works seamlessly across the country.

As it relates to the question around interprofessional teams when we think about the Innovation and Behavioral Health Model, the practice participants that we are envisioning will be in this model will develop multidisciplinary care teams that will be responsible for working with beneficiaries to coordinate and manage the beneficiaries' physical, psychosocial, and behavioral health, as well as therapeutic and recovery needs. And so care team members should really include all individuals and expertise needed to manage the whole person care of each beneficiary. And so that's what we mean when we say interprofessional teams. In addition to the patient and family and caregivers at home, obviously, at the discretion of the beneficiaries, we want them also to be a part of this process. And so, making sure that there is this diverse set of resources working with beneficiaries to ensure that they receive the full spectrum of resources and care that they need—a care coordinator or care manager, behavioral health provider team, the physical health resource, a peer support specialist, community health worker, education and/or employment support and other staff with lived experience. So, really, a fully diverse team of resources that can fully approach the entirety of the person's unique health situation. And so that's what we are talking about when we talk about interprofessional teams.

Eden Tesfaye: Thank you so much, Tequila. My next question is for our SAMHSA colleagues—Trina, you're up again. How does this model differ from the CCBHC model? I think it would also be helpful to spell out that acronym for folks who might not be as familiar with it.

Trina Dutta: Sure, thing Eden, and I feel like that was a trick question because I'll sometimes mess up the acronym, so I'll do my best. So CCBHCs are the Certified Community Behavioral Health Clinics. And folks that are familiar with that, and you see a lot of questions coming through the chat, how does this sort of relate to the CCBHC model? So, the CCBHC model—as many folks on this call, it sounds like, know—is really an opportunity to make sure that community behavioral community behavioral health providers that sort of meet the requirements to serve as CCBHC are providing a full array of what are believed to be really fundamental and important services to an individual seeking specialty behavioral health services. And so, there are a series of nine areas of required care that a CCBHC must provide—and I'm happy, for folks that aren't always sure, happy to put a link in the chat for folks to get a little bit more information. We

actually just updated the criteria recently and did a lot of public engagement in the updates of the CCBHC criteria that folks might find interesting.

I think what is really, I think a key difference between what CMS [inaudible] is trying to do with the IBH model relative to what the CCBHCs afford individuals that are receiving care is that CCBHCs do have a requirement to have to engage in screening around particular physical health issues and then referral to primary care where necessary. But CCBHCs are not unto themselves an integrated care model. There might be some CCBHCs that are doing more full-fledged partnerships with their neighboring Federal Qualified Health Center (FQHC) or whoever's in their community, but that is not one of those sort of requirements in the criteria. Whereas what is being put forward through this IBH model is really creating more of these integrated treatment teams where someone can receive their physical health care, their mental health care, and their substance use treatment.

So, let's say you're going to an OTP (opioid treatment program) and getting your treatment for your opioid use disorder. You could also there get your physical health screening and get ongoing treatment for hepatitis, let's say, or something to that effect in that setting. Whereas in the CCBHC model, it's really focused on making sure that those health screenings are happening and then the appropriate referrals are happening as a result of those screenings. So, I think it's really important to be clear on the distinction. CCBHCs can certainly be part of this, and I think we hope that CCBHCs will engage in this opportunity, but it really will allow them to take the core elements of the CCBHC program and layer in this really important element around integration, which is not a current required service within the CCBHC model. So, I hope that helps folks understand where CCBHCs, as defined, where that sort of stops and where the IBH model picks up and then carries forward to really making sure that people are getting that whole person care that Dr. Delphin-Rittmon talked about.

Eden Tesfaye: Thank you so much, Trina. I just learned something. I appreciate that detailed response. And now we're almost at time. One more question that is for our CMMI team. Tequila, I have a twofold question for you. Is there a timeline for when the eight demonstration states will be selected for this model, and what kind of technical assistance will be available to states participating?

Tequila Terry: Excellent. Yes, there is a timeline. So let me start by saying that the applicants for this model will be state Medicaid agencies with the authority to accept cooperative agreement award funding, and then eligible applicants are all 50 states, Washington, DC, and territories. And so, as we think about the opportunity, we are going to be selecting up to, I'm sorry, up to eight states to enter into the cooperative agreement with CMS to execute on the goals and the vision of the model. The primary applicant again will be Medicaid agencies, and then once the states have been identified, the providers within those selected states would become eligible. So, as part of the state application process, we would envision launching an application cycle this spring so that states will receive a notice of funding opportunity out on grants.gov that will come public, and that will be the indication that the application process is open. So, this spring.

And as we think about where we go with this model, when it comes to the overarching goals, again, what we want to do is improve access. We want to help optimize infrastructure and

resources in states that support the Medicaid and Medicare beneficiaries. And so with that, we want to make sure that we are providing states with resources to provide information on evidence-based practices. So, we will have a number of contractors that will be able to support states on evidence-based practices that we have identified through our partners in SAMHSA. We will also be able to work with them during what's called a pre-implementation period, which we envision will be the first three years of the model, to make sure that they have the resources, the capabilities, the strategies in place to engage providers and all of the tools to really start to think about this idea of value-based payment and how we can make sure that we are building on the efforts that states have started around the country so that both Medicare and Medicaid are aligned. And so, we will certainly work with resources to provide that technical assistance to make sure that they are successful in this model because we really believe that it is important to people around the country to really rethink the way that behavioral health services are being delivered with a more integrated whole person approach.

Eden Tesfaye: Thank you so much, Tequila and Trina, and for all of you who were able to join us for this call. On behalf of HHS, SAMHSA, and CMS, I want to thank each and every single one of you for your efforts on this crisis and for joining us today. We appreciate your partnership and dedication to working with us to address the ongoing behavioral health crisis our country is facing. I also want to give a special thanks to our speakers today, HHS Secretary Xavier Becerra, Assistant Secretary Dr. Delphin-Rittmon, and CMS Deputy Administrator and Director for the Center for Medicare and Medicaid Innovation Dr. Liz Fowler, for their commitment to improving the quality of behavioral health care in our country. They are truly blazing a trail for all people to access the behavioral health care they need. With that, this concludes our call. We hope all of you have a great rest of your day and enjoy your Friday eve.