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Whitepaper

Value Based Care in Behavioral Health

CMS's New Innovation in Behavioral Health (IBH) Model

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In recent years, CMS has been investing resources and rolling out programs to introduce value-based care models focusing on a variety of medical specialties. On January 18, CMS announced the Innovation in Behavioral Health (IBH) Model, which will begin in the Fall of 2024. This program is set to run across 8 states from 2024 to 2032, with a 3-year implementation period. While the participating states and practices are still being selected, this program's core design has already been released. The IBH Model will focus on improving quality of care and outcomes for both behavioral and physical health of its participating populations in Medicaid and Medicare, specifically patients with moderate to severe mental health conditions and/or Substance Use Disorder (SUD). The program is aiming to bridge the gap between behavioral and physical health, while also aligning payment between Medicaid and Medicare for integrated services. While details are still being released, the key pillars, program design, and eligibility for the IBH Model have been communicated to stakeholders.

The IBH Model focuses on behavioral healthcare, physical healthcare, and community support, with the key pillars being:

1. Care Integration
2. Care Management
3. Health Equity
4. Health Information Technology

A further look into the core elements of the program reveals an emphasis on interdisciplinary teams tracking and sharing data and outcomes to address the multi-faceted needs of patients while also streamlining all lines of care. Throughout the program, care teams are expected to continuously screen and assess patient needs to develop the best care program that addresses not only their mental health needs, but physical and Health-Related Social Needs (HRSN) as well.

The key to the IBH Model's design lies with the practice participants at its core. The breakdown of participating providers is aimed to include:

- Community-Based Behavioral Health Organizations
- Community Mental Health Centers
- Opioid Treatment Centers
- Safety Net Providers
- Public and Private Practices that offer outpatient mental health services and/or SUD services

The participating providers will act as the patient's frontline of care, similar to a primary care provider, in that the providers will complete the initial program screening and assessments to determine the patient's best treatment path. If a participating provider does not have the resources to care for a patient's needs as determined by an initial screening, the providers will refer the patient out to another provider while still managing their overall treatment plan. Participating providers will also be partnered with their state specific mental health/SUD agencies and at least one Medicaid Managed Care Organization (MCO) to provide them with guidance throughout the program. In addition to health assessment screenings, participating providers will be responsible for leading interdisciplinary teams to create a Health Equity Plan (HEP) which addresses patients' Health-Related Social Needs (HRSN), like housing, food, and transportation. Patients' health equity needs are to be reassessed every year.

In terms of payment design, the program is split into 2 stages. Of the 8-year program, the first 3 years are to address implementation of the model and build practice capacity to administer the program. During this time, participating providers will receive funding to improve health IT infrastructure, support transformation activities, and address staffing if needed. Additionally, any practices that participate in the Medicare payment model during this time may also receive additional funding to support the model activities. Model years 4 to 8 will see a change in funding that switches to a per-beneficiary-per-month payment for providers that participate in the Medicare payment model. In year 4, a Medicaid payment model will also be implemented in addition to the existing Medicare payment model. On top of these payments, practices will also receive additional performance-based payments during years 4 through 8.

To be eligible to apply for the program, providers must meet all the following requirements:

- Are licensed by the state awardee to deliver behavioral services -- either mental health and/or substance use disorders
- Meet all state-specific Medicaid provider enrollment requirements
- Are eligible for Medicaid reimbursement
- Serve adult Medicaid beneficiaries (age 18 or older) with moderate to severe behavioral health conditions
- Provide mental health and/or substance use disorder services at the outpatient level of care.

While this program is still unfolding and applications are not yet open, this is an excellent opportunity for behavioral health providers to keep on their radar if implementing or improving a value-based care model is of interest. Behavioral health providers that meet all eligibility requirements listed and fall under one of the above outlined provider types are encouraged to apply.