U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation

Innovation in Behavioral Health (IBH)

Notice of Funding Opportunity Type: New

Funding Opportunity Award Type: Cooperative Agreement

Notice of Funding Opportunity Number: CMS-2Q2-25-001

Federal Assistance Listings Number (CFDA): 93.610

Notice of Funding Opportunity Posting Date: June 17, 2024

Applicable Dates:

Letter of Intent to Apply Due Date: N/A

Electronic Application Due Date: September 23, 2024, by 11:59 pm Eastern Standard Time (EST)

Anticipated Issuance Notice(s) of Award: December 17, 2024

Anticipated Period of Performance: January 1, 2025 - December 31, 2032

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Executive Summary

The Innovation in Behavioral Health (IBH) Model (the "Model") is an eight-year, voluntary service delivery and payment model promoting integrated care in behavioral health (BH) settings. The IBH Model will test the impact of a value-based payment (VBP) model aligned across Medicaid and Medicare that supports an integrated care delivery framework in specialty BH organizations and settings for adult Medicaid, Medicare, and dually eligible beneficiaries with moderate to severe mental health conditions and/or substance use disorders (SUDs).

The Centers for Medicare & Medicaid Services (CMS), through its Center for Medicare & Medicaid Innovation (Innovation Center), will select up to eight state Medicaid agencies (SMAs) to participate in the Model. Implementation will begin in January 2025 and end in December 2032. The Model will have an eight-year performance period, which will be comprised of a three-year Pre-Implementation Period along with a five-year Implementation Period. Up to $7.5 million dollars in cooperative agreement award funding will be available to each selected Recipient over the course of the eight years.

Item	Description
HHS Awarding Agency	Centers for Medicare & Medicaid Services (CMS)
CMS Awarding Center	Center for Medicare and Medicaid Innovation (The Innovation Center)
Notice of Funding Opportunity Title	Innovation in Behavioral Health
Authorization	Section 1115A of the Social Security Act (the Act)
Federal Assistance Listings Number (CFDA)	93.610
Funding Opportunity Type	New
Funding Opportunity Number	CMS-2Q2-25-001
Type of Award	Cooperative Agreement
Type of Competition	Competitive

Letter of Intent	N/A
Application Due Date and Time	September 23, 2024, by 11:59 pm EST
Anticipated Issuance Notice(s) of Award	December 17, 2024
Period of Performance Start Date	January 1, 2025
Period of Performance End Date	December 31, 2032
Anticipated Total Available Funding	$60 million (subject to availability of funds)
Estimated Maximum Award Amount	$7.5 million per Recipient
Estimated Maximum Number of Recipients	8

A. Program Description

A1. Purpose

This Notice of Funding Opportunity (NOFO) provides details and instructions on how to apply to the Innovation in Behavioral Health (IBH) Model.

The IBH Model will test the impact of a value-based payment (VBP) model aligned across Medicaid and Medicare that supports an integrated care delivery framework in specialty BH organizations for adult Medicaid, Medicare, and dually eligible beneficiaries with moderate to severe mental health conditions and/or substance use disorders (SUDs). The IBH Model framework for integrated care in BH settings will:

- Build and strengthen connections to physical health (PH) care for beneficiaries;

- Promote screening and referral for health-related social needs (HRSNs[1]);
- Leverage care management and care coordination to increase access to and engagement with primary care and HRSN services; and
- Encourage investments in certified health information technology(health IT) products and infrastructure improvement for their practice and patient population.

CMS will evaluate the Model's ability to:

- Improve quality of care;
- Increase access to care;
- Achieve greater equity in outcomes;
- Reduce avoidable emergency department and inpatient utilization, and thereby reduce federal program spending under Medicare and Medicaid; and
- Strengthen health IT systems capacity.

CMS will award up to eight cooperative agreement awards to state Medicaid agencies (SMAs). The Model will consist of a three-year Pre-Implementation Period along with a five-year Implementation Period as follows:

- **Pre-Implementation Period**: Three-year Pre-Implementation Period begins January 1, 2025, and ends on December 31, 2027.
- **Implementation Period**: Five-year Implementation Period begins on January 1, 2028, and ends on December 31, 2032.

This NOFO provides detailed information regarding the level of funding, flexibilities, and requirements for Recipients.

A2. Authority

Section 1115A of the Social Security Act (the Act) authorizes the Secretary of the Department of Health and Human Services to test innovative payment and service delivery models expected to reduce Medicare, Medicaid, or Children's Health Insurance Program (CHIP) expenditures while preserving or enhancing the quality of care.

The Medicaid elements of the IBH Model shall operate according to existing Medicaid law, regulation, and sub-regulatory guidance, including, but not limited to, all requirements of any Medicaid demonstration projects under Section 1115 of the Act.

A3. Background

The United States is currently facing an unprecedented BH crisis, which was further exacerbated by the COVID-19 public health emergency that began in 2020.(1) A quarter of Medicaid

[1] HRSNs are an individual's unmet, adverse social conditions that contribute to poor health. These needs – including food insecurity, housing instability, unemployment, and/or lack of reliable transportation – can drive health disparities across demographic groups. An individual's HRSN are a result of their community's underlying social determinants of health (SDOH).

beneficiaries have BH diagnoses, yet they account for nearly half of total Medicaid expenditures.[2] An increasing number of Americans have mental health conditions and substance use disorders (collectively referred to in this document as "behavioral health" or "BH"). As of 2022, 23.1 percent of adults age 18 or older (or 59.3 million people) had a mental illness in the past year.[3] Among people age 12 and older, 17.3 percent (or 48.7 million people) had a SUD in the past year. Additionally, during the COVID-19 public health emergency, racial and ethnic minority communities experienced disproportionately higher rates of psychosocial stressors. The BH system has long been uncoordinated and under-resourced, resulting in the following long-standing challenges.

1. Poor Clinical Outcomes & Premature Mortality: People with BH conditions more frequently report co-occurring health conditions, such as diabetes, cardiovascular disease, and metabolic conditions, and higher rates of tobacco use.[4] Moreover, people with BH conditions are more likely to live with untreated or unmanaged HIV/AIDS and hepatitis C.[5, 6] Without adequate attention to PH needs, adults with mental health conditions and/or SUDs often have more emergency department (ED) visits and potentially preventable medical hospitalizations resulting from uncontrolled chronic conditions.[7] Adverse HRSNs further contribute to the medical comorbidity of people with BH conditions. Research has found that, "persons with mental illness have increased rates of poverty…lack of access to healthy food choices, unsafe living conditions, exposure to early trauma, chronic psychological stress, and poor social networks."[8]

Due in part to these factors, people with BH conditions experience worse health outcomes and significantly increased risk of premature mortality.[9-11] Premature mortality among people with mental illness is further magnified by substance use.[12] Preventable PH conditions contribute to premature mortality among people with severe mental illness and SUDs, reducing their lifespan by an average of 10 - 20 years.[13, 14] Compared to the general population, people living with serious mental illness (SMI) and/or moderate to severe SUDs have worse health outcomes and premature mortality due to: access to care obstacles, stigma related to receiving care, and untreated health conditions.[15, 16] A substance use disorder increases risk for overdose, accidental injury, attempted suicide, associated medical conditions, infectious diseases, and mental health conditions.

2. Increased Expenditures: Mismanaged (or unmanaged) BH conditions can lead to difficulty managing people's other chronic conditions as well as overutilization of certain types of costly care across the continuum, particularly in emergency department settings that are expensive and not aimed at prevention.[17] Total spending on BH increased approximately 62 percent between 2006 and 2015.[18] CMS spends substantially more on beneficiaries with BH conditions compared to spending for beneficiaries without.[19] People with co-occurring BH and PH conditions have higher overall health care needs and expenditures, and there is an opportunity for an intervention targeted at these people that aims to improve outcomes and reduce unnecessary spending. These higher costs are not just attributable to the costs of needed BH treatment, but to the mismanagement of BH conditions and lack of coordinated, accessible care for both BH and PH conditions. Because people with co-occurring BH and PH conditions have higher overall health care needs and expenditures, there is an opportunity for an intervention that aims to increase access to appropriate

levels of prevention and treatment, coordinate care, improve outcomes, and reduce unnecessary spending.

3. Uncoordinated System with Significant Disparities in Care and Outcomes: Negative outcomes and disparities of care for patients with BH conditions are driven by systemic issues, including historical underinvestment in BH care, siloing of BH and PH services, and the stigma of BH treatment.[20] Individuals with mental health disorders often have poor access to and continuity of quality medical care, and exhibit patterns of underusing primary care and overusing emergency and medical inpatient care.[8] Individuals with SUDs often experience difficulties navigating the complex SUD treatment system due in part to structural barriers within the system itself like limited access to providers and treatment, insufficient team training, and policy and legal constraints.[21] The BH care delivery system is often fragmented from PH care and lacks the integrated structures of care that promote long-term recovery.[2] While care in acute clinical settings remains important, there is also a need for clinically appropriate, community-based integrated services to meet people in the settings in which they are already actively engaged.

4. Health Information Technology (health IT) Barriers: BH system challenges are further exacerbated by slow adoption of certified health IT products and infrastructure improvements for their practice and patient population, including certified electronic health record (EHR) technology, and lower participation in health information exchanges (HIEs) among specialty BH providers compared to PH providers, as current reimbursement rates and increasing costs leave specialty BH providers unable to invest in the necessary hardware, software, staff, and training to support integrated care.[22] Many specialty BH providers were not eligible for financial incentives for EHR adoption that were provided to other categories of providers as part of the Health Information Technology for Economic and Clinical Health Act (HITECH Act), of 9, further exacerbating low uptake rates.[23] Interoperability across different providers and settings of care is critical to facilitate the collaboration and communication necessary for integrated, whole person care.

The HHS Substance Abuse and Mental Health Services Administration (SAMHSA) and the HHS Office for Civil Rights has made modifications under the authority of 42 U.S Code § 290dd–2 regarding the confidentiality of substance use disorder patient records, which are codified at 42 C.F.R. Part 2 and generally prohibits certain types of treatment programs from disclosing a patient's SUD information treatment records without patient consent except under specific circumstances such as reporting alleged child abuse, valid court orders, medical emergencies, and health care operations. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules also include protections for protected health information. Additionally, SAMHSA supports the Center of Excellence for Protected Health Information to help educate health professionals, family members, patients and others on HIPAA, Part 2, and other BH privacy requirements.[24] SAMHSA and the Office of the National Coordinator for Health Information Technology (ONC) also are working on efforts to promote use of EHRs by specialty BH providers.[25, 26] Additionally, SAMHSA supports the Center of Excellence for Protected Health

[2] SAMHSA defines recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf

Information to help educate health professionals, family members, patients and others on HIPAA, Part 2, and other BH privacy requirements.[24] SAMHSA and the Office of the National Coordinator for Health Information Technology (ONC) also are working on efforts to promote use of EHRs by specialty BH providers.[25]

5. Lack of Payment Innovation in the BH Space: Payment innovation has not focused on BH services, which are historically underfunded and rely on a patchwork of state, federal, and grant sources. Specialty BH providers often lack a clearly defined role in VBP models designed for PH providers, leaving specialty BH providers with limited opportunities to meaningfully participate in alternative payment models (APMs). There is a lack of BH process measures that evidence has shown are appropriate for use in clinical quality improvement programs. This absence of BH process measures has made it difficult for specialty BH providers to meaningfully engage in accountable care.[27] VBP arrangements have the potential to transform the way providers deliver care, by encouraging more time spent on collaboration and services that may not be traditionally covered under Medicare and Medicaid fee-for-service (FFS).

6. Health Inequity in the BH Space: Mental health care disparities, which include differences in access, quality of care, or treatment outcomes according to race and ethnicity, as well as social determinants such as employment, income, housing, gender, disability, age, sexual and gender identity, and veteran status are quite common in the BH space.[28, 29] After entering care, minority populations are less likely to receive the best available treatments for BH conditions, leading to individuals terminating treatment prematurely. In the last decade, efforts to eliminate or reduce these disparities in the BH space have not been successful in both primary care and specialty psychiatric services.

A3.1 How the IBH Model Addresses These Challenges Through Integrated Care and VBP

The challenges described above demonstrate that there is a need for a broader, federally coordinated effort to advance BH and PH care integration, improve the quality of care, and test innovative payment models within Medicare and Medicaid to achieve better, more equitable outcomes for beneficiaries with BH needs and reduce program expenditures.

Value-based care, where providers are paid based on patient outcomes, has the potential to reduce health care spending and improve overall health. However, specialty BH providers have had limited opportunities to participate in VBP models. The IBH Model will address these challenges by providing a VBP model for specialty BH organizations and settings to deliver whole-person integrated care.

Integrated care improves access to general health care by fostering better communication, alignment, and collaboration among providers caring for individuals with complex BH and co-occurring priority health conditions. Members of a care team collaborate to establish a comprehensive treatment plan addressing the person's biological, psychological, and HRSNs. For

many individuals with moderate to severe BH (MSBH) needs and co-occurring PH conditions, the BH setting may be the setting in which they are most actively engaged to receive needed care.

Significant progress has been made in developing various frameworks to build upon and advance integrated care[30-33], but the barriers described in Section A3 Background persist. The IBH Model will help minimize the barriers to high quality integrated care as exhibited in *Table A.1*.

Table A.1: IBH Model care delivery solutions for barriers to integrated care

Barriers to Care	IBH Care Delivery Solutions
1. **Poor Clinical Outcomes:** ***People often face barriers to having their PH needs identified in BH settings.*** This is due in part to a lack of: provider knowledge, support, and training related to PH screening needs; patient knowledge regarding PH screening needs; clarity regarding provider responsibility and accountability for screening for PH conditions; as well as insufficient resources and time during visits to facilitate screening and associated referrals.[34, 35]	The care delivery framework will prioritize specialty BH practices as the entry points for integrated, value-based care. Interprofessional care teams will provide screening, assessment, treatment, and referral for PH and BH needs with ongoing care management and individual-level interventions to address HRSNs and move towards health equity[3].
2. **Increased Expenditures:** ***BH and PH services and providers are often siloed, and people are not connected with the range of health services they need.*** This fragmentation can be especially difficult for people with BH diagnoses and results in underutilization of primary care, lack of access to specialty PH care, and the overuse of emergency department and inpatient medical care.	Interprofessional care teams will collaborate to establish a comprehensive treatment plan addressing the person's biological, psychological, and HRSNs, improving access to PH care by fostering better communication, alignment, and collaboration among providers caring for individuals with complex BH and co-occurring chronic conditions. The Model will also support the development of care pathways and protocols to ensure that people are connected with needed PH care when a need is identified.
3. **System Challenges:** ***Broader health system lacks capacity to address HRSNs.*** Individuals with BH conditions have increased rates of poverty, limited access to healthy food choices, and unsafe living conditions, which have been shown to exacerbate PH comorbidities.[8]	The IBH Model will require HRSN screening and referral using a validated screening tool, such as the Accountable Health Communities (AHC) HRSN Screening Tool and ensure that providers consider HRSNs within their treatment plans.
4. **Health IT Barriers:** ***Limited investment opportunities for specialty BH providers.*** Many specialty BH providers were not eligible for the EHR adoption financial incentives that were provided to other categories of providers as part of the Health Information Technology for Economic and Clinical	The IBH Model will provide specialty BH practices and SMAs infrastructure and cooperative agreement funding and technical assistance necessary for them to effectively adopt and implement health IT tools and to participate in local, regional, or state information sharing systems.

[3] Health equity means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

Health Act (HITECH) Act enacted in 2009, further exacerbating low uptake rates.[23]	
5. **Lack of Payment Innovation:** ***Payment innovation has not focused on specialty BH practices.*** Specialty BH practices often lack a clearly defined role in VBP models, leaving them with limited opportunities to meaningfully participate in APMs.	The IBH Model will provide an on-ramp to value-based payment by providing support for necessary infrastructure and health IT funding, preparing these providers to participate in VBP models. The IBH VBP model will align Medicare and Medicaid to enhance multi-payer alignment.
6. **Health Inequity in BH:** ***Disparities in access to and quality of care, use of care, and comprehensiveness of insurance coverage are persistent in BH care.*** Disparities can be rooted in historical exclusion from social and economic that result in barriers to care and unequal treatment over time.	The IBH Model will aim to achieve greater equity in outcomes. Practice Participants will engage in activities that foster equitable care through HRSN screenings, a population needs assessment, and a health equity plan (HEP)[4], which will detail steps to address the population needs and disparities identified in the population needs assessment, including how the Practice Participant will build care teams that reflect the needs of the population based on the population needs assessment.

A3.2 Alignment with Federal Priorities and State Medicaid Program Trends and Themes

The IBH Model is aligned with the BH priorities set by CMS and the Department of Health and Human Services (HHS) in the September 2022 HHS Roadmap for Behavioral Health Integration. The IBH Model will support these priorities by:

- Reducing silos across programs and settings; and
- Ensuring that "the full spectrum of BH care will be integrated into health care, social service, and early childhood systems to ensure all people have equitable access to evidence-based culturally appropriate, person-centered care."[36]

In addition, the IBH Model is designed to harness state interest and capacity-building in BH and build directly on this architecture, where appropriate. Specific examples that may support the IBH Model include:

- States have been the early innovators in designing and operationalizing VBP efforts among specialty BH practices through various Medicaid innovation initiatives including but not limited to waivers, demonstration programs, and grants.[37]
- Approximately eight states are utilizing flexibilities under Section 1115 of the Social Security Act to cover HRSN services that would otherwise not be available for federal

[4] A health equity plan aims to provide organizations and its stakeholders a clear framework to becoming an organization that values and prioritizes health equity.

match, including services such as housing and housing supports, transportation assistance, and nutritional services.

- Over twenty states noted initiatives in their American Rescue Plan Act of 2021 Section 9817 State Spending Plans related to mental health, substance use disorder treatment, and initiatives focused on HRSNs.
- States have also undertaken the Certified Community Behavioral Health Clinic (CCBHC) demonstration, the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) program, and the Medicaid State Plan option to provide coordinated care through the establishment of Health Homes[5] for individuals with chronic conditions (see Section 1945 of the Social Security Act) to improve access to BH care, improve statewide BH crisis systems and develop comprehensive approaches to PH and HRSNs.[38-40] As of December 2023, 20 states support 35 health home models to support care coordination for patients with complex needs, including those with BH conditions.

A4. Program Requirements

Below are the core functions Recipients are required to complete in the Pre-Implementation and Implementation Periods of the IBH Model, with associated examples of cooperative agreement funding use.[6] Recipients may fulfill these requirements themselves and may also work with managed care entities or other state entities like agencies with regulatory authority over mental health and/or substance use disorder providers to ensure these tasks are completed. Of note, the funding provided pursuant to the Cooperative Agreement may not be claimed for Federal Financial Participation (FFP) purposes.

Recipients also have reporting and evaluation requirements throughout the performance period as detailed in Section F6. Reporting.

Recipients must detail their potential plans to operationalize the core functions as part of their application as further described in Section D2.4.1 Project Narrative.

A4.1 Model Structure Overview

The IBH Model will focus on state-based innovation, led by the state Medicaid agency (SMA) as the Recipient, to test a care delivery framework where the BH setting is the facilitator of integrated care. Specialty BH practices and settings (see Section A4.1.1 Definitions within the selected states will be the Practice Participants and entry points for adult Medicaid, Medicare, and dually eligible beneficiaries to receive integrated care. Recipients of this award will develop a Medicaid Payment Approach that includes a Medicaid performance-based payment (PBP). The Medicaid Payment Approach shall align with the Integration Support Payment (ISP) and Medicare PBP developed by CMS (further details available in Appendix XI Medicare Payment Approach Details). The Medicaid Payment Approach will be implemented in parallel to the Medicare Payment Approach

[5] https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html

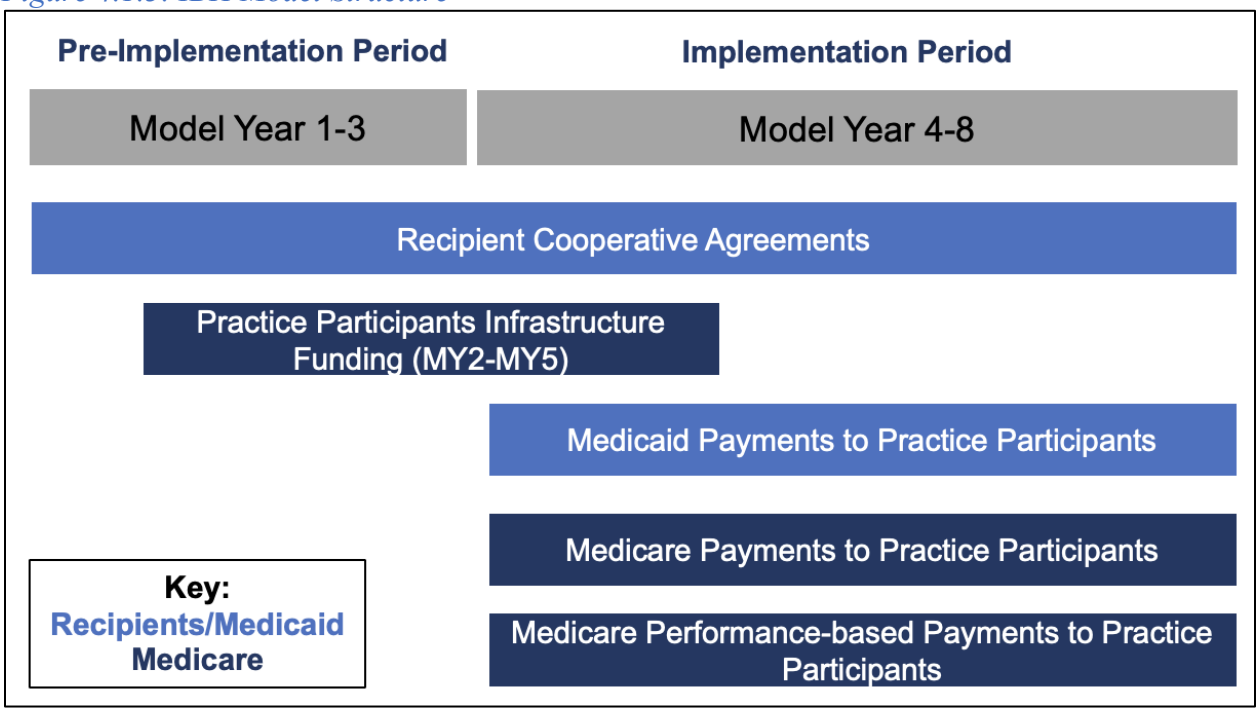
[6] This is not an exhaustive list of requirements or cooperative agreement funding use.

for eligible Practice Participants within the selected states. Recipients can operate the IBH Model across their state or in a specified sub-state area.

CMS will award, through a competitive process, cooperative agreements to up to eight successful Recipients. During the three-year Pre-Implementation Period, Recipients will be required to undertake several readiness and technical assistance activities to support Practice Participants and develop their Medicaid Payment Approach in partnership with CMS. The Pre-Implementation Period is designed to help Recipients:

- identify and recruit Practice Participants alongside relevant partners (Such as MCOs or state mental health authorities and/or single state agencies for SUDs;
- support their Practice Participants in developing the needed infrastructure and technical expertise to implement the care delivery framework;
- meet data reporting requirements; and
- establish a Medicaid Payment Approach to support the care delivery framework.

Figure 4.1.3: IBH Model Structure



A4.1.1 Model Definitions and Components

IBH Model Definitions	
Infrastructure Funding	Payments made by Recipients to Practice Participants to support and fund investments in certified health IT products and infrastructure improvements for their practice and patient population, including (1) improving data infrastructure; (2) establishing quality goals; (3) supporting data collection efforts to advance toward accountable care and the development of a health equity plan; and (4) support practice transformation activities.
Integration	The coordination (and as appropriate, provision) of PH care[7] by the BH care team and in the BH setting, along with attention to HRSNs and appropriately matched BH interventions. Integration in the IBH Model is a person-centered approach to identify and address (as appropriate within scope of practice) PH in the BH setting in

[7] Physical health care includes care and services for non-behavioral health conditions (i.e., mental health and SUDs) and is inclusive of oral health.

	which the person with moderate to severe BH conditions may be already or more frequently engaged to supporting whole-person health. This care may be co-located or virtual.
Physical Health (PH) Consultant	A PH provider who specializes in the diagnosis, evaluation, and therapeutic management of PH conditions and is qualified to prescribe medication (physician, nurse practitioner, etc.). The PH Consultant participates in regular review of the clinical status of beneficiaries receiving IBH services and advises the billing practitioner and care management team about screening and follow-up for positive screens, PH diagnosis, treatment initiation, care options, monitoring for complications of PH conditions, and options for resolving issues with beneficiary adherence and tolerance of PH treatment with a culturally informed and person-centered approach. The PH Consultant also advises on managing any negative interactions between beneficiaries' PH and BH treatments and HRSNs and offers a referral for direct provision of primary care when clinically indicated and suggests specialty care options as needed. The PH Consultant could be an in-house provider working at a specialty BH practice or could be an outside provider who contracts with a specialty BH practice.
Physical Health (PH) Providers	Physicians and non-physician practitioners whose primary area of practice involves the diagnosis, evaluation, and therapeutic management of non-BH conditions.
Primary Care	Primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.
Specialty BH Organizations and Settings	A health care provider, practice, facility, or other community-based organization delivering BH treatment services outside of an inpatient, emergent, or urgent care level of care where BH services are available to beneficiaries and are the predominate health care service type delivered, or

	where longitudinal BH services are available and delivered by a specialty BH provider. This includes local health departments, or another entity that is part of a local government behavioral health authority where a locality, county, region, or state maintains authority to oversee behavioral health services at the local level and uses the entity to provide those services. This longitudinal accountable BH care arrangement involves a Practice Participant who agrees to be accountable for quality, utilization, patient experience, and care integration over a sustained period.
Specialty Behavioral Health ("BH") Providers	Specialty BH providers refers to physicians, non-physician practitioners, and other eligible professionals whose primary area of practice involves the diagnosis, evaluation, and therapeutic management of mental health and SUD conditions, as permitted under federal and state law. Specialty BH providers must be eligible to bill for services (i.e., be billing practitioners) and may include physicians (medical doctors or doctors of osteopathy), clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners, physician assistants, and independently practicing psychologists with marriage and family therapists, and mental health counselors as specified in the CY2024 Physician Fee Schedule final rule.

IBH Model Components	
Care Delivery Framework	An Integration framework for adult Medicaid and Medicare beneficiaries with MSBH implemented for Practice Participants statewide or within a sub-state region.
Commercial payer participation	Recipients are encouraged to use existing relationships with commercial payers to further strengthen payer alignment efforts in their states.
Medicaid participation	Practice Participants that currently serve (or will serve) Medicaid beneficiaries and/or are currently billing Medicaid in participating states by the start of model year (MY) 2. Practice Participants must at minimum participate in their state's Medicaid Payment Approach to participate in the IBH Model. Practices that participate in the Medicaid

	Payment Approach may be eligible to participate in the Medicare Payment Approach. State agreements with Practice Participants will follow existing state protocols for Medicaid participation. Recipients will lead the design of the Medicaid Payment Approach and care delivery framework and provide technical assistance and programmatic support to Practice Participants.
Medicare participation	Practice Participants that participate in their state's Medicaid Payment Approach *and* are accepted to participate in the Medicare Payment Approach. Practice Participants will enter into separate participation agreements with CMS that govern the Medicare Payment Approach. Providers that do not participate in the Medicaid Payment Approach cannot participate in the Medicare Payment Approach.
Multi-Payer Approach	The IBH Model is focused on multi-payer alignment. Multi-payer alignment is critical to achieving model success because it streamlines care delivery efforts and payment for IBH Practice Participants across their patients and lines of business. The IBH multi-payer approach consists of the following principles: • **Directional alignment**: CMS will work with Recipients to closely align on areas of the Model that directly reduce provider burden and are important to model aims and evaluation of outcomes, such as quality measurement, the type and format of data provided, and learning priorities. CMS will not require Recipients to build identical payment arrangements to other Recipients and/or to what is proposed in the Medicare ISP and PBP. Directional alignment is detailed further in Section A4.4.4: Multi-Payer Alignment. • **Medicaid Flexibility**: Recipients may customize certain model elements, such as Medicaid payment systems and care delivery, while remaining directionally aligned with IBH's Medicare Payment Approach. Specifically, CMS will require Recipients to move Practice Participants away from traditional Medicaid FFS payment, but

	Recipients will have flexibility to choose what type of non-FFS Medicaid payment to implement. (See Sections A4.4 IBH Payment Strategy and A4.3 IBH Care Delivery Framework for specific areas of flexibility.)
Practice Participation	Eligible specialty BH organizations and settings ("Practice Participants") may elect to participate by delivering the IBH care delivery framework (A.4.3 IBH Care Delivery Framework) and, in exchange, receive payment for their eligible beneficiaries (defined further in Section A4.2.1 Eligible Practice Participants). Practice Participants may also be eligible to receive specific funding to procure necessary health IT upgrades such as adopting EHRs.
SMA Participation	Recipients (SMAs) receive cooperative agreement funding in both the Pre-Implementation and Implementation Periods to support the development of key model activities, including, but not limited to, the Medicaid Payment Approach, care delivery framework, and key data sharing and infrastructure activities.

This section displays the Recipient cooperative agreement requirements for the pre-implementation and implementation periods. Table A.4.1.2 exhibits a summary of each requirement and where further details can be found.

Table A.4.1.2: Cooperative agreement requirements – at a glance:

Requirement	Description	Relevant Section
• **Recruit IBH Practice Participants**	• The Recipient will be required to work with relevant parties to recruit eligible BH Practice Participants to the IBH Model	• A4.2 Recruit Practice Participants
• **Design and implement the IBH care delivery framework**	• The Recipient will collaborate with CMS, Practice Participants, and relevant parties to design and implement the IBH care delivery framework	• A4.3 IBH Care Delivery Framework
• **Design and implement the IBH Medicaid payment**	• The Recipient will design, establish, and implement the	• A4.4 IBH Payment Strategy

arrangement	IBH Medicaid Payment Approach in partnership with CMS	
• **Distribute infrastructure and cooperative agreement funding**	• The Recipient will distribute cooperative agreement and Infrastructure Funding to help achieve model goals	• A4.5 Infrastructure Development and Funding Distribution
• **Participate in the convening structure**	• The Recipient will aid in identifying and implementing a convening of relevant IBH parties	• A4.6 Convening Structure
• **Participate in model data, quality, and evaluation efforts**	• The Recipient will enable the continuous flow of IBH Model data, including through quarterly measure submission and technical assistance to Practice Participants	• A4.7 Data, Quality, and Evaluation

A4.2 Recruitment of Practice Participants

A4.2 Recruitment Requirements:

Pre-implementation period requirements	Implementation period requirements
During the pre-implementation period, Recipients must: • Implement the BH practice recruitment strategy. ○ Identify, recruit, and enroll eligible BH Practice Participants. • Secure a letter of intent from at least one managed care organization (MCO), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs) (where applicable) to participate in the IBH Model. • Secure a letter of intent from the State Mental Health authorities and/or Single state agencies for SUDs.	*During the implementation period, recipients must:* • Enroll and retain BH Practice Participants. • Continue to recruit Practice Participants through the end of MY 4.

Recipients are required to solicit interest and recruit Practice Participants into the IBH Model who meet the eligibility criteria detailed below in Section A4.2.1 Eligible Practice Participants and must submit a practice recruitment strategy with their application. CMS encourages Recipients to include State Mental Health Authorities and/or Single State Agencies for SUDs, and managed care organizations, risk-based prepaid inpatient health plans (PIHPs), risk-based prepaid ambulatory health plans (PAHPs)[8], or other intermediaries in developing the practice recruitment strategy given their knowledge of existing practice networks. The practice recruitment strategy shall include:

a. A plan for recruiting Practice Participants into the IBH Model, including key partners and how they may support recruitment activities.
b. Plans to include outreach with rural, safety-net specialty BH providers, under-resourced providers, tribal providers, and providers serving vulnerable populations in the recruitment strategy.
c. An estimated number of Practice Participants enrolled in the IBH Model by the end of MY 3.
d. An estimated number of total Medicaid enrollees with MSBH conditions to be attributed to the IBH Model for the entire duration of the Implementation Period.

Recipients (or their fiscal intermediaries) are required to have Practice Participants recruited into the IBH Model by the start of MY 2 and may continue recruiting Practice Participants through the end of MY 4.

In addition to recruiting Practice Participants, the Recipient must secure a letter of intent (LOI) from at least one MCO, PIHP, or PAHP, if the Recipient's BH network is managed through an MCO, PIHP, or PAHP, at the time of submitting this application. The Recipient must also secure a letter of intent from their State Mental Health Authorities and/or Single State Agency for SUDs.

CMS will work with participating state Medicaid agencies to determine the pathway for implementing the Medicaid payment arrangement, including any state plan amendments, waivers (including but not limited to Medicaid section 1115(a) authority, 1915 authority), or Medicaid managed care contract modifications that may need to be approved.

A4.2.1 Eligible Practice Participants

Within the Recipient's proposed geographical service area, specialty BH organizations and settings will be eligible Practice Participants who, at the time of application, meet all the following criteria:

- Have at least one BH provider that is an employee, leased employee, or independent contractor of the practice and:
    1) Is licensed by the state to deliver BH treatment services; and
    2) Meet any state-specific Medicaid provider enrollment requirements and is eligible for Medicaid reimbursement.

[8] All references to PIHPs and PAHPs refer to risk based PIHPs and PAHPs

- Meet all state-specific requirements to deliver BH services, if applicable; and
- Serve adult Medicaid beneficiaries (age 18 or older) with moderate to severe BH conditions; and
- Provide MH and/or SUD treatment services at the outpatient (OP) level of care. This does not include the intensive outpatient (IOP) level of care.

Practices that provide only case management[9] or only recovery services or do not provide direct delivery of diagnostic or treatment of BH services are **not** eligible to be Practice Participants.

Inpatient and post-acute care settings are **not eligible** to participate in the IBH Model. Post-acute care includes, but may not be limited to, home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. The IBH Model has adopted this policy to assure program integrity and avoid duplicate services and payments with inpatient and post-acute care prospective payment systems and value-based purchasing programs.

Examples of eligible Practice Participants may include but are not limited to:

- Community Mental Health Centers (CMHCs);
- Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes that provide specialty BH care services;[10]
- Rural Health Clinics (RHCs) that provide specialty BH care services;[10]
- Critical Access Hospital (CAH) outpatient BH clinics;
- Independent health care providers with and without clinic affiliations;
- Certified Community Behavioral Health Clinics (CCBHCs);
- Opioid Treatment Programs (OTP);
- Private specialty clinics with and without medical center affiliations.
- Specialty substance use disorder provider organizations;
- Tribal health organizations and clinics; and
- Local and territorial health departments and governments or other entity that is part of a local government BH authority where a locality, county, region, or state maintains authority to oversee BH services at the local level and uses the entity to provide those services.

Practice Participants will be identified using a combination of their tax identification number (TIN) and national provider identifier (NPI), cross-referenced through the required provision of Medicaid provider identification numbers.

To be eligible to participate in the model, when the state recruits a practice to participate, that practice must serve, at the outpatient level of care, at least 25 Medicaid MSBH beneficiaries on average per month. As outlined in Section A4.2.2 Eligible Beneficiaries, all adults served by the

[9] The Social Security Act, § 1915(g)(2), defines case management services as those assisting individuals eligible under the State plan in gaining access to needed medical, social, educational, and other services. Case management services do not include the direct delivery of an underlying medical, educational, social, or other service for which an eligible individual has been referred.
[10] Additional information regarding FQHC and RHC eligibility requirements will be released in future guidance materials.

eligible Practice Participant are eligible to receive model services where medically necessary and appropriate regardless of diagnostic status. The Innovation Center anticipates each state will include approximately 10,000 Medicaid beneficiaries with MSBH conditions throughout the course of the Model. To reduce practice burden and ensure an equitable continuity of services, states are encouraged to require Practice Participants to treat all Medicaid beneficiaries with BH needs through the IBH care delivery framework, where the services are deemed reasonable and medically necessary.

The specific BH diagnoses defined by CMS, in consultation with clinical subject matter experts from SAMHSA, as "moderate to severe" are listed in Appendix XIV .[11] CMS reserves the right to consider changes should diagnoses need to be added or removed from the list of MSBH diagnoses. CMS will communicate any changes to Recipients with advance notice. Recipients will work with their Practice Participants, State Mental Health authorities and Single state agencies for SUDs and partnering MCO (or other fiscal intermediary) to develop a process to verify that practices serve the minimum number of Medicaid MSBH beneficiaries, no less than annually. Additionally, recipients will make their Practice Participant Lists available to CMS as part of their model reporting requirements detailed in Section F6.3 Performance Milestones.

The Practice Participant eligibility criteria will be the basic framework that Recipients will be required to use to identify eligible Medicaid Practice Participants. Recipients (and as applicable their partners, such as MCOs, PIHPs, or PAHPs) may not apply further limiting eligibility criteria in addition to the criteria laid out by CMS, except for limiting eligibility by sub-state region as allowable and identified in its application.

Medicaid Practice Participants will also be eligible to participate in the Medicare Payment approach of the Model, assuming they are enrolled as fee-for-service Medicare providers and are in good standing,[12] and meet the IBH Practice Participant criteria. Practice Participants will not be allowed to participate in the Model as Medicare-only providers but may choose to participate only in the Medicaid payment arrangement. Ideally, all IBH Model Practice Participants will participate in both Medicaid and Medicare to bolster multi-payer alignment.

A4.2.2 Eligible Beneficiaries

All adult Medicare and/or Medicaid beneficiaries receiving care from eligible Practice Participants will be eligible for the Model, regardless of their specific BH diagnoses, if the services are deemed reasonable and medically necessary. If services are not reasonable and medically necessary (i.e., the level of care required by the IBH care delivery framework is not needed), the beneficiary will not be enrolled in the IBH Model. Recipients shall encourage Practice Participants to educate

[11] The IBH Model's "moderate to severe" behavioral health conditions are not to be confused with SUD mild, moderate, or severe classifications that are based on the number of diagnostic criteria that are fulfilled. Thus, in this NOFO, "moderate to severe" does not refer to those specific SUD classifications.

[12] Good standing means able to bill Medicare, Medicare Provider Enrollment, Chain, and Ownership System (PECOS) is up to date, and provider does not have any outstanding fraud and abuse litigation.

beneficiaries regarding IBH services and develop standardized practices to assess a beneficiary's need for the IBH care delivery framework services.

A4.3 IBH Care Delivery Framework

A4.3 Section Requirements:

Pre-implementation period requirements	Implementation period requirements

During the pre-implementation period, Recipients must:
• Design and prepare implementation of the IBH Medicaid care delivery framework as described in this section.
  ○ Provide updates on the design of the care delivery framework in quarterly progress reports.
	During the implementation period, Recipients must:
	• Implement the IBH Medicaid care delivery framework as described in this section.
	  ○ Provide implementation updates, successes, challenges, and lessons learned in quarterly progress reports.

The Recipient must design and prepare for implementation of the IBH care delivery framework that enables Practice Participants and their partners to deliver care integration, care management, and health equity services as detailed below in Section A4.3.1 Care Delivery Framework Overview.

The Recipient must provide updates on the development of the care delivery framework in Quarterly Progress Reports during the pre-implementation period. The IBH care delivery framework must be ready for implementation by Practice Participants at the start of MY 4. Recipients must adhere to all applicable Federal, state, and local laws and ordinances, and shall work with their Convening Structure to determine what patient authorizations and reauthorizations may be required to implement the IBH Model as designed, for example, to engage in data sharing activities.

The Recipient must implement the IBH care delivery framework including maintaining the infrastructure, processes, and programs established during the model Pre-Implementation Period throughout the duration of the Model. As detailed below and throughout this NOFO, these include, but are not limited to, maintaining and supporting required staff to implement the Model, and ensuring all required services are being furnished by Practice Participants and their partners. Additionally, Recipients must maintain relationships with Practice Participants and MCOs, PIHPs, PAHPs, or other fiscal intermediaries.

Examples of funded activities:

- Practice transformation activities for Practice Participants to carry out the IBH care delivery framework.
- Clinical subject matter support to implement the IBH care delivery framework.
- Benefit design activities to support the implementation of the IBH care delivery framework.

A4.3.1 Care Delivery Framework Overview

The Recipient is responsible for developing the IBH Medicaid care delivery framework in partnership with CMS according to the requirements set forth in this document. Recipients will leverage convenings with commercial payers, potential Practice Participants, and other stakeholders to design and operationalize the IBH Model's Medicaid component of the care delivery framework. The Recipient will use a shared vision for population health and health equity outcomes, considering state-specific nuances and context, to build the Medicaid care delivery framework, capitalizing on existing infrastructure and capacity within the state. The Innovation Center will publish further care delivery framework guidance in model pre-implementation.

Required Elements: The IBH Model's care delivery framework includes three required core elements necessary to test a standard of integrated, person-centered care in specialty BH organizations and settings. Recipients will aid Practice Participants in delivering the following services:

1) **Care integration**: Practice Participants will screen, assess, treat, and refer patients as needed for both BH and PH conditions, within the scope of practice of the Practice Participants' providers.
2) **Care management**: an interprofessional care team will address the needs of the beneficiary and provide ongoing care management across the beneficiary's BH and PH needs.
3) **Health equity**: Practice Participants will engage in activities that foster equitable care through HRSN screenings, a population needs assessment, and a health equity plan.

Optional and Complementary Components: As previously noted, the IBH Model encourages Recipients to build on existing initiatives, and as such, Recipients may include additional care delivery services, particularly those that are relevant to their state or sub-state context. The care delivery framework requirements listed in Section A4.3.3 Care Delivery Framework Requirements are necessary to reach model directional alignment for integration and shall not deter additional innovation at the state level.

- The IBH Model encourages Recipients to provide additional services, as relevant to their populations and context.
- Recipients are encouraged to build on existing policy infrastructure and integrate the IBH Model into existing Medicaid BH models focused on the priority population (beneficiaries with moderate to severe BH conditions) including but not limited to CCBHCs, Medicaid Health Homes, OTPs, and the PIPBHC program.

A4.3.2 Priority Health Condition Requirements: Diabetes, Hypertension, Tobacco Use

The IBH Model will use diabetes, hypertension, and tobacco use as measures of care integration. Therefore, Practice Participants must screen eligible beneficiaries for diabetes, hypertension, and tobacco use. These priority health conditions were based on:

- evidence on their prevalence in the BH beneficiary population;
- the level of spending on each condition by CMS;
- clinical expertise on the ability to treat these conditions in the BH setting; and
- the increased risk of morbidity, disability, and mortality for beneficiaries associated with these conditions.

Assessment and treatment of these conditions in BH settings can be carried out by an in-person PH consultant. Alternatively, a telehealth appointment may also be used for assessment and treatment where the use of telehealth appointments is otherwise allowed.

***Mandatory Components*:** Recipients will develop a Medicaid Payment Approach that enables their Practice Participants to screen and assess the beneficiary's PH needs, followed with appropriate treatment and/or referral. Screening must be evidence-based and must include, at a minimum, diabetes, hypertension, and tobacco use. Screening may include, but is not limited to:

- Reviewing the beneficiary's medical history and medications to assess for a current diagnosis;
- Assessing risk factors or symptoms; and
- Performing screening labs or tests in accordance with evidence-based guidelines.

***Optional Components*:** Recipients may require additional priority health conditions to be included in each beneficiary's screening. Recipients are encouraged to include:

- conditions that are a priority within the Recipient's state or regional context;
- conditions where health disparities are prevalent; and
- conditions that can enhance the case for post-model sustainability. For example, high-cost conditions that have savings potential within the proposed geographic region.

For example, a Recipient may choose to include hepatitis C as a priority health condition.
If a Recipient chooses to add additional priority health conditions, the Recipient shall propose an accompanying quality measure to assess outcomes.

A4.3.3 Care Delivery Framework Requirements

The requirements for the IBH Model care delivery framework are listed in the table below. The first two columns of the table include requirements for Recipients and Practice Participants. The third column lists examples of enhanced innovation opportunities for Recipients and Practice Participants to drive further innovation. The fourth column shows existing initiatives and policies

as examples of activities or requirements that are occurring in states. The latter two columns are not exhaustive and are intended for illustrative purposes only.

Core Element	Recipient Requirements	Practice Participant Requirements	Enhanced Innovation Opportunities	Existing Initiatives and Policies

Care Integration	• Provide evidence-based guidelines for BH and PH screenings to Practice Participants as needed.
	• Evaluate and map Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes to ensure all IBH requirements can be delivered.
	• Work with intermediaries to evaluate primary care provider networks and access standards to ensure IBH beneficiaries can access PH care in a timely manner.
	• Work with the convening structure and or intermediaries to facilitate learnings and TA around care integration.
	• Work with CMS to ensure compliance with Medicaid rules and secure any necessary modifications to existing program structures.
		• Use evidence-based guidelines to screen and assess BH and PH conditions, and HRSNs as part of the IBH Welcome Visit.[13]
		• Use evidence-based guidelines to screen and assess BH and PH conditions and HRSNs as part of ongoing patient care.
		• Screen to determine if a beneficiary is engaged with a provider to receive primary care services.
		• Build a comprehensive care plan with input from a PH consultant[14].
		• Consult with a PH provider on PH treatment initiation, care options and monitoring for complications of PH conditions, and negative interactions of PH with BH treatment and HRSNs[15].
			• Recipients may establish guidelines around the provision of PH treatment in the BH setting, including but not limited to:
			  ○ Telehealth consultation by a PH provider,
			  ○ Co-location of a PH provider,
			  ○ Treatment by a dual-trained or certified BH/PH provider, and/or
			  ○ Protocol-guided treatment initiation with PH provider referral and follow-up
				• CCBHC demonstrations and grants
				• Medicaid Health Homes
				• PIPBHC program

[13] The IBH Welcome Visit also involves the receipt of informed consent from the beneficiary for IBH Model services and inclusion in the model.

[14] Practice Participants who cannot provide identified E&M services within their scope of practice will be encouraged to develop an annual care agreement or other relationship with PH providers outlining roles and shared accountability and will be required to submit a roster of their partnering PH providers; the roster would make the listed PH providers eligible to use a new or modified consult and/or care management code. If no roster is in place, the PH provider will use existing professional consult codes for payment. Referral to a specific PH care provider shall align with the beneficiary's preferences; if the beneficiary's physical health provider is not included on the roster under this model with the Practice Participant, the physical health provider shall use existing professional consult codes for payment.

		• Re-evaluate the care plan based on patient outcomes, with input from a PH consultant if needed. • Treat identified BH and PH conditions based on the specialty BH provider's scope of practice or refer to a PH provider as needed. • Refer beneficiaries to social services to address identified HRSNs, with support from a community health worker, peer support specialist, or other navigator as needed. • Track beneficiary goals, treatment progress, and/or outcomes using a standardized patient-reported outcome measure. • The implementation and use of certified Health IT products and infrastructure improvements for their practice and patient population		
Core Element	**Recipient Requirements**	**Practice Participant Requirements**	**Enhanced Innovation Opportunities**	**Existing Levers**
Care Management	• Recipients will provide state-specific guidance to Practice Participants on utilization of any state-based data warehouse or care management tools for health care and social service navigation	• Provide care management that includes person-centered planning, care coordination, utilization management, transitional care services, and health care navigation for each beneficiary's BH and PH conditions and HRSNs.	• Recipients may add additional care management requirements for Practice Participants, with associated quality metrics as appropriate	• MCO may support providers with data analytics, care management workflows, provide encounter information

		• Provide beneficiary self-management support, and outreach and engage beneficiaries in BH and PH care, with support of peer support workers or other clinical staff. • Establish care pathways to ensure that identified conditions are tracked over time, beneficiaries are receiving care included in the care plan, and that updates to the care plan occur when there are relevant changes in a beneficiary's status. • Establish procedures for and manage instances of hospitalization, emergency department use, and other care transitions (admission, discharge, and transfer) • Track and monitor beneficiaries' BH and PH conditions, HRSNs, and treatment needs to coordinate across disciplines		and claim line feed, provide data on member preferences, educate providers on existing programs or opportunities for members to connect them appropriately, enrollment support, connect with social support agencies and organizations etc.
Core Element	**Recipient Requirements**	**Practice Participant Requirements**	**Enhanced Innovation Opportunities**	**Existing Levers**

Health Equity	• Facilitate relationships between social service agencies and Practice Participants through introductions, shared meetings, and appropriate connections to facilitate warm hand-offs (e.g., through the Model's convening structure). • Provide Practice Participants with a population needs assessment detailing the health disparities experienced by the Practice Participant's service population. This population needs assessment: • Will include cultural, linguistic, geographic, and technological needs, the impacts of large-scale public health emergencies (e.g., COVID-19), and BH and PH treatment needs as well as HRSNs. • Identify existing disparities in outcomes stratified by certain characteristics. • Will include a statewide plan that identifies the strengths and challenges in how	• Screen each beneficiary for HRSNs on a minimum of an annual basis and use this information to inform the beneficiary's care plan. • Participants will (1) choose a state-required HRSN screening instrument or (2) select questions for each required domain from the Gravity Project's list of validated, health IT-encoded screening instruments, located in the National Library of Medicine Value Set Authority Center, or (3) from a list of HRSN screening instruments provided by CMS. • Develop and implement protocols for screening, referrals, and follow-up of HRSNs. • Build a health equity plan (HEP) that details steps Practice Participants will take to address the population needs and disparities identified in the population needs assessment, including how the Practice Participant will build care teams that reflect the needs of the population based on the population needs assessment. The HEP shall stipulate how the Practice Participant will address disparities that disproportionately impact their service populations.	• Recipients may develop and implement statewide protocols for screening, referral, and follow up of HRSNs. • Recipients may be able to use new or existing waiver authorities or demonstrations to fund the provision of social services for identified HRSNs. • Recipients may add additional state requirements for HRSN data collection in addition to the Innovation Center-approved HRSN screening tools. • Recipients may facilitate closed-loop referrals with social service agencies by providing appropriate data warehousing and management. • Recipients are encouraged to use an existing population needs assessment that is completed for another state or federal program	• Existing population health/needs assessments • State-led health equity coalitions • State departments of social and/or human services • Section 1115 demonstration • HRSN opportunities • Managed care contracts • SAMHSA block grants

	the Recipient is addressing these disparities at the state level. • Provide suggested opportunities for how Practice Participants can address disparities within their practice and align their efforts with state activities. • Be no less than 5 years old and be updated at least every 5 years during this model.			

A4.4 IBH Payment Strategy

A4.4 Section Requirements:

Pre-implementation period requirements	Implementation period requirements

During the pre-implementation period, recipients must:
• Develop the IBH Medicaid Payment Approach by the end of MY3 for implementation at the start of MY4.
  ○ Provide updates on the design of the Medicaid Payment Approach in quarterly progress reports.
  ○ The Medicaid Payment Approach shall include an attribution approach.
	During the implementation period, recipients must:
	• Implement the IBH Medicaid Payment Approach.
	  ○ Provide Medicaid Payment Approach updates, successes, challenges, and lessons learned in quarterly progress reports.
	  ○ Provide CMS with a list of Medicaid attributed beneficiaries on a quarterly basis.

The Recipient must develop an IBH Medicaid Payment Approach that includes all of the required services detailed in Sections A4.3 IBH Care Delivery Framework, A4.4.1 Medicaid Payment Approach Overview, and D2.4.1 Project Narrative. The IBH Medicaid Payment Approach must have a performance-based payment component which includes all practice-based measures detailed in Section A4.7.2.1 State-based and Practice-based Measures. Recipients are encouraged to engage members of their Convening Structure (further described below) in the design of their Medicaid payment arrangement. The Medicaid Payment Approach must be established by the end

of MY 3 for Practice Participants to utilize at the start of MY 4. The Recipient must communicate successes and difficulties in developing their Medicaid Payment Approach with their federal Project Officer so they can help in providing technical assistance. Examples of relevant updates in the design phase of the Medicaid Payment Approach include but are not limited to:

- Identifying the applicable federal or state authorities to establish the IBH Model Medicaid Payment Approach;
- Developing the IBH Model payment rates; and
- Designing and implementing any necessary billing procedures.

The Recipient must implement the approved Medicaid Payment Approach starting at the beginning of MY 4. The Recipient shall clearly report progress and impediments in implementing the Medicaid Payment Approach in quarterly progress reports. Such updates shall include information about the performance-based payments that the Practice Participants are receiving, including but not limited to:

- Collection of cost data to support monitoring and overall evaluation of the IBH payment approach;
- Performance of practice participants in the Medicaid Payment Approach and PBP;
- Successes and challenges of implementing the Medicaid Payment Approach.

Please note that payments for the Medicaid Payment Approach are required to come from existing state Medicaid funds. The federal funds provided as part of this NOFO cannot be used to cover any clinical services or administrative expenses for which the state is claiming federal financial participation for Medicaid administrative services.

A4.4.1 Medicaid Payment Approach Overview

The Medicaid Payment Approach shall support practice participants in achieving person-centered care and include value-based incentives that reach the care teams who deliver care and incentivize practice participants to invest in and adopt new approaches to care delivery and integration of care, while striking a balance of financial and clinical risk that is appropriate and manageable. The Medicaid Payment Approach includes the Medicaid Payment Approach and the PBP. The Medicaid Payment Approach and PBP shall move Recipients away from traditional Medicaid FFS payments to value-based payments. More specifically, Recipients must at a minimum initially meet the LAN Category 2A payment model with ties to infrastructure (such as those provided for health IT investments). No later than MY 4, the payment shall progress to at least a LAN Category 2B and transition to a Category 2C or above for select measures in MY 5, where payments are based on FFS architecture with ties to reporting and performance on specific quality measures. The IBH Model's Medicaid Payment Approach is built to be flexible to meet the unique needs of individual states, and to be adaptable in conjunction with existing state Medicaid programs. CMS recognizes that many states have undergone comprehensive innovation in BH benefit design and payment. In addition, many states have implemented, or are considering implementing, existing Medicaid state-based initiatives, such as behavioral Health Homes and CCBHCs.

The IBH Model's approach to Medicaid payments aims to:

- Leverage the strengths and innovation of Recipients;
- Harness the policy momentum in states;
- Bring Medicare to the table; and
- Develop aligned Medicare and Medicaid alternative payment models that provide stability and support providers during their transition to value-based care. Recipients have flexibility in designing their approach to the Medicaid IBH payment model to allow the state to align IBH with their state's current BH delivery systems design and priorities.

As described in Section A4.1 Model Structure Overview, the IBH Model will include aligned Medicaid and Medicare Payment Approaches. Each payment approach includes the same core elements, described below. Recipients who are currently participating in the federal CCBHC Demonstration and want to include their CCBHC Demonstration providers in the IBH Model shall reference Appendix X: Medicaid Payment Scenarios for Health Homes and CCBHCs for information about Infrastructure Funding, payment, and performance-based payments.

The IBH Model's approach to multi-payer alignment is designed to provide flexibility across three core features in a way that enables payer alignment and offers Practice Participants a glidepath to VBP. The Model's multi-payer alignment approach is built with key elements that are required across payers, but with considerable room for customization. If desired, Recipients are permitted to use the Medicare Payment Approach (Appendix XI Medicare Payment Approach Details) to build their Medicaid Payment Approach, increasing alignment between payers while also promoting state innovation.

A4.4.2 Medicaid Payment Approach Requirements

The IBH Model allows states to build their own Medicaid Payment Approach in partnership with, and subject to approval by, CMS, use existing state or federal authorities (i.e. State Plan Amendments, 1915 waivers, Section 1115(a), managed care contracts) or use the Medicare Payment Approach as a basis for their payment design. Recipients may also be able to adapt an existing Medicaid payment authority to meet IBH Model requirements. The Cooperative Agreement funding can be used in part for developing the Recipient's Medicaid Payment Approach, and CMS will also offer technical assistance to Recipients in this development process. The Medicaid Payment Approach must be established by the end of MY 3 for Practice Participants to utilize at the start of MY 4 and must shift that payment away from traditional Medicaid FFS. The payment principles and guidelines outlined further in Section D2.4.1 Project Narrative are flexibly designed to align with a variety of state Medicaid BH programs or payment arrangements (e.g., BH MCOs, PIHPs, PAHPs, and Medicaid FFS).

The IBH Model recognizes that many Medicaid programs have invested significant time and resources into developing BH programs and payment authorities. Therefore, the Model will not ask Recipients to revert to less sophisticated payment strategies if they have already developed (or are on track to implement) their Medicaid Payment Approach that can be leveraged for the purposes of the IBH Model.

Recipients have flexibility, subject to CMS approval, in reaching directional alignment in the design of the following components of their Medicaid Payment Approach:

- **Payment type**: Whether the payment uses a per-beneficiary per-month (PBPM), prospective payment system (PPS), or fee-for-service[16].
- **Financial risk level:** If the payment includes upside risk, downside risk, or a combination of both.
- **Performance-based payment strategy:** How the Recipient plans to reward improvements in quality and potential reductions in cost at the Practice Participant level. Please note that the Recipients' performance-based payment strategy must at least align with the Medicare Payment Approach's performance-based payment strategy.
- **Attribution strategy:** Recipients are required to attribute Medicaid beneficiaries using an attribution methodology outlined as part of their Medicaid Payment Approach. Recipients are not required to replicate the Medicare attribution methodology outlined in Appendix XII: CMS Attribution Methodology for Medicare and Dually Eligible Beneficiaries. However, the Recipient must align their approach with the Medicare attribution methodology and send CMS a list of Medicaid attributed beneficiaries on at least a quarterly basis.

Core Required Elements of the Medicaid Payment Approach

- **Payments for implementing the care delivery framework:** Recipients will make payments to Medicaid Practice Participants to support the package of services and activities under the care delivery framework, as described in Section A4.3 IBH Care Delivery Framework, beginning at the start of MY 4. Recipients may rely on existing Medicaid programs to implement this care delivery framework, where existing programs can provide the required level of alignment as described in Section A4.3 IBH Care Delivery Framework. Under the aligned Medicare model, Practice Participants that participate in Medicare will also receive an Integration Support Payment (ISP), as described in Appendix XI Medicare Payment Approach Details, that will be paid to Practice Participants beginning at the start of MY 4. Medicaid Payment Approach payments must come from existing state Medicaid funds, and the federal funds provided pursuant to this NOFO may not be used to cover any clinical services or administrative expenses for which the state is claiming federal financial participation for Medicaid administrative services.
- **Performance based payments (PBP) to Practice Participants that participate in Medicaid:** Recipients must also make Performance Based Payments to Practice Participants, in addition to payments for clinical services during Mys 4 – 8. The PBP may be upside-only or may include downside risk and shall be designed to encourage and reward behaviors such as data reporting, the advancement of care quality and accountability across multiple dimensions including care integration, care coordination, care efficiency, and patient centered-outcomes as demonstrated through performance on

[16] The Medicaid payment Approach must have a performance-based payment that aligns with the Medicare payment arrangement, at a minimum.

certain model quality measures. The PBP to Medicaid providers will be paid for out of existing state Medicaid funds. The Medicare Payment Approach will also include an aligned PBP, as described in Appendix XI Medicare Payment Approach Details.

A4.4.3 Practice Participant Infrastructure Funding:

The IBH Model includes Infrastructure Funding during MY 2–5 for Practice Participants to develop infrastructure and capacity that will be necessary to address challenges to implement the care delivery framework for their patient population. Infrastructure Funding is available to Practice Participants through two mechanisms:

- **Infrastructure Funding to Practice Participants who participate in both the Medicaid and Medicare Payment Approaches**:
    - Practice Participants who participate in the IBH Medicare Payment Approach may receive Infrastructure Funding directly from CMS.

- **Infrastructure Funding to Practice Participants who participate in the Medicaid Payment Approach but not the Medicare Payment Approach**:
    - Recipients must implement a standardized practice needs assessment process to determine the final amount of Infrastructure Funding to pass through to each Medicaid-only practice.
    - Funding allocated towards infrastructure costs on behalf of the Practice Participant(s) will remain restricted until the Recipient submits a detailed budget for these costs and subsequently receives CMS approval.
    - More details on this requirement are available in Section A4.5 Infrastructure Development and Funding.

Please note that federal funding provided to Recipients pursuant to their Cooperative Agreement for infrastructure-related activities may not also be claimed for Medicaid Federal Financial Participation (FFP) purposes. Regardless of whether Infrastructure Funding is facilitated by CMS or Recipients, Practice Participants can use the Infrastructure Funding for the uses identified below in Table A4.4.3. Recipients can also propose additional categories of permitted uses that are not currently listed, subject to review and approval by CMS.

Practice Participants with existing EHRs may be allowed to use Infrastructure Funding to further the goals of the Model, such as updating their EHR to allow for HRSN referral. Recipients may also use their Cooperative Agreement funding to support similar, aligned activities, and will be encouraged to offer centralized resources and TA to their Practice Participants. Examples of activities that Infrastructure Funding may be used for are listed in *Table A4.4.3*.

Table A4.4.3: Examples of ways Practice Participants are allowed to use Infrastructure Funding from Recipients.

Category of activity	Example activities
Health IT and data sharing capacity building	• Adoption and upgrading of EHRs • Adoption, use and maintenance of interoperability solutions, including legal and technical costs associated with engaging in data exchange activities • Use of standards, including support for piloting of priority emerging data standards for BH[17]. Training on relevant privacy and confidentiality regulations such as 42 CFR Part 2 to promote secure and appropriate data sharing practices, population management and quality reporting
Telehealth tools	• Telehealth needs assessment, tools, and in-practice support and accessibility capabilities to connect the patient to a primary care or specialty provider, including use of audio-only telehealth as appropriate • Training and technical assistance to enhance knowledge around telehealth rules, regulations, and best practices.
Practice transformation activities	• Developing new clinical and payment infrastructure, policies, procedures, and workflows for systematic screening and tracking of PH conditions and HRSNs, referrals, and /or social service agency referrals as well as ongoing clinical coordination. • Implementing organization change management activities to facilitate provider behavior change, mastery, and self-efficacy in providing integrated care. • Hiring and training of care coordination staff such as peer support workers, community health workers, or other applicable staff • Training staff on integration, goals, and new clinical workflows. • Collaborating with PH consultants to establish care protocols. • Establishing formal or informal agreements with primary care providers and formal or informal

[17] For example, Practice Participants could explore piloting activities for USCDI+ Behavioral Health, an initiative developed by SAMHSA and ONC to address core data and interoperability for behavioral health needs beyond the scope of USCDI (United States Core Data for Interoperability). For more information, see: https://uscdiplus.healthit.gov/uscdi?id=uscdi_record&table=x_g_sshh_uscdi_domain&sys_id=8deaa2658778465098e5edb90cbb3597&view=sp

	agreements with social service organizations for enhanced referral. • Developing communication strategies to notify patients and caregivers regarding screening opportunities and clinical changes they may expect to see, such as added HRSN screenings or peer support worker assistance. • Arranging for phlebotomy or increased availability of CLIA-waived laboratory testing, on site, including quality assurance and quality control standards.

A4.4.4: Multi-Payer Alignment

Due to the likelihood that many Recipients may already have BH innovations underway, the IBH Model is intentionally designed to ensure Recipients can continue to build on these efforts. Some Recipients may have developed well-established relationships with MCOs and commercial payers, and CMS expects Recipients to use these relationships to advance multi-payer alignment in their state. In addition, Recipients will build their care delivery framework and Medicaid Payment Approach in alignment with the requirements outlined in this NOFO.

Below, *Table A4.4.4* shows key areas of directional alignment among Recipients, Medicare, (and, where applicable, commercial payers to the core model design elements. This approach provides a way for Recipients, MCOs, PIHPs, PAHPs, intermediaries, and other commercial payers taking part in, or aiming to align with, the IBH Model to move forward with a shared model framework while limiting provider burden in the process.

Table A4.4.4: IBH Medicare, Medicaid, and Multi-Payer Alignment Principles

Design Element	Design Feature	Directional Alignment Required Elements for Recipients
IBH Payment Strategy	Payment alignment	• Recipients must develop a Medicaid Payment Approach that is new, adapted from, or complements existing payment approaches in their state. • At a minimum, the Recipient's Medicaid Payment Approach must begin with pay for reporting by MY 4, (LAN Category 2B) and shift into pay for performance on certain measures by MY 5 (LAN Category 2C). • Recipients will ensure alignment and eliminate

		payment duplication of any state waiver or demonstration that provides payment for services listed in this NOFO.
	Risk adjustment	• Recipients are encouraged to implement a Medicaid Payment Approach that uses a risk adjustment methodology for both clinical and social risk factors[18]
	Attribution	• Beneficiary attribution is a method to associate beneficiaries with Practice Participants for the purposes of payment. Recipients will attribute Medicaid beneficiaries to the IBH Model using the Recipient's own attribution methodology (or using an existing attribution model, such as health homes) that generally aligns with the Model's Medicare alignment parameters. For example, Recipients will send each Medicaid Practice Participant a list of its attributed Medicaid beneficiaries on a quarterly basis during the Model Implementation Period. • Recipients will provide CMS, on a quarterly basis, a list of all dually eligible and Medicaid-attributed beneficiaries.
Data, Quality, and Evaluation	Quality measures	• Recipients and MCOs, PIHPs, or PAHPs must agree to report on the state-based quality measures listed in Table A4.7.1. • Recipients, MCOs, PIHPs, or PAHPs, will help Practice Participants to submit practice-based measures.

[18] Though the Medicare risk adjustment methodology is currently under development, initial plans include leveraging non-clinical (social) and clinical risk factors. See Appendix XI: Payment Approach Details for additional detail.

	Quality incentives	• Recipients must develop a performance-based Medicaid Payment Approach using the quality measures listed in Table A4.7.2 under practice-based measures. Recipients shall add measures for any additional PH conditions they plan to add into the care delivery framework.
Convening Structure	Frequency	• Alongside CMS, identify a third-party convener to host the IBH Model-related efforts six months after the start of the pre-implementation period. • By the start of MY 2, the convening structure must meet no less than quarterly.

**Recipients shall refer to Section A.4.3.3 Care Delivery Framework Requirements to reach directional alignment for the care delivery framework..*

A4.5 Infrastructure Development and Funding

A4.5 Section Requirements:

Pre-implementation period requirements	Implementation period requirements
During the pre-implementation period, Recipients must: • Develop yearly funding requests for Cooperative Agreement Funding • Distribute funding to eligible parties, where applicable • Develop and implement the Health IT implementation plan • Provide cooperative agreement funding to Medicaid only Practice Participants between MYs 2-5 using a standardized practice needs assessment process	*During the implementation period, Recipients must:* • Develop yearly funding requests for Cooperative Agreement Funding • Distribute funding to eligible parties, where applicable

Recipients are required to develop detailed annual plans for Cooperative Agreement funding use, in a form and manner specified by CMS, as part of their non-competing continuation (NCC) application. The annual plans must address the following factors:

- Practice participants that participate in the IBH Medicare Payment Approach will receive Infrastructure Funding directly from CMS. Medicaid-only Practice Participants cannot receive Infrastructure Funding from CMS and, instead, must receive Infrastructure Funding from the Recipient as available under this cooperative agreement.

- Recipients will be required to allocate a portion of cooperative agreement funding for each Medicaid only Practice Participant between MYs 2-5 using a standardized practice needs assessment process. This funding must be passed through for practice-level Infrastructure Funding.

- Recipients shall plan to set aside approximately $100,000 in cooperative agreement funding per Medicaid-only Practice Participant for budgeting purposes.

- Recipients must implement a standardized practice needs assessment process to determine the final amount of Infrastructure Funding to pass through to each Medicaid-only Practice Participant.[19]

    - If this needs assessment discovers a Medicaid-only practice has part of the necessary infrastructure needed for implementing the IBH Model, the Recipient is permitted to distribute only partial Infrastructure Funding to support practice transformation.

- Each Medicaid-only practice shall receive at least a portion of infrastructure funding for practice transformation activities.

    - Recipients can distribute Infrastructure Funding to Medicaid-only Practice Participants during MYs 2-5, as a one-time payment, or in more frequent installments.
    - The practice needs assessment process for Medicaid-only practices is required to align to the process set forth by CMS for practices participating in the Medicare Payment Approach (Appendix XI). The needs assessment must assess for relevant infrastructure such as adoption of certified health ITIT, HIE integration, other population health management tools, as well as the need for practice transformation activities.
    - Recipients may cap Infrastructure Funding for Medicaid-only Practice Participants at 30 percent of the Recipients' total cooperative agreement funds. If the Recipient chooses to cap infrastructure funding for Medicaid-only Practice Participants at 30 percent of the Recipient's total cooperative agreement funds, the Recipient must work with CMS on a plan for how to appropriately target the funding. Recipients can provide more than 30 percent of their total cooperative agreement funds if they

[19] The Innovation Center will provide further information on the Medicare needs assessment in the pre-implementation period.

choose.
    - Funding allocated towards infrastructure costs on behalf of the Practice Participant(s) will remain restricted until the Recipient submits a detailed budget for these costs and subsequently receives CMS approval.

- Recipients and Practice Participants may seek other sources of funding to supplement Infrastructure Funding activities. Recipients shall communicate other sources of funding used to CMS via programmatic reporting, including assurances that such other sources do not duplicate or supplant cooperative agreement funding.

- The requirements listed in Appendix VII: Health IT Capabilities and Support for Practice Participants apply regardless of the funding source for the Infrastructure Funding.

Recipients will be required to develop a Health IT Implementation Plan. The Health IT Implementation Plan shall be submitted as part of the NOFO application. The Health IT Implementation Plan shall detail how Cooperative Agreement funding, specifically Infrastructure Funding to Practice Participants, would aid in achieving the anticipated future state of health IT and data infrastructure and capacity. Furthermore, the Health IT Implementation Plan shall detail:

- Existing goals for health IT and how the IBH Model can help the applicant reach these goals;
- Existing data infrastructure;
- Approaches to ensuring privacy and confidentiality consistent with applicable laws, including HIPAA, 42 CFR Part 2 and state requirements;
- Existing and projected (if awarded) staff capacity;
- Existing and projected (if awarded) data analytic capabilities;
- Experience supporting value-based payment and quality reporting;
- Anticipated technical assistance needs in meeting model requirements related to data and health IT;
- Facilitate data sharing agreements between Practice Participants and payers;
- Provide data and health IT technical assistance to Practice Participants;
- Enable Practice Participants to use quarterly data in support of continuous quality improvement.
- Submit relevant claims and encounter data;
- Facilitate data alignment between payers, MCOs, PIHPs, PAHPs, intermediaries and Practice Participants; and
- Support health information exchange to identify admissions, discharges, transfers, and other events important to care coordination.

Example of health IT uses for infrastructure funds:

- Health IT and practice transformation funding for Practice Participants.
- Statewide infrastructure necessary to implement the IBH Model.

A4.6 Convening Structure

A4.6 Section Requirements:

Pre-implementation period requirements	Implementation period requirements

During the pre-implementation period, recipients must:
• Alongside CMS, identify a third-party convener to host the IBH Model-related efforts six months after the start of the pre-implementation period.
• The convening structure must begin meeting no later than the start of MY2.
• Meet with the convening structure on no less than a quarterly basis.
  ○ Use the convening structure to develop the Medicaid Payment Approach among the relevant parties.
  ○ Use the convening structure to develop the Medicaid care delivery framework among the relevant parties.
  ○ Provide updates on convenings in quarterly progress reports.
	During the implementation period, recipients must:
	• Implement the convening structure:
	  ○ Provide necessary technical assistance for Practice Participants.
	  ○ Develop strategies to improve performance on the state and Practice-based measures.
	  ○ Develop performance improvement projects at the state or sub-state level.
	  ○ Troubleshoot issues with data sharing among model partners.
	  ○ Share best practices among payers, Practice Participants, and other interested parties.

In cooperation with CMS, recipients will identify a third-party convener within six months after the start of MY1. The third-party convener is intended to serve as a neutral forum to bring together IBH Model stakeholders including the State, CMS, Practice Participants, community organizations, and others to drive consensus on model design elements and shared priorities. If a third-party convener is not readily identifiable, recipients may act as conveners for up to the first 1.5 years of the model. During this time, CMS will work with states/territories to identify a third-party convener to support this effort – thus reducing state burden and allowing states to come to table with stakeholders on prioritizing outcomes, measures, and model design. As a party to the convenings, recipients will sustain or build upon or support the development of convening initiatives. Examples of neutral conveners envisioned in this work include but are not limited to Quality Improvement Organizations, academic or philanthropic organizations, or other organizations focused on aligned care transformation and improvement efforts.

Section A.4.6.1 Members of the Convening Structure exhibits essential and recommended interested parties for the convening structure. Recipients will aid in garnering alignment from the essential and recommended members listed below.

The convening structure will align interested parties on efforts to improve key BH outcomes through priority setting, operational support, and learning activities. The convening structure must begin meeting no later than the start of MY 2, and must meet no less than quarterly, thereafter. In the Pre-Implementation Period, the interested parties in the convening structure will collaborate to design model components and ensure specific components reach directional alignment, where applicable (Section A4.4.4 Multi-Payer Alignment).

At a minimum, Recipients are expected to use the convening structure along with support from CMS to:

- Improve data collection and sharing efforts among payers, Practice Participants, and community-based organizations (where applicable).
- Provide a channel for CMS, SMAs, and MCOs, State Mental Health authorities and Single state agencies for SUDs, (or other intermediaries) to communicate technical assistance to Practice Participants.
- Accelerate the development and implementation of the Medicaid Payment Approach.
- Identify additional model priority health conditions in addition to diabetes, hypertension, and tobacco use, such as the human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), sexually transmitted infections, intellectual/developmental disabilities, asthma, heart disease, obesity/overweight, and hepatitis.
- Identify additional practice-based and state-based quality measures (where applicable).
- Design the Recipient's Population Needs Assessment as specified in Section A4.3.3 Care Delivery Framework Requirements
- Collaborate with CMS to make corrections and improve data in a timely manner.

Example funded activities:

- Support implementation and operational activities of the convening structure.
- Support to share best practices among the convening structure.

A.4.6.1 Members of the Convening Structure

The convening structure will optimally use a collective impact approach to drive alignment among the Recipient, Practice Participants, and other interested parties regarding their shared visions and measurements, and mutually reinforcing activities. The convening structure will also optimally incorporate continuous communication among members as a core backbone group that will provide ongoing support, drive momentum, and advance model development by guiding vision and strategy.

Table 4.6.1: Members of convening structure.

Essential members	Recommended members
• State/territorial Medicaid agencies • State, local, tribal, and/or territorial and public health agencies • State Mental Health Authorities and Single State Agencies for SUDs • Licensing agency • Managed care organizations (or other intermediaries) • Specialty behavioral health provider organizations • Physical health providers • Social service agencies • Beneficiaries with lived experience (states are encouraged to consider a diversity of participating beneficiaries, and compensation for participation). • Family members and caregivers • Federally recognized tribes and tribal governments (where applicable).	• Patient advocacy organizations • Commercial payers • Criminal justice • Faith-based entities • Major employers • Crisis system service providers • Community based organizations and social services providers which address food, transportation, etc. • Data service organization (e.g., relevant health information networks) • State/territorial primary care association • Other tribes and tribal governments (where applicable) • Other government agencies such as those working on education and employment • State or community substance use prevention coalitions.

A4.7 Data, Quality, and Evaluation

Section Requirements:

Pre-implementation period requirements	Implementation period requirements
During the pre-implementation period, recipients must: • Facilitate data sharing agreements between providers and payers • Provide data-related technical assistance to Practice Participants • Submit relevant claims and encounter data • Facilitate data alignment across interested parties in the model.	*During the implementation period, recipients must:* • Report on required state and practice-based quality measures • Continue to facilitate alignment in data sharing, reporting, and decision making. • Provide technical assistance to Practice Participants • Work with Practice Participants to use quarterly data to make necessary course corrections within the model. • Submit relevant claims and encounter data • Participate in the state-wide quality improvement program

CMS, through the Innovation Center, with its federal partners and external stakeholders, has started building the foundation toward a health system that achieves equitable outcomes through high-quality, affordable, person-centered care. To make this lasting change, the Innovation Center is incorporating patient and caregiver perspectives across the lifecycle of its models, implementing more patient-reported outcome measures (PROMs) to quantify and qualify what matters to beneficiaries, and evaluating patient and caregiver experience in models.

Recipients are required to submit the quality measures listed in Table A4.7.1 State Based Measures (see Section A4.7.2.1 State-based and Practice-based measures) to CMS on a quarterly and annual basis for their Medicaid population.

Example funded activities:

- Hire an IBH Model Data Analyst, or other relevant data staff
- Practice transformation activities to improve the flow and usage of data for decision making.
- Activities to support data sharing among payers and providers needed to support model operations.
- Data warehousing and management.
- Support for the development of admission, discharge, and transfer (ADT) systems.

A4.7.1 Data Collection, Reporting, and Analysis

Recipients play a pivotal role in arranging efforts related to model data collection, sharing, and analysis. Recipients must ensure that monitoring and evaluation data is collected, analyzed, and shared in a timely fashion to support IBH Model goals in collaboration with MCOs, PIHPs, PAHPs, intermediaries, and State Mental Health authorities and Single state agencies for SUDs, CMS, and CMS contractors for monitoring and evaluation.

Recipients must hire or leverage data expertise to assist in data coordination and analysis. CMS encourages states to consider the scope of their implementation, such as the potential number of Practice Participants, and statewide versus sub-state implementation, to decide the full level of effort needed for model data activities. Recipients are also responsible for taking any steps required under applicable laws to engage in data sharing under the model, including obtaining required authorizations. As previously noted, Recipients are allowed to use cooperative agreement funding to support model data efforts. Recipients are also required to:

- **Facilitate data sharing agreements between providers and payers**: In the Pre-Implementation Period, Recipients must prepare to share quality measure and process data (e.g., by connecting to an HIE or health information network) with Practice Participants that enables them to improve care delivery and achieve model-specified performance outcomes such as care coordination. Partnering MCOs, PIHPs, and PAHPs, (or intermediaries) are required to contribute to data sharing efforts. Where applicable, the Recipient shall coordinate data sharing strategies with State Mental Health authorities and Single state agencies for SUDs.
- **Provide technical assistance to Practice Participants**: The Recipient will use the Pre-Implementation Period to provide technical assistance to Practice Participants to capture model data. Also, applicable MCOs, PIHPs, PAHPs, or other intermediaries may provide this technical assistance to Practice Participants. CMS will provide technical assistance to Recipients on capturing and reporting data as well as improving key outcomes.
- **Submit relevant claims and encounter data**: Recipients or partnering MCOs, PIHPs, PAHPs, or intermediaries are required to submit timely and accurate Medicaid claims and/or encounter data through the Transformed Medicaid Statistical Information System (T-MSIS). If necessary, an alternative mechanism will be approved by CMS, to ensure compliance with the requirements for data submission for model monitoring and evaluation under 42 C.F.R. § 403.1110. Recipients must work with Practice Participants and CMS to address any issues or questions on sharing such data.
- **Facilitate data alignment:** The Recipient is required to streamline the data reporting requirements at the state and federal level. For example, the Recipient shall align IBH Model quality reporting with other state or federal initiatives, to the extent possible, to limit practice burden. This includes alignment with MCOs, PIHPs, or PAHPs (or intermediaries) and state agencies for mental health and/or substance abuse.

A4.7.2 Quality Strategy

Measures are core to the IBH Model's quality strategy, which seeks to evaluate the Model's ability to achieve the goals of improving quality of care, increasing access to care, achieving greater equity in outcomes, reducing avoidable emergency department and inpatient utilization (thereby reducing Medicare and Medicaid program expenditures), and strengthening health information technology (health IT) systems capacity. The Model's quality strategy strives to advance Recipients and Practice Participants alike toward achieving the Model's desired outcomes, enabling quality improvement, reaching greater alignment among payers, as well as assisting in facilitation of model evaluation. The Innovation Center will use several measures, including at least one PROM, to monitor Recipient performance in the implementation and operation of the Model, as well as patient care delivered by Practice Participants.

CMS will keep Recipients abreast of any new measures that are developed or prioritized through the annual Measures Under Consideration[20] list and may explore changing the measure set as the Model evaluation policy develops (adding, modifying, and/or removing measures). CMS reserves the right to consider changes should a measure need to be suspended, suppressed, or removed due to changes in standards of care or data evaluation considerations, and CMS will communicate any changes in the measures to Recipients with advance notice and will work with Recipients to modify reporting requirements.

The Model's quality strategy will measure several key areas, including:

- Health outcomes targeted by the Model
- Care coordination
- Beneficiary utilization of services
- HRSNs
- Patient-reported outcome measures
- Physical health screening

These measures areas will be addressed through a combination of state-based and practice-based measures. *Table A4.7.1* below shows state-based measures to be included in the Model. *Table A4.7.2* shows practice-based measures to be included in the Model.

Recipients must report state-based measures data and practice-based measures data, for Medicaid beneficiaries, directly to CMS in a process to be outlined in the Cooperative Agreement Program Terms and Conditions. The anticipated level of burden for reporting on quality measures, including the number of hours and cost, is available in Appendix VIII State-Based Quality Measure Data Reporting Burden. Applicants shall consider model reporting requirements in their decision to implement the model across their entire state or in a sub-state region. For example, applicants shall consider the capacity and infrastructure available in the area they intend to operate the model in. Data submission requirements will include the following:

[20] As part of the CMS Pre-Rulemaking process for programs under Section 3014 of the Affordable Care Act, the Department of Health and Human Services (DHHS) must annually issue a Measures under Consideration List (MUC List)

- Data submitted must be beneficiary level-data, unless noted otherwise. Reporting data in the aggregate will not be sufficient to effectively evaluate model outcomes.
- Please see details on performance-based payments in the Medicare payment appendix for more information on what practice-based measures must be included in the Medicaid Payment Approach.

Practice Participants participating in the Medicare side of the IBH Model will submit Practice-based measures for Medicare beneficiaries directly to CMS.

A4.7.2.1 State-based and Practice-based measures

For National Committee for Quality Assurance (NCQA) Measures: CMS will provide measure materials to model Participants for all IBH Model required NCQA quality measures. NCQA measures and specifications are owned by NCQA. NCQA holds a copyright on these materials and may rescind or alter these materials at any time. Users of the NCQA measures and specifications shall not have the right to alter, enhance or otherwise modify the NCQA measures and specifications, and shall not disassemble, recompile, or reverse engineer the NCQA measures and specifications. Participants may not provide NCQA materials to any other person, entity, organization, or association. Except for employees of the Participant, each person, entity, organization, or association, including agents, vendors, and consultants of the Participant, is required to separately purchase a license to obtain, access, and use the NCQA materials, including but not limited to using the measures and specifications to calculate measure results.

Table A4.7.1: State-based measures

Measure	Description	Steward	CBE[21] endorsement number	CMIT[22] measure family ID	Alignment
Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD)	Percentage of ED visits for beneficiaries aged 18 and older with a principal diagnosis of a SUD, or any diagnosis of drug overdose, for which there was follow-up. Two	NCQA	3488	264	Medicaid Adult Core Set, CCBHC, Medicaid 1945 Health Home Core Set

[21] CMS-contracted consensus-based entity (CBE) refers to the entity with a contract under section 1890(a) of the Act responsible for quality measure endorsement, measure maintenance, synthesizing evidence, and convening key interested parties to make recommendations regarding performance measurement.

[22] The CMS Measure Inventory Tool (CMIT) is the repository of record for information about the measures which CMS uses to promote healthcare quality and quality improvement.

	rates are reported: * Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) * Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)				
Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Percentage of emergency department (ED) visits for beneficiaries aged 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: * Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) * Percentage of ED visits for	NCQA	3489	265	Medicaid Adult Core Set, CCBHC, Medicaid 1945 Health Home Core Set

	mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)				
Plan All-Cause Readmissions (PCR-AD)	For beneficiaries ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: • Count of Index Hospital Stays (IHS) • Count of Observed 30-Day Readmissions • Count of Expected 30-Day Readmissions	NCQA	N/A	561	Medicaid Adult Core Set, CCBHC, Universal Foundation Measures

Follow up after Hospitalization for Mental Illness: Age 18 or older (FUH-AD)	Percentage of discharges for adults ages 18 and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported. Percentage of discharges for which beneficiary received follow-up within 30 days of discharge Percentage of discharges for which the beneficiary received follow-up within 7 days of discharge	NCQA	0576	268	Medicaid Adult Core Set, CCBHC, Medicaid 1945 Health Home Core Set
Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)[23]	The percentage of members 18-75 years of age with diabetes (type 1 or type 2) who had a HbA1c at the following levels: HbA1c Control (<8.0%) and HbA1c Poor Control (>9.0%)	NCQA	0059 and 0575	204/148	Medicaid Adult Core Set, CCBHC, Universal Foundation Measures, HRSA Health Center Program Uniform Data System

[23] The Diabetes Control measure is now known as *Glycemic Status Assessment for Patients with Diabetes*.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Percentage of Medicaid beneficiaries ages 18 to 64 with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA	1932	202	Medicaid Adult Core Set
Emergency Department Utilization+	Reports the observed and expected ED utilization rates for the population.	NCQA	N/A	1755	N/A
Each state will pick one of the following two measures to include in their program to better capture the importance of screenings for PH conditions in the IBH Model.					
Colorectal Cancer Screening (COL-AD)	Percentage of beneficiaries ages 45 to 75 who had recommended screening for colorectal cancer.	NCQA	0034	139	Medicaid Adult Core Set, HRSA Health Center Program Uniform Data System
Breast Cancer Screening (BCS-AD)	Percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer.	NCQA	2372	093	Medicaid Adult Core Set, HRSA Health Center Program Uniform Data System

Table A4.7.2: Practice-based measures

Measure	Description	Steward	CBE endorsement number	CMIT measure family ID	Alignment
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user.	NCQA	0028/0028e	596	CCBHC, MIPS, HRSA Health Center Program Uniform Data System
Controlling high blood pressure	Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period	NCQA	N/A	236	CCBHC, MIPS, HRSA Health Center Program Uniform Data System
Emergency Department Utilization+	Reports the observed and expected ED utilization rates for the population.	NCQA	N/A	1755	N/A

Patient-reported outcomes and Measurement-based care attestation	Measure under development by CMS.				
Screening for Social Drivers of Health	Percent of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.	CMS	N/A	487	CCBHC MIPS

A4.7.2.2 State Quality Improvement Program

Recipients will participate in a quality improvement program (tied to state-based measures) separate from the performance-based payment component of the Medicaid Payment Approach for Practice Participants (tied to practice-based measures).

- During the Implementation Period, ten percent of the annual cooperative agreement funding will be restricted, not guaranteed, and subject to achievement on reporting and performance improvement on the IBH Model state-based measures. (Detailed in Section A4.7.2.1 State-based and Practice-based Measures.)
- The performance benchmarks for the state-based measures will include partial and full achievement categories that correspond to earning a certain proportion of the cooperative agreement funding available for each measure.
- CMS, along with its contractors, will provide support to both Recipients and their Practice Participants on the state-wide quality improvement program.

A4.7.3 Evaluation

The independent evaluation of the IBH Model will consider the model pre-implementation and implementation periods, along with key outcomes related to model goals. This will be accomplished through using a mixed-methods approach that incorporates both qualitative and quantitative data. In support of gathering the necessary data for these analyses, recipients are required to ensure compliance and participation with the IBH model evaluation by all model participants and partners in model evaluation, including:

- the Recipient;
- any MCOs or intermediaries with whom the Recipient forms memorandum of understandings (MOUs); and

- clinical delivery site providers and staff, patients, and any other individuals or entities in the Model's evaluation conducted by the Innovation Center.

Specifically, the Recipient shall attest to its capacity to participate and help facilitate individual patient- and program-level data provision and qualitative evaluation tasks, which may include:

- arranging site visits, observations, interviews and focus groups with providers and patients as well as program staff;
- tracking data from screening patients for HRSNs;
- submitting patient medical information through a system that complies with all applicable privacy requirements, including HIPAA and 42 C.F.R. Part 2 and applicable state requirements;
- gathering required patient consent/authorization;
- and other activities as needed.

All Recipients must be able to provide personal identifiers that will allow all Practice Participants to be identified in Medicaid claims. Recipients are solely responsible for any necessary procedures and approvals needed by Institutional Review Boards (IRBs). Recipients are also solely responsible for obtaining any other permissions from beneficiaries, their organizations, or state entities that may be needed to share or analyze internal data. These procedures and approvals shall not hinder cooperation with evaluation activities, data collection, or data sharing and submission to CMS or its contractors related to this award. Recipients may use award funds to pay for a full-time equivalent staff member with data and evaluation experience to help in accomplishing such tasks and ensuring full cooperation.

A5. Technical Assistance and Information for Prospective Applicants

Prior to the application deadline, CMS hosts a series of webinars to provide details about the IBH Model to answer questions from potential applicants regarding this funding opportunity. Information about the webinars will be posted on the IBH Model website at https://www.cms.gov/priorities/innovation/innovation-models/innovation-behavioral-health-ibh-model.

B. Federal Award Information

Federal Award Information:

B1. Total Funding	**$60 million**
B2. Award Amount	Up to $7.5 million to each Recipient **Pre-implementation period:** $1,250,000 in MY1, $1,000,000 in MYs 2-3 **Implementation period:** $1,000,000 in MYs 4-6. $750,000 in MY7, and $500,000 in MY8.

B3. Anticipated Award Dates	December 17, 2024
B4. Period of Performance	Overall: January 1, 2025, through December 31, 2032 After the initial award, continued funding is distributed via Non-Competing Continuation Awards **Eight total budget periods:** Budget Period 1: January 1, 2025 – December 31, 2025 Budget Period 2: January 1, 2026 – December 31, 2026 Budget Period 3: January 1, 2027 – December 31, 2027 Budget Period 4: January 1, 2028 – December 31, 2028 Budget Period 5: January 1, 2029 – December 31, 2029 Budget Period 6: January 1, 2030 – December 31, 2030 Budget Period 7: January 1, 2031 – December 31, 2031 Budget Period 8: January 1, 2032 – December 31, 2032 **Each budget period corresponds to a MY as detailed in the chart below. For example, budget period 1 reflects the same dates as MY 1.
B5. Number of Awards	Up to 8 awards
B6. Type of Award	Cooperative Agreement Statutes, regulations, policies, that apply to grants also apply to cooperative agreements, unless the award itself provides otherwise. References throughout this NOFO to grants also apply to cooperative agreements unless this NOFO states otherwise. Please refer to section F4. Cooperative Agreement Terms and Conditions of Award.
B7. Type of Competition	Open to All Eligible Applicants

Model year with performance periods and associated funding.

Model year	Performance period	Maximum Cooperative Agreement Funding
Pre-implementation period		
Model Year 1	January 1, 2025 – December 31, 2025	$1,250,000
Model Year 2	January 1, 2026 – December 31, 2026	$1,000,000
Model Year 3	January 1, 2027 – December 31, 2027	$1,000,000
Implementation period		

Model Year 4	January 1, 2028 – December 31, 2028	$1,000,000
Model Year 5	January 1, 2029 – December 31, 2029	$1,000,000
Model Year 6	January 1, 2030 – December 31, 2030	$1,000,000
Model Year 7	January 1, 2031 – December 31, 2031	$750,000
Model Year 8	January 1, 2032 – December 31, 2032.	$500,000

C. Eligibility Information

C1. Eligible Applicants

Eligible applicants are state Medicaid agencies (SMAs) with the authority and capacity to accept the Cooperative Agreement award funding. Eligible applicants are all 50 states, Washington DC, and U.S. territories. Eligible U.S. territories include American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the United States Virgin Islands. Applicants may select to participate at the state level or designate a sub-state region, subject to CMS approval during the application review.

(Select all that apply)

Government Organizations

- ✓ **State governments**
- ☐ County governments
- ☐ City or Township governments
- ☐ Special District governments
- ☐ Native American tribal governments (Federally recognized)
- ☐ Native American tribal organizations (other than federally recognized tribal governments)

Education Organizations

- ☐ Independent School Districts
- ☐ Public and State Controlled Institutions of Higher Education
- ☐ Private institutions of higher education
- ☐ Public Housing Organizations
- ☐ Public housing authorities
- ☐ Indian housing authorities

Nonprofit Organizations

- ☐ Nonprofits having a 501(c)(3) status with the IRS, other than institutions of higher education

- ☐ Nonprofits that do not have a 501(c)(3) status with the IRS, other than institutions of higher education
- ☐ For-profit Businesses (organizations other than small businesses)
- ☐ Small Businesses
- ☐ Individuals
- ☐ Others (if selected, required additional narrative information below)
- ☐ Unrestricted (if selected, required to include additional narrative information below)

C2. Cost Sharing or Matching

This program has no cost-sharing requirement. If you choose to include cost-sharing funds, we will not consider it during review. However, we will hold you accountable for any funds you add, including the requirements for grant reporting.

C3. Letter of Intent

N/A

C4. Ineligibility Criteria

Non-applicable

C5. Single Application Requirement

Applicants may submit only one application.

C6. Continued Eligibility

Recipients must demonstrate satisfactory progress during the previous budget period to be issued additional year funding through a non-competing continuation award. Non-competing continuation funding is a recipient's request for additional funding for the next subsequent Budget Period within an approved competitive segment (i.e., period of performance). Such funding is requested either through an application or a performance report, as explained in the terms and conditions of the award. A non-competing continuation application does not compete with other applications for support. Continued funding is contingent on satisfactory progress, compliance with the terms and conditions, and the availability of funds. Satisfactory progress will include, but is not limited to, meeting milestones described in Section F6.3 Performance Milestones. Expectations for satisfactory progress will also be included in the Cooperative Agreement terms and conditions.

At any time in the period of performance, Recipients could receive decreased funding, or their award could be terminated in accordance with 45 CFR § 75.372 "Termination" if they fail to perform the requirements of the award.

C7. EIN, UEI, Login.gov and SAM Regulations

All applicants must have the following to submit an application to Grants.gov:

- a valid Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN)
- a Unique Entity Identifier (UEI)
- a Login.gov account, and
- active registration in the System for Award Management (SAM) database (https://www.sam.gov/)

See Appendix II. Application and Submission Information on how to get registered.

C8. Faith-Based Organizations

Faith-based organizations are not eligible to apply.

C9. Other Eligibility Requirements

Non-applicable

D. Application and Submission Information

D1. Address to Request Application Package

You must submit your application through Grants.gov. Grants.gov has information about the online application process. See "How to Apply for Grants" at Grants.gov for electronic submission instructions. Refer to Appendix II. Application and Submission Information for additional requirements and instructions.

D2. Content and Form of Application Submission

D2.1 Application format

Disqualifying Factors

Any application that is ineligible, incomplete, or non-responsive will not move forward.
CMS may not consider an application that:

- Is from an organization that does not meet eligibility conditions.
- Requests funding above the award ceiling shown in the funding range.
- Is not submitted through Grants.gov.
- Is incomplete based on the initial screening.

However, the CMS Division of Grants Management Director and/or Deputy Director may continue the review process for an ineligible application if it is in the best interests of the government to meet the objectives of the program.

Each application must include all contents of the application package, in the order indicated, and conform to the following formatting specifications:

- Page size is 8.5" x 11" (one side only), 1" margins (top, bottom, and sides).
- All pages of the project and budget narratives as well as other required narrative documents must be paginated in a single sequence.
- Font size must be at least 12-point with an average of 14 characters per inch (CPI).
- The Project Narrative must be double-spaced. The page limit for this document is 60 pages.
- Program Duplication Documentation. The page limit for this document is 5 pages.
- The Budget Narrative may be single-spaced. The page limit for this document is 15 pages.
- The Business Assessment of Applicant Organization may be single spaced. The page limit for this document is 12 pages.
- Tables must have a font size of at least 12-point with a 14 CPI and may be single spaced. Tables are counted towards the applicable page limits.
- The project abstract is restricted to a one-page summary that may be single-spaced.
- The following required application documents are **excluded** from the page limitations described previously:
    - Standard Forms, (SF-424, SF-424A, SF-LLL)
    - Application Cover Letter/Cover Page (if applicable),
    - Project/Performance Site Location(s) Form, and
    - Indirect Cost Rate Agreement/Cost Allocation Plan.
- The total number of additional appendices per application may be no more than 20 to include MCO, PIHP, PAHP, or other fiscal intermediary as well as State Mental Health authorities and Single state agencies for SUDs letters of support (where applicable), resume and/or curriculum vitae, job descriptions, and organization chart. Refer also to Section D2.4.4 Appendices.

D2.2 Standard forms

You must complete the five standard forms identified below. You can also view them and see their instructions at Grants.gov (Forms).

1. Project Abstract Summary

Write a one-page summary of the proposed project including the purpose and outcomes. Do not include any proprietary or confidential information. We will use this document for information sharing and public information requests if you get an award. Be succinct and use plain language. Include:

- Goals of the project
- Total budget
- Description of how funds will be used.

2. SF-424: Official Application for Federal Assistance

You must complete all sections of the SF-424. **The Authorized Organizational Representative (AOR) must complete and electronically sign this form.**

Note: The signature of the individual that submits the application to Grants.gov populates throughout the application. The signature must match the name of the AOR. Other signatures will not be accepted. The AOR is the applicant's designated representative, who can make legally binding commitments for your organization. When the AOR authorizes an application, they agree that the organization will assume all award obligations.

Special instructions include:

☐ **In Item 15** "**Descriptive Title of Applicant's Project**":

HHS awarding agencies must establish detailed and accurate award descriptions at the time they make a federal financial assistance award. Award descriptions are:

• critical to ensuring accountability and transparency and

• a primary means to inform the public of the purpose of the federal funding that is distinct from the programmatic level information in the Assistance Listings.

Elements of a Strong Award Description

Robust award descriptions provide an understanding of the award's purpose and include a description of award-specific activities and purpose. A strong award description will have all the following elements:

• Specifics about the award purpose
• Activities to be performed
• Expected deliverables and outcomes
• Intended beneficiaries or Recipients
• Sub-Recipient activities, (if known)

Characteristics of a Strong Award Descriptions

A strong award description will have the following characteristics:

• Uses plain language an average reader can fully understand
• Is brief and succinct
• Is unique on USA Spending
• Does not use or limits abbreviations or acronyms

Examples of Strong Award Descriptions:

The Council of Inspectors General on Integrity and Efficiency's Pandemic Response Accountability Committee (PRAC) shared the following examples of effective award descriptions. These, or other agency-specific examples, can be shared with applicants to assist them in developing their award descriptions.

- **Example One**: Construction of pedestrian & bicycle facilities on the Broadway corridor. Broadway @ St. James St- Foxhall Ave. Streetscape improvements & enhancements include sidewalks, curbing, bike lanes, ped bump-outs, and lighting.
- **Example Two**: Levittown Beauty Academy, LLC is creating distance education for students affected by Covid-19. Schools cannot use physical location and students are now doing their schoolwork online.

☐ **Check "No" to item 19c. as review by State Executive Order 12372 does not apply.**

3. SF-424A: Budget Information Non-Construction

Refer to Appendix I. for more information on completing this form.

4. SF-LLL: Disclosure of Lobbying Activities

You must complete and submit the SF-LLL form. If you do not engage in lobbying, please insert "Non-Applicable" on the form (fields 10a and 10b) and include the required AOR name, contact information, and signature. Please note that the application kit available online on the Grants.gov website is used for many programs and therefore Grants.gov may designate this form as optional to allow for flexibility amongst programs. However, this form is **required** as part of the application package and must be submitted for the application to be considered eligible for review.

5. Project/Performance Site Location(s) Form

This form is required as part of the application package and must be submitted for the application to be considered eligible for review. Please note that the application kit available online in Grants.gov is used for many programs and therefore Grants.gov may designate this form as optional to allow for flexibility amongst programs.

D2.3 Application cover letter or cover page (optional)

The applicant may choose to include a cover letter or cover page to detail its interest in participation in the IBH Model.

D2.4 Program Requirements and Expectations

D2.4.1 Project Narrative

The project narrative must give a clear and concise description of your project. Articulate in detail the proposed goals, measurable objectives, and milestones in accordance with the instructions and content requirements provided below, consistent with the criteria described in Sections A4.

Program Requirements and E1. Criteria. Review these sections carefully to make sure you answer all questions and cover all topics the reviewers will look at.

Below are the required and optional elements of the project narrative including a brief description of the type of information required within each specific section. The project narrative is double-spaced and cannot exceed 60 pages in length. This page limit does not include resumes for key personnel, job descriptions, budget narrative, or organizational charts.

1. **Characteristics of the proposed model service area and model population (required):**
    a. Applicants shall clearly propose whether the IBH Model would be implemented on a statewide/territory-wide or a sub-state/-territory basis. If the applicant wishes to implement within a sub-state/-territory region they must provide justification and rationale for this selection, including consideration of the demands of implementation at a state-wide level and the benefits to evaluation from sub-state/-territory implementation. Furthermore, applicants shall specify the geographic area(s) in which they propose to implement the Model.
        - Descriptions could include ZIP codes; identification of political subdivisions such as counties, parishes, or cities; census tracts; any other unit that will unambiguously specify the boundaries of the geographic focus area.
        - Applicants proposing to implement within a sub-state/-territory region are encouraged to include in their application a potential appropriately matched comparison group within another region of the state/territory. This comparison group is intended to aid in facilitation of a robust evaluation by providing a population that does not receive the Model's services to compare outcomes to. CMS, the Recipient, and the evaluation contractor would work closely to further specify this comparison group in the Pre-Implementation Period.
    b. In addition to information about the existing treatment and network capacity, the applicant must provide as much of the information outlined below as possible for adult Medicaid beneficiaries with MSBH conditions residing in the proposed model service area for the period 2020-2022. Where feasible, applicants shall disaggregate these statistics by age, sex, race, and ethnicity. Data must be submitted in aggregate format and be fully de-identified in accordance with the HIPAA Privacy Rule standard at 45 C.F.R. § 164.514(b). The tables provided in Appendix IX: Model context data templates are provided as a guide for applicants. Applicants must detail the sources used to calculate the data presented as well as limitations of the data sources used in the tables. When data are unavailable, applicants can use proxies, but shall state the potential limitations of the data.
        - *Prevalence of Mental Illness and SUDs:*
            - Beneficiaries with mental illness
            - Beneficiaries with SUDs
            - Beneficiaries with co-occurring mental illness and SUDs
        - *Co-occurring PH and BH conditions:*
            - With one or more PH conditions

        - With diabetes
        - With hypertension
    - *Utilization:*
        - 30-day all-cause readmissions
        - Emergency department visits with a principal diagnosis of mental illness or a SUD
        - All-cause emergency department visits

2. **Organizational capacity of applicant organization (required):** Applicants must demonstrate their capacity to organize and manage the IBH Model, and to work collaboratively across key state agency, payer, practice, and community-based partners. The following information is required:
    a. Describe existing staff capacity (e.g., providing job descriptions including positions that may be currently vacant for all key staff that will be involved in the project).
    b. Identify the individual who will be the Project Director (primary liaison to the Innovation Center for the model) and provide a resume or CV for that person.
    c. Provide an organizational chart that identifies lines of authority and names the AOR.
    d. Describe the anticipated role of any subrecipients or contractors that may be engaged to develop and/or implement the IBH Model. Subrecipients or contractors may be already identified or could be identified later.
    e. Applicants shall describe the current state of service provision for integrated behavioral and PH care for beneficiaries with MSBH, including but not limited to detail on:
        i. Gaps in care delivery and funding for beneficiaries with MSBH conditions toto further illustrate how the applicant would leverage the IBH Model infrastructure, learning, and funding to improve care.
        ii. Their experience designing and implementing VBP initiatives and Medicaid BH programs, including but not limited to, Medicaid health homes, CCBHC demonstrations and/or grants, or other state led initiatives.
        iii. The provider network including network administrators like MCOs, PIHPs, PAHPs, or other fiscal intermediaries used to deliver BH services in the state.
        iv. The current healthcare provider and treatment capacity serving adult Medicaid beneficiaries with MSBH conditions, including information about Medicaid beneficiary access to relevant providers and treatment facilities within the proposed model service area for the types of care listed in Section A4.3 IBH Care Delivery Framework.

3. **Model intervention (required):** Applicants must attest they understand all requirements laid out in Section A4.3.3 Care Delivery Framework Requirements, and are committed to meeting the requirements, if awarded a cooperative agreement.

    Recipients will have time during the pre-implementation period along with technical assistance from CMS to fully develop their care delivery framework. In this section, applicants must

detail their intended process for developing the IBH care delivery framework in their proposed geographic service area, if awarded a cooperative agreement. Applicants shall detail:

a. The stakeholders they intend to work with to design the care delivery framework and the role of the interested parties (State Mental Health authorities and Single state agencies for SUDs, MCOs, members of the convening structure, community-based organizations, clinical state SMEs).
b. Intermediate steps and processes in developing the care delivery framework (Development of landscape analyses, publishing guidance documents for Practice Participants, hiring clinical SMEs, or hosting meetings with the IBH convening structure).
c. How cooperative agreement funding would be used to support the development of the care delivery framework (Consultant support in developing the care delivery model, supporting the convening structure).
d. Areas of care delivery framework design where the Recipient would anticipate needing technical assistance (If awarded).

Applicants are encouraged to reference the below care delivery requirements in detailing their intended process for developing the care delivery framework. For example, applicants can detail the process they would follow to help facilitate relationships between social service agencies and Practice Participants.

- Map current service provision and workflows to IBH Model requirements. Determine how best to adapt existing clinical workflows to accommodate new services – this shall include specific detail on attribution, screening and identification of PH conditions, care planning, procedures for tracking and follow-up on identified conditions, and supporting adherence to the care plan for model participants.
- Oversight and provider compliance for Practice Participant requirements across the core elements of the Model: Care Management, Care Integration, and Health Equity.
- Provide evidence-based guidelines for BH and PH screenings to Practice Participants as needed.
- Provide state-specific guidance to Practice Participants on utilization of any state-based data warehouse or care management tools for health care and social service navigation.
- Facilitate relationships between social service agencies and Practice Participants through introductions, shared meetings, and appropriate connections to facilitate warm hand-offs (leveraging convening structure as appropriate).
- Provide Practice Participants with a population needs assessment detailing the health disparities experienced by the Practice Participant's service population.

4. **Medicaid Payment Approach (required):** Applicants must attest they understand all requirements laid out in Section A4.4.2 Medicaid Payment Approach Requirements, and are committed to meeting the requirements, if awarded a cooperative agreement. The Medicaid Payment Approach must include all services outlined in Section A4.3.3 Care Delivery Framework Requirements.

The applicant is not required to determine the final federal or state authorities at the time of application; however, during the Pre-Implementation Period, the Recipient will work with the Innovation Center and CMCS to determine which federal or state authority will work best for the Recipient's context and goals. In addition, the Innovation Center and CMCS will provide technical assistance to aid Recipients in developing technical aspects of their payment approach with alignment to the Medicare Payment Approach including the ISP and PBP.

Similar to the previous section, applicants must detail their intended process for developing the Medicaid Payment Approach, including:

a. The stakeholders they intend to work with to design the Medicaid Payment Approach and the role of interested parties. (State Mental Health authorities and Single state agencies for SUDs, MCOs, members of the convening structure, community-based organizations, clinical state SMEs).
b. Intermediate steps and processes in developing the Medicaid Payment Approach (Conducting rate setting analyses, onboarding actuarial consultants (Where relevant), or hosting meetings with the IBH convening structure).
c. How cooperative agreement funding would be used to support the development of the Medicaid Payment Approach (Actuarial support in developing the Medicaid Payment Approach, supporting the convening structure).
d. Areas of Medicaid Payment Approach design where the Recipient would anticipate needing technical assistance (If awarded).

Applicants are encouraged to reference the key areas in Table D2.4.1 in their applications. For example, applicants shall describe how they would intend to develop a performance-based payment strategy that is aligned with the Medicare PBP and meets the needs of intended Practice Participants.

Table D2.4.1: Medicaid Payment Approach requirements and alignment principles

Category	Payer alignment principle(s)
1. How the applicant plans to create, leverage, or redesign an existing payment approach	Applicants are encouraged to leverage existing delivery system architecture to build or adapt their payment approaches and bolster sustainability.
2. The types of Practice Participants to be reimbursed under the payment approach	The proposed Practice Participants meet the provider eligibility criteria outlined in Section A4.2 Recruitment of Practice Participants.
3. The service types, units, or costs to be paid under the payment approach	Applicants are not required to use the same service, procedure, or G codes used in the Appendix XI Medicare Payment Approach Details; however, the applicant must ensure that services and procedures reimbursable in the Medicaid Payment Approach cover care management, care coordination, and health equity, in their Medicaid Payment Approach.
4. The rate determination methods the applicant anticipates using to develop the Medicaid Payment Approach	Not applicable
5. Performance based payment strategy	• At a minimum, the Medicaid performance-based payment strategy must start with pay-for reporting in MY 4 and evolve into pay-for-performance by MY 5. • Applicants are encouraged to consider their intended Practice Participants existing experience in value-based purchasing when determining whether to incorporate downside risk into their Medicaid Payment Approach.
6. Quality measures	• The applicant must include all measures in *Table A4.7.2: Practice-based measures*, in their Medicaid performance-based payment strategy.

Category	Payer alignment principle(s)
	• Please note, applicants are only required to use the Practice-based measures for their performance-based payment component.

5. **Behavioral health practice recruitment strategy (required):** Recipients must outline their practice recruitment strategy for the IBH Model that meet the eligibility criteria specified in Section A4.2 Recruitment of Practice Participants. CMS encourages states to collaborate with their State Mental Health authorities and Single state agencies for SUDs, MCOs, PIHPs, or PAHPs in developing their Practice Participant recruitment strategy (where applicable), given their experience managing provider networks. The applicant's BH practice recruitment strategy shall include:
    a. A plan for recruiting Practice Participants into the IBH Model, including key partners and how they may support recruitment activities.
    b. Plans to include outreach with rural safety-net specialty BH providers, under-resourced providers, tribal providers, and providers serving vulnerable populations in the recruitment strategy.
    c. An estimated number of Practice Participants to be enrolled in the IBH Model by the end of MY 3.
    d. An estimated number of total Medicaid enrollees with MSBH conditions to be attributed to the IBH Model for the entire duration of the Implementation Period.

6. **Health IT implementation plan (required):** Applicants must describe the current and future state of data and health IT infrastructure in the proposed model service area. Model participants shall detail how cooperative agreement funding including health IT funding to Practice Participants would aid in achieving the anticipated future state of health IT and data infrastructure and capacity. Furthermore, the applicant shall detail:
    a. Existing data infrastructure to support integration between BH and PH;
    b. Existing and projected (if awarded) staff capacity;
    c. Existing and projected (if awarded) data analytic capabilities to support BH integration;
    d. Experience supporting value-based payment and quality reporting;
    e. Intermediate steps and processes in developing the Health IT implementation plan;
    f. Anticipated technical assistance needs in meeting model requirements related to data and health IT; and
    g. In describing the future state of data and health IT, applicants shall describe their ability and plans to meet the requirements laid out in Appendix VII: Health IT Capabilities and Support for Practice Participants and described below:

i. Facilitate data sharing agreements between Practice Participants and payers.
ii. Provide data and health IT technical assistance to Practice Participants.
iii. Enable Practice Participants to use quarterly data to make necessary course corrections within the Model.
iv. Submit relevant claims and encounter data.
v. Facilitate data alignment between payers, MCOs, PIHPs, PAHPs, intermediaries and Practice Participants.
vi. Support health information exchange to identify admissions, discharges, transfers, and other events important to care coordination.

7. **Sustainability Plan (required):** Applicants shall clearly describe their commitment to ensuring the IBH Model is sustainable after the IBH Model concludes (see Section B4, Period of Performance). Specifically, applicants shall address how they will design specific model components with sustainability in mind. For example, the applicant must describe how they would build sustainability planning into the design of their Medicaid Payment Approach.

8. **Budget impact analysis (required):** The applicant shall include a section to exhibit the IBH Model's potential impact on health outcomes and Medicaid spending for beneficiaries with MSBH conditions. More specifically applicants shall:
    a. *Impact on health outcomes:* Exhibit how IBH Model implementation in the applicants proposed geographic service area will impact health outcomes. This includes a description of how they will maximize the effect of their proposed intervention on the Model aims set out in Section A1 Purpose.
    b. *Cost savings projection:* Applicants must use this section to provide a financial model that illustrates anticipated Medicaid spending for the Model population, comparing a projection of the intervention to a projection in the absence of the intervention, over the same period.

9. **Identify additional priority health conditions for inclusion in the Model (optional):** As part of their application, applicants have the option of identifying additional priority health conditions outside of diabetes, hypertension, and tobacco use, such as HIV/AIDS sexually transmitted infections, intellectual/developmental disabilities, asthma, heart disease, obesity/overweight and hepatitis. Should an applicant choose to include additional priority health conditions they shall also include data to support the addition of such conditions in *Characteristics of the proposed model service area and model population.* In addition, the applicant shall include proposed quality measures to track key outcomes of the priority health condition(s) in the *Medicaid Payment Approach requirements.* The additional conditions and quality measures are subject to CMS review and approval. CMS would not include any additional measures as part of the State Quality Improvement Program.

D2.4.2 Budget Narrative

Applicants must supplement Form SF-424A with a Budget Narrative. The budget narrative includes a yearly breakdown of costs, for each line item outlined in the SF-424A, according to the relevant 12-month budget period. Include a clear description of the proposed costs for each activity within the line item and associate each cost with either Pre-Implementation Funding or Implementation Funding. The budget narrative must clearly define the proportion of the requested funding designated for each activity and justify applicants' readiness to receive funding. The budget must separate funding administered directly by the applicant as the lead agency, from funding sub-awarded to other partners.

Applicants must provide detailed budget justifications for each activity and cost proposed to be funded under this award along with full computations for budget estimates. Applicants must also clearly link each activity to the goals and milestones of this NOFO and be consistent with program requirements. Indirect costs must be reasonable and are only reimbursable per HHS grants policy.

To ensure administrative oversight, the Budget Narrative must identify a Project Director who is an employee of the applicant organization. This narrative must provide assurances that this individual will dedicate sufficient time to this award, funded through this award or in-kind, to perform the required roles and responsibilities and ensure effective monitoring of funds under this award. The percentage FTE proposed by the applicant must ensure effective monitoring by the Project Director and is subject to review by CMS.

Medicaid-only Practice Participants cannot receive Infrastructure Funding from CMS and, instead, must receive Infrastructure Funding from the Recipient as available under this cooperative agreement. Funding allocated towards infrastructure costs on behalf of the Practice Participant(s) will remain restricted until the Recipient submits a detailed budget for these costs and subsequently receives CMS approval. For more information, see Section A4.5 Infrastructure Development and Funding.

This program has no cost-sharing requirement. If you choose to include cost-sharing funds, we will not consider it during review. However, we will hold you accountable for any funds you add, including the requirements for grant reporting.

For more information and instructions for completing the SF-424A and Budget Narrative, please refer to **Appendix I. Guidance for Preparing a Budget Request and Narrative.**

D2.4.3 Program Duplication (maximum 5 pages)

Applicants must provide an explanation of how they would use IBH Model funds to provide new and distinct care integration, care management, and health equity for Medicaid beneficiaries with MSBH in the proposed model service area. The explanation shall identify how they would build upon current programs and initiatives, if applicable, while avoiding duplication with Medicaid, Title V, and any other federal, state, or local funding used for care coordination expenses for or related to the attributed population. In addition, applicants must describe their strategy for avoiding program duplication if they are simultaneously participating in a similar program

serving Medicaid beneficiaries with MSBH in the proposed model service area including with a Medicaid health home, or CCBHC initiative.

D2.4.4 Appendices

- Letter of support from at least one MCO, PIHP, or PAHP. The letter of support must indicate commitment from the MCO, PIHP, or PAHP to assist with model implementation activities and operationalize the Medicaid Payment Approach (**required** for states administering BH services through MCOs, PIHPs, or PAHPs).
- Letters of support from State Mental Health authorities and/or Single state agencies for SUDs **(required)**
- Other letters of support from community and governmental partners (optional)
- Resumes and/or curriculum vitae (**required** for identified managers, Project Director, and all other Key Personnel identified at the time of application)
- Job Descriptions for key model personnel **(required)** (Can be provided in the project narrative or this appendix)
- Organization Chart **(required)** (Can be provided in the project narrative or this appendix)
- Letters of Support (from the applicant's governor or state legislators, hospitals, primary care providers, others) (optional)
- Letters of interest from specialty BH practices (optional)

D2.4.5 Business assessment of applicant organization (maximum 12 pages)

CMS evaluates the risk posed by an applicant before they receive an award. This analysis of risk includes your organization's financial stability, quality of management systems, internal controls, and the ability to meet the management standards prescribed in 45 CFR Part 75.

You must review, answer, and submit the business assessment questions outlined in Appendix III. Business Assessment of Applicant Organization.

D3. Unique Entity Identifier and System for Award Management (SAM)

Unless you are an individual or federal awarding agency that is excepted from those requirements under 2 CFR 25.110(b) or (c), or has an exception approved by the federal awarding agency under 2 CFR 25.110(d)), you are required to:

- register in SAM.gov before submitting an application;
- provide a valid unique entity identifier in the application; and
- continue to maintain an active SAM registration with current information at all times during which your agency has an active Federal award or an application or plan under consideration by a CMS.

The federal awarding agency may not make a federal award to you until you have complied with all applicable unique entity identifier and SAM requirements. CMS may determine that you are not qualified to receive a federal award and use that determination as a basis for making a federal award to another applicant if you have not fully complied with the requirements by the time CMS is ready to make a federal award.

D4. Submission Dates and Times

All applications must be submitted electronically and received through Grants.gov by the date and time below. Applications received after 11:59 pm, Eastern Time, may not be reviewed or considered for award.
Due Date for Applications
September 23, 2024
11:59 PM Eastern U.S. Time (Baltimore, MD)

D5. Intergovernmental Review

Program is not subject to Executive Order 12372, "Intergovernmental Review of Federal Programs" (45 CFR 100). Please check box "C" on item 19 of the SF 424 (Application for Federal Assistance) as Executive Order 12372 does not apply to these cooperative agreements.

D6. Cost Restrictions

Cooperative Agreement funding is to be used for Recipient's costs in developing and operationalizing the IBH Model. Cooperative Agreement funds may not be used to pay providers for services covered under Medicare, Medicaid, and/or CHIP, including services already covered under such programs or any newly covered services under this model. Recipients are encouraged to leverage other Medicaid funding sources, such as Medicaid 90/10 funding, to advance the Model aims.[24] Recipients will be required to develop the Medicaid Payment Approach in accordance with CMS and state-based Medicaid policy but will not receive cooperative agreement funding to finance the care delivery services provided under the Model (see Section A4.4 IBH Payment Strategy).

Recipients may fulfill the Care Delivery Framework requirements themselves and may also work with managed care entities or other state entities like State Mental Health authorities and Single state agencies for SUDs to ensure these tasks are completed.

D6.1 Direct Costs

Funding under this NOFO can only cover functions of the IBH Model and is to be used for the Recipient's costs in developing and operationalizing the IBH Model. Funding may be used for statewide infrastructure, health IT, staffing, interoperability projects, and the convening structure.

[24] Medicaid 90/10 funding refers to funding available for health information exchange activities through the Medicaid Electronic Health Records Incentive Program. SMD Letter #11-004 further details Medicaid 90/10 funding.

D6.2 Indirect Costs

See Section F2. Administrative and National Policy Requirements for more information on indirect costs.

D6.3 Prohibited Uses of Award Funds

CMS supports state flexibility, and the IBH Model may be used to complement existing Medicaid programs. However, the additional federal funding provided under the IBH Model may not be used to replace or duplicate existing Medicaid coverage or payments. All direct care delivery services must be covered by existing state Medicaid funds. Federal funds provided by CMS pursuant to this Model may not be used to fund coverage for additional services. Further, funding provided pursuant to the Cooperative Agreement may not be used to duplicate Medicaid covered services and payments, nor may this funding be used for the purpose of FFP. Recipients may, where necessary, be required to separately submit a State Plan Amendment of 1115 waiver request.

The following activities are not allowable unless an exception is specifically authorized by statute or stated otherwise in this NOFO:

- Pre-award costs.
- Matching requirements to any other Federal funds or local entities.
- Services, equipment, or supports that are the legal responsibility of another party under Federal, State, or Tribal law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
- Goods or services not allocable to the approved project.
- Supplanting or duplicating existing state, local, tribal, or private funding of infrastructure or services, such as staff salaries, etc.
- Construction.
- Capital expenditures for improvements to land, buildings, or equipment which materially increase their value or useful life as a direct cost, except with the prior written approval of the federal awarding agency.
- The cost of independent research and development, including their proportionate share of indirect costs (unallowable in accordance with 45 CFR 75.476).
- Funds related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive Order proposed or pending before the Congress or any state government, state legislature or local legislature or legislative body.
- Certain telecommunications and video surveillance equipment. See 2 CFR 200.216 to make sure this does not apply to any proposed equipment in your application.
- Meals unless in limited circumstances such as:
    - Subjects and patients under study;

- Where specifically approved as part of the project or program activity (not grantee specific), e.g., in programs providing children's services; and
- As part of a per diem or subsistence allowance provided in conjunction with allowable travel.

- Of note, the funding provided pursuant to the Cooperative Agreement may not be claimed for Federal Financial Participation (FFP) purposes.
- To pay providers for services covered under Medicare, Medicaid, and/or CHIP, including services already covered under such programs or any newly covered services under this model.
- Costs of any Medicaid-covered service at any time during the Model, nor may they be used to supplant or duplicate existing resources that cover the costs of Medicaid-covered services or administrative expenses.
- Other services that are provided after, or because of, the IBH Model. For example, transportation, travel, or construction expenses.
- ISP payments or any other direct clinical services.

D7. Mandatory Disclosure

Submission is required for all applicants, in writing, to CMS and to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to:

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Attn: Director, Division of Grants Management

7500 Security Blvd, Mail Stop B3-30-03
Baltimore, MD 21244-1850

AND

U.S. Department of Health and Human Services
Office of Inspector General
ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW, Cohen Building
Room 5527
Washington, DC 20201

URL: https://oig.hhs.gov/fraud/report-fraud/index.asp
(Include "Mandatory Grant Disclosures" in subject line)
Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or

Email: MandatoryGranteeDisclosures@oig.hhs.gov

Materials must be scanned and emailed to the Grants Management Specialist assigned to this NOFO.

D8. HHS Form 690

If the applicant receives an award, the applicant must follow all applicable nondiscrimination laws. The applicant agrees to this when they register in SAM.gov. Applicants must also submit an Assurance of Compliance (HHS-690). To learn more, see the HHS Office for Civil Rights (OCR) website.

Subrecipients that receive funding from Recipients (including contractors under grants) rather than directly from CMS, also are required to file an HHS 690. The applicant is responsible for determining whether those organizations have the required Assurance on file and, if not, ensuring that it is filed with OCR.

E. Application Review Information

E1. Criteria

Merit reviewers use the NOFO to evaluate each application. Applicants shall pay particular attention to Sections **A4. Program Requirements**, **D2.4 Program Requirements and Expectations**, and the criteria in Section **E1 Criteria**.

The merit review panelists will assess and score applicants' responses with the criteria below, using a scale of 100 total base points.

- Incomplete, unclear, and confusing proposals will receive point reductions.
- Project Narratives with significant content deficiencies may receive a score of zero.
- Proposals that merely restate the content of the NOFO, without responding to the Program Requirements and Application Review Criteria, will receive a score of zero.
- Each part of the Project Narrative is weighted as indicated below.
- The scoring criteria breakdown is reflective of the total possible number of points available, but each item is scored on a range starting from zero. Points are awarded based on the quality of the applicant's response.
- You must document all source material. If any text, language, or materials are from another source, you must be clear if it is a quote and cite it. Also cite any sources if you use numbers, ideas, or other material that are not your own. If you do not follow this requirement, the reviewers will reduce their scores accordingly. They may choose to award no points at all.

Section	Topics	Total Available Points	Scoring Criteria Breakdown
Project Narrative			
1.	Characteristics of the proposed model service area and model population	10	(5 Pts) **Description and justification of state/territory OR sub-state/territory region,** including summary of health care delivery system redesign in the region and, if proposing sub-state region, rationale for proposed sub-state region. (5 Pts) **Provision of required data to exhibit need for the IBH Model,** including data on prevalence and utilization for the MSBH population in the proposed model service area.
2.	Organizational capacity of applicant organization	10	(5 Pts) **Description of the entity** that will perform the cooperative agreement activities under this funding opportunity, including: • Description of **key personnel** including identifying one individual to serve as Project Director. • If key personnel have not yet been hired, applicants shall provide a hiring strategy and job descriptions shall be included. • Description of the anticipated role of any subrecipients or contractors that may be engaged to help implement the Model, including State Mental Health authorities and Single state agencies for SUDs. • An **organizational chart** to be included in the Project Narrative or as an appendix clearly identifies the reporting relationships of key personnel assigned to oversee this intervention. (5 Pts) **Description of the current state of service provision for integrated behavioral and physical health care for beneficiaries, including:** • Gaps in care delivery and funding • Prior experience and capacity designing and implementing VBP initiatives and behavioral health programs. • The provider network and network

			administrators.
3.	Model intervention	12.5	(12.5 Pts) **Applicants must describe their intended process for developing the IBH care delivery framework.** More specifically applicants must detail: • (2.5 Pts) The stakeholders they intend to work with to develop the framework. • (5 Pts) Intermediate steps and processes in developing the framework. • (2.5 Pts) How cooperative agreement funding could support the development of the framework. • (2.5 Pts) Areas where applicants would anticipate needing technical assistance in designing their framework. In describing their intended process applicants shall reference key care delivery requirements.
4.	Medicaid Payment Approach	12.5	(12.5 Pts) **Applicants must describe their intended process** for developing the IBH Medicaid Payment Approach. More specifically applicants must detail: • (2.5 Pts) The stakeholders they intend to work with to develop the Medicaid Payment Approach. • (5 Pts) Intermediate steps and processes in developing the Medicaid Payment Approach. • (2.5 Pts) How cooperative agreement funding could support the development of the Medicaid Payment Approach. • (2.5 Pts) Areas where applicants would anticipate needing technical assistance in designing their Medicaid Payment Approach. In describing their intended process applicants shall reference key Medicaid Payment Approach requirements in Table D.2.4.1 Medicaid Payment Approach requirements and alignment principles.
5.	Behavioral health practice recruitment strategy	12.5	• (7.5 Pts) **Applicant details their plan for recruiting specialty BH practices in the IBH Model**. Applicants must clearly

			outline their plans to recruit rural safety-net specialty BH providers, under-resourced providers, tribal providers, and providers serving vulnerable populations. • (2.5 Pts) **Applicants must provide an estimated anticipated number of Practice Participants in the IBH Model.** • (2.5 Pts) **Applicants must provide an estimated number of IBH Medicaid enrollees with MSBH conditions to be attributed to the model for the entire duration of the Implementation Period.** If an applicant proposes to reach 10,000 Medicaid beneficiaries or more, they are eligible to receive up to 2.5 points. If an applicant proposes to reach fewer than 10,000 beneficiaries, they are eligible to receive up to 1 point.
6.	Health IT implementation plan	12.5	Description of current state and/or future planned health IT state. This must include: - (2.5 Pts**) Description of existing data infrastructure action plans and governance and any gaps that would be addressed under this model.** - (2.5 Pts) **Description of staff capacity, data analytic capabilities, and experience supporting value-based payment and quality reporting.** - (7.5 Pts) **Description of ability to leverage health IT to meet Model requirements, including data alignment, sharing/flow/linking capacity across potential partners and participants, sharing data and facilitating data collection for care delivery and monitoring and evaluation purposes.** In describing the future state, participants must further describe their ability to use current

			infrastructure or model funding to: - Facilitate data sharing agreements between Practice Participants and payers. - Provide data and health IT technical assistance to Practice Participants. - Intermediate steps and processes in developing the Health IT implementation plan. - Enable Practice Participants to use quarterly data to make necessary course corrections within the Model. - Submit relevant claims and encounter data including provision of unique Medicaid identifiers. - Facilitate primary data collection from Practice Participants. - Facilitate exchange of information necessary to identify admissions, discharges, transfers, and other events necessary to support care coordination. - Facilitate data alignment between payers, MCOs, PIHPs, PAHPs, intermediaries and Practice Participants.
7.	Sustainability Plan	10	(10 Pts) **Describe the strategy for sustaining the Model after Cooperative Agreement funding ends**, including the applicant's commitment to sustainability and their process of including sustainability into specific activities like development of the Medicaid Payment Approach or care delivery framework.
8.	Budget impact analysis	5	(2.5 Pts) **Impact on quality of care:** Applicants will use this section to describe how IBH could impact quality of care and ultimately health outcomes within their proposed geographic service area. Strategies to make data-driven decisions.

			(2.5 Pts) **Cost Savings Projection:** Applicants must use this section to provide a financial model that illustrates anticipated Medicaid and/or CHIP spending for the Model population, comparing a projection including the intervention to a projection in the absence of the intervention, over the same period.
Budget Narrative			
1.	Budget Narrative	15	(5 Pts) **Detailed budget,** See Appendix I, Guidance for Preparing a Budget Request and Narrative (7.5 Pts) **Reasonableness of requested funding according to tasks proposed:** Applicants must exhibit how requested funds are in alignment with the IBH Model goals. • (2.5 Pts) Funds requested are reasonable based on the total available funding and each activity is linked to the goals of this NOFO and consistent with the IBH model requirements. • (2.5 Pts) Funds requested are reasonable to support personnel costs. If utilizing a subrecipient to carry out the Required Core Functions or Optional Functions, then the applicant has described how the subrecipient will operate functions of the intervention. • (2.5 Pts) Funds requested are reasonable based on proposed project goals. The time commitment of the proposed project director and other key project personnel appear sufficient to assure proper direction, management, and prompt completion of the project. (2.5 Pts) **Program Duplication Documentation** Recipient clearly identifies areas where there is potential for duplication of funding and describes a strategy for ensuring non duplication of funding.

Total Base Points	**100**

E2. Merit Review and Selection Process

CMS will consider the geographic diversity and scale of all applications, as well as the quality of applications, in making final award determinations. In addition, CMS will consider the Recipient's participation in other CMS models, including but not limited to Making Care Primary, States Advancing All-Payer Health Equity Approaches and Development, and Transforming Maternal Health to diversify entities receiving awards. CMS will also consider the estimated number of Medicaid enrollees with MSBH conditions to be attributed to the IBH Model for the entire duration of the Implementation Period.

The application itself is not a legally binding agreement and does not require any applicant or CMS to enter into a cooperative agreement. CMS will select Recipients at CMS's sole discretion unless statutorily prohibited. Such selection will not be subject to administrative or judicial review, per Section 1115A(d)(2)(B) of the Act.

Please refer to Appendix V. Merit Review and Selection Process for more information on the review and selection process..

E3. Federal Awardee Performance Integrity Information System (FAPIIS)

In accordance with 45 CFR Part 75:

i. CMS, prior to making a federal award with a total amount of federal share greater than the simplified acquisition threshold[25], is required to review and consider any information about the applicant that is in the designated integrity and performance system accessible through SAM (see 41 U.S.C. 2313);

ii. An applicant, at its option, may review information in the designated integrity and performance systems accessible through SAM and comment on any information about itself that the HHS awarding agency previously entered and is currently in the designated integrity and performance system accessible through SAM.

iii. CMS will consider any comments by the applicant, in addition to the other information in the designated integrity and performance system, in making a judgment about the applicant's integrity, business ethics, and record of performance under federal awards when completing the review of risk posed by applicant as described in §75.205.

[25] *Simplified acquisition threshold* means the dollar amount below which a non-federal entity may purchase property or services using small purchase methods. Non-federal entities adopt small purchase procedures to expedite the purchase of items costing less than the simplified acquisition threshold. The simplified acquisition threshold is set by the Federal Acquisition Regulation at 48 CFR Subpart 2.1 (Definitions) and in accordance with 41 U.S.C. 1908.

F. Federal Award Administration Information

F1. Federal Award Notices

If successful, applicants will receive a Notice of Award (NoA) signed and dated by the CMS Grants Management Officer. The NoA is the legal document authorizing the cooperative agreement award and issued to the applicant as listed on the SF-424. The NoA is available to the applicant organization through the online grants management system used by CMS and Recipient organizations, GrantSolutions. Any communication between CMS and applicant prior to issuance of the NoA is not an authorization to begin performance of a project.

If unsuccessful, CMS notifies the applicant electronically via the email address as listed on its SF-424, within 30 days of the award date of the program.

F2. Administrative and National Policy Requirements

A. National/Public Policy Requirements

By signing the application, the authorized organizational official certifies that the organization will comply with applicable public policies. Each Recipient is responsible for establishing and maintaining the necessary processes to monitor its compliance and that of its employees and, as appropriate, subrecipients and contractors under the award with these requirements. Recipients shall consult the applicable Appropriations Law, Exhibit 3 of the HHS Grants Policy Statement, titled Public Policy Requirements, located in Section II, pages 3-6, as well as the terms and conditions of award for information on potentially applicable public policy requirements.

Recipients shall review and comply with the reporting and review activities regarding accessibility requests outlined in Appendix IV Accessibility Requirements.

B. Administrative Requirements

- All equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the applicant's original application or agreed upon subsequently with CMS and may not be used for any prohibited uses.
- Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project.
- This award is subject to 45 CFR Part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS awards [available at http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75], which implements 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards ("Uniform Guidance") effective December 26, 2014. See below for more information.

Uniform Administrative Requirements, Cost Principles, and Audit Requirements

Applicant and Recipients shall take note of the following information found in 45 CFR Part 75:

Uniform Administrative Requirements

In accordance with 45 CFR §75.112, all Recipients receiving federal funding from CMS must establish and comply with the **conflict-of-interest policy requirements** outlined by CMS (available for applicant upon request).

In accordance with 45 CFR §75.113, **Mandatory Disclosures**, the non-Federal entity or applicant for a Federal award must disclose, in a timely manner, in writing to the HHS awarding agency or pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Non-Federal entities that have received a Federal award including the term and condition outlined in Appendix XII to 45 CFR Part 75 are required to report certain civil, criminal, or administrative proceedings to SAM. Failure to make the required disclosures can result in the imposition of any of the remedies described in §75.371, including suspension or debarment. (See also 2 CFR Parts 180 and 376, and 31 U.S.C. 3321). For specific information on reporting such disclosures to CMS and HHS please see Section F3. Terms and Conditions of this NOFO.

Cost Principles

CMS grant and cooperative agreement awards provide for reimbursement of actual, allowable costs incurred and are subject to the Federal cost principles. The cost principles establish standards for the allowability of costs, provide detailed guidance on the cost accounting treatment of costs as direct or indirect, and set forth allowability and allocability principles for selected items of cost. Applicability of a set of cost principles depends on the type of organization. Recipients must comply with the cost principles set forth in HHS regulations at 45 CFR Part 75, Subpart E with the following exceptions: (1) hospitals must follow Appendix IX to part 75; and (2) commercial (for-profit) organizations are subject to the cost principles located at 48 CFR subpart 31.2. As provided in the cost principles in 48 CFR subpart 31.2, allowable travel costs may not exceed those established by the Federal Travel Regulation (FTR).

There is no universal rule for classifying certain costs as either direct or indirect (also known as Facilities & Administration (F&A) costs) under every accounting system. A cost may be direct with respect to some specific service or function, but indirect with respect to the Federal award or other final cost objective. Therefore, it is essential that each item of cost incurred for the same purpose is treated consistently in like circumstances either as a direct or F&A cost to avoid double-charging of Federal awards. Guidelines for determining direct and F&A costs charged to Federal awards are provided in 45 CFR §§75.412 to 75.419. Requirements for development and submission of indirect (F&A) cost rate proposals and cost allocation plans are contained in Appendices III-VII, and Appendix IX to Part 75.

Indirect Costs

CMS will reimburse indirect costs to Recipients under an award if (1) allowable under the governing statute, regulations, or HHS grants policy; (2) the Recipient requests indirect costs; and

(3) the Recipient has a federally approved indirect cost rate agreement covering the grant supported activities and period of performance, or the non-federal entity has never received an indirect cost rate, except for those non-Federal entities described in Appendix VII(D)(1)(b) to 45 CFR part 75, and elects to charge a de minimis rate of 10% of Modified Total Direct Costs (MTDC).

If the applicant entity has a current negotiated indirect cost rate agreement (NICRA) and is requesting indirect costs, a copy of the current NICRA must be submitted with the application.

Commercial (For-Profit) Organizations: Indirect Costs are allowable under awards to for-profit organizations. The for-profit Recipient must have a federally approved indirect cost rate agreement covering the grant supported activities and period of performance. Indirect cost rates for for-profit entities are negotiated by DFAS in the Office of Acquisition Management and Policy, National Institutes of Health (if the preponderance of their federal awards are from HHS), available at http://oamp.od.nih.gov/dfas/indirect-cost-branch, or other Federal agency with cognizance for indirect cost rate negotiation. If there is no federally approved indirect cost rate for the specific period of performance and the for-profit Recipient has never received an indirect cost rate, then the non-federal entity may elect to charge a de minimis rate of 10% of MTDC.

Cost Allocation

In accordance with 45 CFR §75.416 and Appendix V to Part 75 – State/Local Government-wide Central Service Cost Allocation Plans, each state/local government will submit a plan to the HHS Cost Allocation Services for each year in which it claims central service costs under Federal awards. Guidelines and illustrations of central service cost allocation plans are provided in a brochure published by the HHS entitled "A Guide for state, Local and Indian Tribal Government: Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government." A copy of this brochure may be obtained from the HHS Cost Allocation Services at:
https://www.hhs.gov/about/agencies/asa/psc/indirect-cost-negotiations/index.html.
A current, approved cost allocation plan must be provided to CMS if central service costs are claimed.

Public Assistance Cost Allocation Plans

Appendix VI to Part 75 – Public Assistance Cost Allocation Plans, provides that state public assistance agencies will develop, document and implement, and the Federal Government will review, negotiate, and approve, public assistance cost allocation plans in accordance with Subpart E of 45 CFR part 95. The plan will include all programs administered by the state public assistance agency. Where a letter of approval or disapproval is transmitted to a state public assistance agency in accordance with Subpart E, the letter will apply to all Federal agencies and programs. This Appendix (except for the requirement for certification) summarizes the provisions of Subpart E of 45 CFR part 95.

Audit Requirements

The audit requirements in 45 CFR Part 75, Subpart F, apply to each award Recipient fiscal year that begins on or after December 26, 2014. A non-Federal entity that expends $750,000 or more

during the non-Federal entity's fiscal year in Federal awards must have a single or program-specific audit conducted for that year in accordance with the provisions of Subpart F, Audit Requirements.

Commercial Organizations (including for-profit hospitals) have two options regarding audits, as outlined in 45 CFR §75.501 (see also 45 CFR §75.216).

F3. Terms and Conditions

This Notice of Funding Opportunity is subject to the Department of Health and Human Services **Grants Policy Statement (HHS GPS)**
at http://www.hhs.gov/sites/default/files/grants/grants/policies-regulations/hhsgps107.pdf.
The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary. Standard and program specific terms of award will accompany the NoA. Potential applicants shall be aware that special requirements could apply to cooperative agreement awards based on the circumstances of the effort to be supported and/or deficiencies identified in the application by the HHS review panel.

HHS regulation (45 CFR Part 75) supersedes information on administrative requirements, cost principles, and audit requirements for grants and cooperative agreements included in the current HHS Grants Policy Statement where differences are identified. Recipients must also agree to respond to requests that are necessary for the evaluation of national efforts and provide data on key elements of their own grant or cooperative agreement activities.

Non-Discrimination Legal Requirements for Recipients of Federal Financial Assistance
Should you successfully compete for an award, Recipients of federal financial assistance (FFA) from HHS will be required to complete an HHS Assurance of Compliance form (HHS 690) in which you agree, as a condition of receiving the grant, to administer your programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, age, sex and disability, and agreeing to comply with federal conscience laws, where applicable. **See Section D8 for additional information regarding HHS 690.** This includes ensuring that entities take meaningful steps to provide meaningful access to persons with limited English proficiency; and ensuring effective communication with persons with disabilities. Where applicable, Title IX and Section 1557 prohibit discrimination based on sexual orientation, and gender identity, the HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS.

See https://www.hhs.gov/civil-rights/for-providers/provider-obligations/index.html and https://www.hhs.gov/civil-rights/for-individuals/nondiscrimination/index.html.

- For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html and https://www.lep.gov.

- For information on your specific legal obligations for serving qualified individuals with disabilities, including providing program access, reasonable modifications, and to provide effective communication, see http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html.
- HHS funded health and education programs must be administered in an environment free of sexual harassment, see https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html.
- For guidance on administering your project in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see https://www.hhs.gov/conscience/conscience-protections/index.html and https://www.hhs.gov/conscience/religious-freedom/index.html.

Material Noncompliance
CMS may terminate any award for material noncompliance. Material noncompliance includes, but is not limited to, violation of the terms and conditions of the award; failure to perform award activities in a satisfactory manner; improper management or use of award funds; or fraud, waste, abuse, mismanagement, or criminal activity.

Bankruptcy. In the event a Recipient or one of its subrecipients enters proceedings relating to bankruptcy, whether voluntary or involuntary, the Recipient agrees to provide written notice of the bankruptcy to CMS. The Recipient must furnish the written notice within five (5) days of the initiation of the proceedings relating to bankruptcy filing and sent to the CMS Grants Management Specialist and Project Officer. This notice includes:

- the date on which the bankruptcy petition was filed,
- the identity of the court in which the bankruptcy petition was filed,
- a copy of all the legal pleadings, and
- a listing of Government grant and cooperative agreement numbers and grant offices for all, and
- Government grants and cooperative agreements against which final payment has not been made.

Prohibition on certain telecommunications and video surveillance services or equipment:
As described in 2 CFR 200.216, Recipients and subrecipients are prohibited to obligate or spend grant funds (to include direct and indirect expenditures as well as cost share and program) to:

(1) Procure or obtain;

(2) Extend or renew a contract to procure or obtain; or

(3) Enter into contract (or extend or renew contract) to procure or obtain equipment, services, or systems that use covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any

system. As described in Pub. L. 115-232, section 889, covered telecommunications equipment is telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).

i. For public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities).

ii. Telecommunications or video surveillance services provided by such entities or using such equipment.

iii. Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of the National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise, connected to the government of a covered foreign country.

F4. Cooperative Agreement Terms and Conditions of Award

The administrative and funding instrument used for this program is a Cooperative Agreement, an assistance mechanism used when CMS anticipates substantial CMS programmatic involvement with each Recipient during the performance of the activities. Under each Cooperative Agreement, CMS' purpose is to support and stimulate the recipients' activities by involvement in, and otherwise working jointly with, the award recipient in a partnership role. To facilitate appropriate involvement during the period of this Cooperative Agreement, CMS and the recipient will be in contact at least once a month, and more frequently when appropriate.

The cooperative agreement roles and responsibilities are as follows:

Centers for Medicare & Medicaid Services

CMS will have substantial involvement in program awards, as outlined below:

- Technical Assistance – CMS hosts opportunities for training and/or networking, which may include conference calls, topic-specific webinars, office hours, and other vehicles.
- Collaboration – CMS actively coordinates with other relevant Federal Agencies including, but not limited to, the Indian Health Service, the Internal Revenue Service, the Department of Homeland Security, the Administration for Children and Families, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control and Prevention, and the Social Security Administration. In this way, CMS facilitates compliance with the terms of the Cooperative Agreement and effectively supports recipients.
- Learning System – Recipients will be required to participate in and provide support to regional learning in pursuit of a shared vision for population health and health equity outcomes within the state, including Practice Participants as well as other essential and

recommended members of the Convening Structure. CMS will partner with awardees through the learning system to operationalize a data-driven and goal-oriented learning system to enable the success of all participants in the Model that builds from existing infrastructure and capacity within the state. Model participants will also have opportunities to join learning communities with other Recipients and access tools and supports to help them adopt new payment and care delivery methods.

- Project Officers and Monitoring – The recipient can expect substantial collaboration, participation, and/or intervention in the oversight of the project by CMS. Substantial involvement may include collaboration or participation by CMS program staff in activities specified in the Notice of Award (NoA) and, as appropriate, decision-making at specified milestones related to performance, e.g., requiring CMS approval before undertaking the next phase of a project, collaborating in the design of a service delivery model, etc. Substantial involvement pertains to programmatic involvement **not** administrative oversight.

Recipients

Award recipients and assigned points of contact retain the primary responsibility and dominant role for planning, directing, and executing the proposed project as outlined in the terms and conditions of the Cooperative Agreement and with substantial CMS involvement. Recipients shall engage in the following activities:

- Comply with the terms and conditions of the award.
- Collaborate with CMS staff to implement and monitor the project.
- Submit performance measures as requested by CMS.
- Submit all required performance assessments, evaluations, and financial reports as stated in the Terms and Conditions.
- Attend and take part in monthly calls (or more often as needed) with the CMS Project Officer (PO) on progress and challenges. The meetings will include key personnel and the PO.
- Attend and take part in any virtual meetings.
- Participate in targeted learning activities throughout the course of the IBH model, including the period after selection but prior to performance start date; responding to surveys or other mechanisms to assist CMS in identifying Recipient learning needs; and other items listed in Section F6.5 Learning System Participation.
- Cooperate with CMS-organized model audits and initial assessments of Recipient interventions, data collection, data reporting, and other model terms. Model Audits serve as a compliance-based assessment of Recipients' adherence to model policies to be outlined in the Terms and Conditions. Initial assessments, which occur for the first 12 months of the period of performance, aim to assess whether the Recipients have the operational structures and processes in place to support successful implementation and maintain compliance with certain requirements of the IBH model. Conducting initial assessments during the early stages of model implementation allows for an open dialogue

between CMS and Recipients and an opportunity for direct and timely feedback. Audits, starting in month 12 of the period of performance and continuing through the end of the period of performance, occur after basic education and provision of assistance.

- Any IBH Recipients that also participate in the CCBHC demonstration would need to sign a maintenance of effort (MOE) agreement with CMS and SAMHSA outlining that they will continue to comply with all requirements and services as part of the CCBHC demonstration or grant programs. The IBH Model will require this documentation in the Recipient Specific terms and conditions of the IBH Model cooperative agreement.

F5. Health Information Technology (IT) Interoperability Language

Practice participants that use upfront funding provided under the model for technology investments must ensure that technology purchased aligns with HHS-adopted standards that support interoperability, where applicable.

Successful applicants under this NOFO agree that:

Where award funding involves:	Recipients and subrecipients are required to:
Implementing, acquiring, or upgrading health IT for activities by any funded entity	Use health IT that meets standards and implementation specifications adopted in 45 CFR part 170, Subpart B, if such standards and implementation specification can support the activity. Visit Code of Federal Regulations - Title 45 to learn more.
Implementing, acquiring, or upgrading health IT for activities by eligible clinicians in ambulatory settings, or hospitals, eligible under Section 4101, 4102, and 4201 of the HITECH Act.	Use health IT certified under ONC Health IT Certification Program if certified technology can support the activity. Visit Certification of Health IT to learn more.

If standards and implementation specifications adopted in 45 CFR part 170, Subpart B cannot support the activity, Recipients, and subrecipients are encouraged to utilize health IT that meets non-proprietary standards and implementation specifications developed by consensus-based standards development organizations. This may include standards identified in the ONC Interoperability Standards Advisory, available at https://www.healthit.gov/isa/. Please see Appendix VII for further Health IT Requirements.

F6. Reporting

Federal reporting requirements include:

- Progress Reports
- Federal Financial Report (FFR)
- Federal Funding Accountability and Transparency Act (FFATA)
- Responsibility and Qualification Reports
- Payment Management System (PMS)
- Audit Reporting (Federal Audit Clearing House)
- Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

F6.1 Monitoring

CMS will monitor the performance of each Recipient pursuant to the Terms and Conditions of Award.

Each Recipient will be required to comply fully with CMS' and any CMS contractor's (including, but not limited to, the implementation and monitoring, learning, and evaluation contractors) efforts to monitor the IBH Model. CMS will primarily monitor awards through data collection and reporting. CMS's goal is to monitor and measure model activities in a manner that optimizes its usefulness for both Recipients and the CMS. CMS will closely track model progress through project officers and an implementation and monitoring contractor.

Each Recipient will be required to participate in model monitoring activities that include, but are not limited to:

- Submission of Quarterly Progress Reports
- Regular communications with CMS project officers
- Regular learning system event attendance and participation

F6.2 Progress Reports

Each Recipient will be required to submit quarterly progress reports (QPRs), and an annual progress report (APR). CMS will provide the Recipient with guidance and/or a template for QPR and APR submissions. These reports will include narrative updates on model activities as well as information on operational and performance milestones in accordance with the IBH Model cooperative agreement.

- CMS will use the QPRs and APRs to track progress on model goals, identify technical assistance needs, and inform learning activities for all Recipients.
- The operations and performance milestones will support CMS efforts to confirm that each Recipient is able to meet program requirements and deliver high quality care to beneficiaries.
- CMS will also share these findings with Recipients individually on an ongoing basis for quality improvement purposes.
- Recipients must maintain records of all source data used to calculate program milestone measures and make such data available to the Innovation Center for periodic audits.

- CMS will consider Recipients for enforcement actions including funding restrictions, withholding of funds not yet awarded, or termination if they do not meet the Model reporting requirements outlined in F6.3 Performance Milestones.

F6.3 Performance Milestones

The following milestones, included in *Table F6.3* below, will be included in the Cooperative Agreement Program Terms and Conditions. These milestones are shared to provide applicants an understanding of the requirements for Recipients, however, these milestones and deadlines may be subject to change by CMS.

The milestones are captured under the Implementation Plan. The Implementation plan is due by the end of MY 1. The Recipient will use their application as the basis of their Implementation Plan and update it on a yearly basis with key updates including progress or challenges in reaching performance milestones. For example, the Recipient can note progress on developing their care delivery framework.

Specific remediation activities and enforcement actions are up to CMS discretion. These activities may include, but are not limited to, more frequent engagement with and updates to CMS, reprioritization of activities to address identified challenges, developing a plan to address non-compliance, restricting funds already awarded and/or withholding funds not yet awarded. CMS will support each Recipient in achieving the operational milestones. If a Recipient needs assistance meeting any milestone, the Recipient will contact CMS for technical assistance or other types of support. CMS may also contact Recipients to set up check in calls, technical assistance, or other types of support as needed.

Recipients will not be held accountable if they miss milestones due to the actions of CMS (e.g., CMS delays in approval of authorities and methodologies), assuming the state has demonstrated readiness to meet the milestone by the deadline(s) described in the Cooperative Agreement Program Terms and Conditions.

Table F6.3 Operational Milestones

Implementation Plan			
Requirement	**Description**	**Milestones**	**Due date**
Practice participant recruitment strategy	• The Recipient is required to draft and implement a practice recruitment strategy as described in Section A.4.2	• Develop a draft Practice Participant recruitment strategy, including an estimated number of total Medicaid enrollees with MSBH conditions to be attributed to the IBH Model for the entire duration of the Implementation Period	• As part of this model application

		• Where applicable, secure a letter of intent from a participating MCO, PIHP, PAHP, or other intermediary	• As part of this model application
		• Update the Practice Participant recruitment strategy annually, as needed	• As part of the annual implementation plan update.
		• Provide updates on practice recruitment progress and challenges	• In quarterly and annual progress reports.
Care delivery framework	• The Recipient is required to draft and implement the IBH Model care delivery framework as described in Section A.4.3.	• Work with key stakeholders including Practice Participants, State Mental Health authorities and Single state agencies for SUDs, and MCOs to design the IBH Model care delivery framework	• No later than December 31, 2027
		• Implement the IBH Model care delivery framework	• Starting on January 1, 2028.
		• Provide quarterly updates in QPRs on the status of designing the Medicaid Payment Approach	• In quarterly and annual progress reports.
Medicaid Payment Approach	• The Recipient is required to develop and implement a Medicaid Payment Approach as described in Section A.4.2	• Develop a Medicaid Payment Approach using appropriate state or federal authority	• No later than December 31, 2027
		• Implement the Medicaid Payment Approach among IBH Model Practice Participants	• Starting on January 1, 2028.
		• Provide quarterly updates in QPRs on the status of designing the Medicaid Payment Approach	• In quarterly and annual progress reports.

Health IT Implementation Plan	• The Recipient will be expected to submit an Implementation Plan outlining the type of health IT investments as described in section A4.6 and how these investments will impact the overall goals of the model.	• Develop a draft health IT implementation plan, which includes current and future state of health IT	• As part of this model application
		• Finalize the health IT implementation plan	• December 31, 2025.
		• States will confirm upfront funding for health IT investments has been distributed. States will provide information regarding what kind of health IT investments have been made by the participants, what kind of capabilities these investments are intended to address, and what barriers the participants identified when looking to invest in health IT.	• End of the Implementation Period
		States will submit the following information: • Certified Health IT Capabilities: Did participants use funds to invest in certified health IT? If yes, what capabilities did participants invest in (ex. capturing demographic information, supporting care coordination by sending and receiving summary of care records, providing timely access to view, download, or transmit their heath information, utilizing decision support tools,	• Assessment of Health IT Investments (annual)

		or conducting electronic prescribing). • Health Information Exchange: Did participants engage in health data sharing (e.g., by connecting to an HIE or health information network) to facilitate exchange of electronic health information for care coordination, including participating in arrangements in order to receive electronic notifications for patient transitions of care? • Health Related Social Needs: Did practice participants use IBH Model upfront funding to update existing EHRs to be able to track HRSN screening information and link to social service agencies for referral and follow up? • Best Practices/Barriers: Did participants/states identify any best practices/barriers in the overall implementation of the IBH model when investing in health IT? How did the health IT purchased help accomplish the goals of the IBH model?	

		• Provide quarterly updates in QPRs on the status of implementing the health IT implementation plan	• In quarterly and annual progress reports.
Convening Structure	• The Recipient is required to work alongside CMS to identify a convening structure to operationalize IBH Model components as described in section A.4.7.	• The Recipient will work with CMS to find an existing third-party convener to host the IBH Model	• July 1, 2025.
		• The Recipient will begin no less than quarterly convenings for the IBH Model	• January 1, 2026.
Program duplication documentation	• The Recipient will ensure non-duplication of services and payment	• The Recipient will implement a strategy to ensure non-duplication of services and payment with other federal and state programs	• As part of this model application
		• The Recipient will update its program duplication documentation annually	• Starting December 31, 2025
Compliance plan	• The Recipient will develop or adapt an existing compliance plan to monitor Practice Participants	• The Recipient shall develop compliance standards under the direction of the designated compliance officer (and committee). Training and retraining of the applicable staff on a routine basis with an emphasis on compliance. The compliance plan must be aligned with the DOJ General Compliance Program Guidance[41]	• No later than December 31, 2025

		• Conduct internal monitoring and auditing of the compliance elements with reports readily available.	• No later than quarterly

F6.4 Evaluation

Pursuant to Section 1115A(b)(4) of the Social Security Act, CMS will conduct a formal and concurrent evaluation of each Recipient's performance to assess model impact on spending and quality domains, with the necessary requirements for cooperation in data collection by model participants. The primary goal of the evaluation will be to assess the implementation and effects of the integrated care delivery framework and its supporting payment approach on care utilization and quality of care, along with analysis of any associated impacts on Medicare and Medicaid expenditures, where more robust impacts would be expected under a sub-state implementation scenario. This evaluation will look at all Practice Participants and their attributed beneficiaries, with particular focus on those with moderate to severe BH conditions.

The evaluation will focus on measures of health (both PH and BH) and well-being among the priority population, as well as tracking measures of care coordination, including referrals to PH providers and to address identified HRSNs. Associated measures of progress in health IT infrastructure advancement will also be analyzed. Further, the evaluation will examine the efficacy of implementation based on Practice Participant and beneficiary characteristics and experiences. To the extent possible, given sample size and available data, CMS will additionally investigate whether the intervention reduces emergency department use and hospitalizations, along with tracking other cost and utilization metrics.

This evaluation is expected to cover the Model's three-year Pre-Implementation Period in addition to the five-year Implementation Period. Innovation Center models are exempt from IRB approval. If IRB approvals are necessary at the state or local-level for such actions as managing/handling/transferring clinical or other administrative data, consenting patients to participate, or for collecting measures included in the model beyond claims data, Recipients are solely responsible for any procedures and approvals or any other permissions from their participating organizations or their state that may be needed to submit the relevant data and cooperate with CMS and its contractors on this award. This includes that Recipients may need to develop Medicaid beneficiaries' consent/authorization forms that comply with all applicable federal, state, and local laws governing the access, use, and disclosure of patient data for this model. CMS cannot develop or provide consent/authorization forms for Recipients.

CMS will evaluate each Recipient using the most rigorous evaluation design feasible, applying appropriate quantitative and qualitative methods to examine program outcomes and the processes that lead to successes or challenges. As authorized under 42 C.F.R. § 403.1110, CMS will require Recipients to provide the CMS evaluation contractor with data including, but not limited to:

- Claims and encounter data*:* Recipients must provide all Medicaid claims and encounter data with unique, longitudinally traceable identifiers for the individual beneficiaries attributed to Practice Participants in the Model. Recipients may submit these data through T-MSIS; however, if CMS does not receive all necessary claims and encounter data for attributed beneficiaries through T-MSIS, the Recipient is responsible for obtaining and submitting the required individual-level beneficiary enrollee claims and encounters through an alternative mechanism approved by CMS. This may require coordinating and working with participating MCOs, PIPHs, and PAHPs to ensure proper data availability and submission, depending on the structure of payment for BH in the Recipient's state.
- Electronic health record data: The evaluation may need practices to report data elements from EHRs that are not available from or reliable in other sources (e.g., results of health screenings such as for tracking diabetes a1c levels) for all model enrolled beneficiaries. Whether this data is submitted at the individual or aggregate level will depend on the measure.
- Non-claims-based health and utilization data: Such data may include, but is not limited to, referrals (to other physicians and referrals to address identified HRSNs), patient follow-up on recommended services, interactions with community-based services, and measurement-based care tracking data. Whether this data is submitted at the individual or aggregate level will depend on the measure.
- Qualitative data: Recipients will assist the Model evaluation contractor with the acquisition of qualitative data from Practice Participants, beneficiaries and caregivers, and associated state-level staff, or other relevant stakeholders. Data collection activities that may require the Recipient to cooperate and participate in, include, but are not limited to, arranging and granting interviews; assisting in recruiting for focus groups and individual interviews with model associated state-level staff (i.e. State Medicaid Agency staff), relevant state BH agency staff, Practice Participants, beneficiaries, and beneficiary caregivers; allowing observations of any cooperative agreement or integration capitated payment funded activities; providing program documents such as beneficiary education and staff training materials, provider-participant health equity plans, and community needs assessments; and surveys of staff at Practice Participants and/or beneficiaries. Advanced payment model-related information may include interviews with an MCO, and state personnel associated with implementation, as well as care delivery staff experiencing payment approach implementation.
- Retrospective list of attributed beneficiaries: On an annual basis, the Recipient will provide CMS with a retrospective list of those beneficiaries attributed to Practice Participants to confirm beneficiaries' Medicaid coverage status, which must contain a unique Medicaid identifier that the CMS evaluators can use to longitudinally link beneficiaries to claims and encounter data acquired through T-MSIS (or a backup method approved by CMS).

The evaluation assesses administrative data (e.g., Medicaid claims, encounter data) on an annual basis. Evaluation site visits are no more frequent than annually. Other data (e.g., EHR, screenings, site level) may need to be provided more frequently (e.g., quarterly) in accordance with overall program needs such as model monitoring. The desired data requirements to evaluate this model

most effectively will require coordination and effort on the part of the Recipient. For instance, it is likely this will include the development or enhancement of data systems and the development or implementation and facilitation to ensure agreements are in place for data sharing across providers and partners, such as between specialty BH providers and PH providers or with CBOs.

F6.5 Learning System Participation

Recipients will be required to participate in and provide support to regional learning and convenings in pursuit of a shared vision for population health and health equity outcomes within the state. Recipients must include selected Practice Participants, commercial payers, beneficiary groups, and community-based organizations, and other stakeholders. CMS will partner with Recipients through the learning system to operationalize a data-driven and goal-oriented learning system to enable the success of all participants in the Model that builds from existing infrastructure and capacity within the state. Practice Participants within Recipients' states will also have opportunities to join convenings with Recipients and will access tools and supports organizations need to help them adopt new payment and care delivery methods such as data and data tools, peer-to-peer learning, and accessing data-driven strategies and tactics that are associated with success in the Model.

F6.6 Financial Reports

Recipients are required to record their expenses in real-time as well as submit semi-annual or annual expenditure FFRs.

Recipients must submit a Federal Financial Report (FFR) SF-425 at least annually via the Payment Management System. Frequency of required expenditure reporting, whether semi-annually or annually, is stipulated in the Program Terms and Conditions of the Notice of Award. Instructions on how to complete the FFR can be found (after logging on) at: https://pms.psc.gov/grant-recipients/ffr-updates.html.

F6.7 Federal Funding Accountability and Transparency Act (FFATA) Reporting Requirements

Recipients are required to report certain information about themselves and their first-tier sub-recipients for awards. A specific term is included on your NoA. If your organization is a Recipient of grants or cooperative agreements, you must report on subawards of $30,000. There are additional reporting requirements if:

- 80% or more of your prior year annual gross revenues are from federal awards;
- $25 million or more in annual gross revenues are from federal awards; or
- The public does not have access to compensation information filed under Securities and Exchange Commission (SEC) and IRS requirements.

Additional Guidance on FFATA

- Prime recipients report their own executive compensation if they meet all the criteria, as part of their profile at System for Award Management (SAM)
- Prime recipients report subaward information at the FFATA Subaward Reporting System (FSRS)

F6.8 Responsibility and Qualification Reporting

Recipients that have active federal contract, grant, or cooperative agreement awards with a cumulative value greater than $10,000,000 at any time during the period of performance are **required** to disclose semi-annual information about criminal, civil, and administrative proceedings that reached final disposition within the most recent five-year period and that were connected with the award or performance of an award. Recipients must also make semi-annual disclosures regarding such proceedings and/or affirm that there is no new information to provide. This information will be made publicly available in **Responsibility and Qualification** records (formerly Federal Awardee Performance and Integrity Information System) on SAM.gov.

Additional Guidance

- Responsibility/Qualification Information
- Federal Awarding Agency Review of Risk Posed by Applicants, 2 CFR 200.205

F6.9 Audit Requirements

The audit requirements in 45 CFR Part 75, Subpart F, apply to each award recipient fiscal year that begins on or after December 26, 2014. A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single or program specific audit conducted for that year in accordance with the provisions of Subpart F, Audit Requirements.

For specific questions and information about the submission process, call the FAC toll-free number at 800-253-0696.

F6.10 Payment Management System Reporting Requirements

Once CMS issues an award, the funds are posted in Recipient accounts established in the Payment Management System (PMS). Recipients may then access their funds by using the PMS funds request process.

The PMS funds request process enables Recipients to request funds using a Personal Computer with an Internet connection. The funds are delivered to the Recipient via Electronic Funds Transfer (EFT). If you are a new Recipient, please go to PMS Access Procedures to find information to

register in PMS. If you need further help with that process, please contact the One-DHHS Help Desk via email at pmssupport@psc.gov or call (877) 614-5533 for assistance.

F6.11 Government-wide Suspension and Debarment Reporting Requirements

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification;

i. You certify on behalf of the applicant organization, by submission of your proposal, that neither you nor your principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
ii. Failure to make required disclosures can result in any of the remedies described in 45 CFR § 75.371, including suspension or debarment. (See also 2 CFR parts 180 and 376, and 31 U.S.C. § 3354).
iii. If you are unable to attest to the statements in this certification, you must include an explanation and insert in "Other Relevant Documents."

G. CMS Contacts

G1. Programmatic Questions

For Programmatic questions about this funding opportunity, please contact: IBHModel@cms.hhs.gov

G2. Administrative and Budget Questions

For administrative or budget questions about this funding opportunity, please contact: IBHModel@cms.hhs.gov

H. Other Information

Publication of this NOFO does not oblige CMS to award any specific project or to obligate any available funds. CMS may cancel or withdraw this NOFO at any time. Award decisions are discretionary and are not subject to appeal to any CMS or HHS official or board.

- Applicants must identify proprietary information.

Appendix I. Guidance for Preparing a Budget Request and Narrative

All applications must include a detailed budget and narrative that explains the federal and the non-federal expenditures broken out by the object class cost categories listed on SF-424A − Section B (Budget Category) for non-construction awards.

- You must request funding only for activities that will support this specific Notice of Funding Opportunity.
- The budget and narrative must be consistent with and support the Project Narrative. The proposed costs must be reasonable, allowable, allocable, and necessary for the supported activity.
- Both the Standard Form SF-424A and the Budget Narrative must include a yearly breakdown of costs for the entire period of performance.
- Refer to the program specific Funding Restrictions and Limitations and Standard Funding Restrictions, as well as to 45 CFR Part 75 (for applicable administrative requirements and cost principles).

Assurances and Certifications
When the Authorized Organization Representative (AOR) signs the Application for Federal Assistance SF-424 form, they certify that the they agree to comply with the Assurances for Non-Construction Programs (SF-424B).

Cost Sharing
This program has no cost-sharing requirement. If you choose to include cost-sharing funds, we will not consider it during review. However, we will hold you accountable for any funds you add, including the requirements for grant reporting.

Standard Form SF-424A
All applicants must submit an SF-424A. **Since the total Period of Performance is 8 years, then the Applicant must submit two SF-424A Forms.**

- **(Form 1) SF-424A Form – Costs for Years 1-4**
- **(Form 2) SF-424A Form – Costs for Years 5-8**

Blank SF-424A forms (Budget Information for Non-Construction Programs) can be found at Grants.gov: https://www.grants.gov/forms/forms-repository/sf-424-family

The total aggregate federal costs for the two SF-424A forms reflecting years 1-8 (i.e. combining the total costs from column 5 of each SF-424A form) shall be consistent with the total Federal costs requested on the SF-424, Application for Federal Assistance (field 18a of SF-424).

Review the general instructions provided for form SF-424A and comply with the instructions outlined below.

- Note: The directions in the Notice of Funding Opportunity (NOFO) may differ from those provided by Grants.gov. Please follow the instructions included in this NOFO as outlined below when completing the SF-424A.
- Note: The total requested on the SF-424 (Application for Federal Assistance) reflects the overall total requested on the two SF-424A forms (Budget Information – Non-Construction) for the entire period of performance.

Section A – Budget Summary

- Grant Program Function or Activity (column a) = Enter "Name of Notice of Funding Opportunity" in row 1.
- New or Revised Budget, Federal (column e) = Enter the Total Federal Budget Requested for the project period in rows 1 and 5.
- New or Revised Budget, Non-Federal (column f) = Enter Total Amount of any Non-Federal Funds Contributed (if applicable) in rows 1 and 5. Voluntary committed cost sharing or matching is not expected unless specifically stated otherwise in section C2.
- New or Revised Budget, Total (column g) = Enter Total Budget Proposed in rows 1 and 5, reflecting the sum of the amount for the Federal and Non-Federal Totals.

Section B – Budget Categories

- Enter the total costs requested for each Object Class Category (Section B, number 6) for each year/budget period of the period of performance.

First SF-424A Form (Years 1-4)

- Column (1) = Enter Year 1 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 1 line items is entered in column 1, row k (sum of row i and j).
- Column (2) = Enter Year 2 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 2 line items is entered in column 2, row k (sum of row i and j).
- Column (3) = Enter Year 3 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 3 line items are entered in column 3, row k (sum of row i and j).
- Column (4) = Enter Year 4 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 4 items are entered in column 4, row k (sum of row i and j).

- Column (5) = Enter total costs for years 1-4 for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items are entered in row k (sum of row i and j). The total in column 5, row k shall match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.

Second SF-424A Form (Years 5-8):

- https://www.grants.gov/web/grants/forms/sf-424-individual-family.html#sortby=1Column (1) = Enter Year 5 costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 1 line items is entered in column 1, row k (sum of row i and j).
- Column (2) = Enter Year 6 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 2 line items is entered in column 2, row k (sum of row i and j).
- Column (3) = Enter Year 7 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 3 line items are entered in column 3, row k (sum of row i and j).
- Column (4) = Enter Year 8 estimated costs for each line item (rows a-h), including the sum of the total direct charges (a-h) in row i. Indirect charges are reflected in row j. The total for direct and indirect charges for all year 4 items are entered in column 4, row k (sum of row i and j).
- Column (5) = Enter total costs for years 5-8 for each line item (rows a-h), direct total costs (row i), and indirect costs (row j). The total costs for all line items are entered in row k (sum of row i and j). The total in column 5, row k shall match the total provided in Section A – Budget Summary, New or Revised Budget, column g, row 5.

Budget Narrative – Sample Narrative and Instructions

Applicants must complete a Budget Narrative and upload it to the Budget Narrative Attachment Form in the application kit. Applicants can request funding only for activities not already funded or supported by other funding sources. Awards support separate activities and new federal funding cannot be supplanted by other federal funding. In the budget request, applicant distinguishes between activities funded under this application and activities funded with other sources. Other funding sources include other HHS grant programs, Innovation Center Models, and other federal funding sources as applicable. Insufficient budget detail and justification may negatively impact the review of the application.

A. (Personnel) Salaries and Wages

For each requested position, provide the following information:

- title of position
- name of staff member occupying the position, if available
- annual salary
- percentage of time budgeted for this program (FTE or level of effort)
- total months of salary budgeted
- total salary requested
- justification and description of each role and the scope of responsibility for each position, relating it to the accomplishment of program objectives. These individuals must be employees of the applicant organization.

Note: The Consolidated Appropriations Act restricts the amount of direct salary to Executive Level II of the Federal Executive Pay Scale. This salary cap applies to direct salaries and to those salaries covered under indirect costs, also known as facilities and administrative (F & A).
See the following link for the applicable current salary cap: https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/

Sample Budget

Personnel Total	*$_____*
Grant	*$_____*
*Recipient Share *$_____*	

*Cost sharing only.

Position Title	Name (if known)	Annual	Time	Months	Amount Requested
Project Director	Susan Taylor	$45,000	100%	12 months	$45,000
Finance Administrator	John Johnson	$28,500	50%	12 months	$14,250
Outreach Supervisor	Vacant	$27,000	100%	12 months	$27,000
Total:					$86,250

Sample Justification

Responsibilities shall be directly related to specific program objectives.

Job Description: Project Director - (Name)
This position directs the overall operation of the project; responsible for overseeing the implementation of project activities, coordination with other agencies, development of materials, provisions of in-service and training, conducting meetings; designs and directs the gathering, tabulating and interpreting of required data; responsible for overall program evaluation and for staff performance evaluation; and is the responsible authority for ensuring necessary reports/documentation are submitted to CMS. This position relates to all program objectives.

B. Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation (reference NICRA if applicable). If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed. This information must be provided for each position (unless the rates for all positions are identical).

Sample Budget

Fringe Benefits Total $_____
Grant $_____
Recipient Share $_____*

*Cost sharing only.

Fringe Benefit	**Rate**	**Salary Requested**	**Amount Requested**
FICA	7.65%	$45,000	$3443
Worker's Compensation	2.5%	$14,250	$356
Insurance	Flat rate - $2,000 (100% FTE for 12 months)	$2,000	$2,000
Retirement	5%	$27,000	$1,350
Total			$7,149

C. Travel

Dollars requested in the travel category are for **applicant staff travel only**. Travel for consultants is in the consultant category. Allowable travel for other participants, advisory committees, review panel, etc. is itemized in the same way specified below and placed in the **"Other"** category. Travel incurred through a contract is in the contractual category.

Provide a narrative describing the travel staff members will perform. This narrative includes a justification of why this travel is necessary and how it will enable the applicant to complete program requirements included in the Notice of Funding Opportunity. List where travel will be undertaken, number of trips planned, who will be making the trip, and approximate dates. If mileage is to be paid, provide the number of miles and the cost per mile. The mileage rate cannot exceed the rate set by the General Services Administration (GSA). If travel is by air, provide the

estimated cost of airfare. The lowest available commercial airfares for coach or equivalent accommodations are used. If per diem/lodging is to be paid, indicate the number of days and amount of daily per diem as well as the number of nights and estimated cost of lodging. Costs for per diem/lodging cannot exceed the rates set by GSA. Include the cost of ground transportation when applicable. Please refer to the GSA website by using the following link http://www.gsa.gov/portal/content/104877.

Sample Budget

Fringe Benefits Total	*$_____*
Grant	*$_____*
Recipient Share$_____*	

*Cost sharing only.

Purpose of Travel	**Location**	**Item**	**Rate**	**Cost**
Site Visits	Neighboring areas of XXX	Mileage	$0.655 x 49 miles (use mileage rate in effect at time of mileage incurrence) x 25 trips	$802
Training (ABC)	Chicago, IL	Airfare	$200/flight x 2 persons	$400
		Luggage Fees	$50/flight x 2 persons	$100
		Hotel	$140/night x 2 persons x 3 nights	$840
		Per Diem (meals)	$49/day x 2 persons x 4 days	$392
		Transportation (to and from airport)	$50/shuttle x 2 persons x 2 shuttles	$200
		Transportation (to and from hotel)	$25/shuttle x 2 persons x 2 shuttles	$100
				$2,834

Sample Justification

The Project Coordinator and the Outreach Supervisor will travel to (location) to attend a conference on the following topic XXXX held once a year in Chicago, IL. Attending this conference is directly linked to project goals/objectives and is a necessity because XXXX. The information and tools we will gather from attending this conference will help us to carry out project objectives by XXXX. A sample itinerary is provided upon request. The Project Coordinator will also make an estimated 25 trips to birth center sites to monitor program implementation (# of birth centers, # of trips per site). We are still in the process of identifying all birth center sites and identifying an average mileage total for each site. This travel is necessary to ensure birth center sites are consistently and systematically collecting birth center data and submitting by deadlines provided.

On-site monitoring will enable us to address concerns. This travel also furthers our efforts to carry out specific project goals for the following reasons_____.

D. Equipment

Equipment is tangible nonexpendable personal property, including exempt property, charged directly to the award having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. However, consistent with Recipient policy, lower limits may be established.

Note: Technology items such as computers that do not meet the $5,000 per unit threshold or an alternative lower limit set by Recipient policy that may therefore be classified as **supplies**, must still be individually tagged and recorded in an equipment or technology database. Provide justification for the use of each equipment item and relate it to specific program objectives. List maintenance or rental fees for equipment in the "Other" category. Ensure that all IT equipment is uniquely identified. Show the unit cost of each item, number needed, and total amount.

Sample Budget

Equipment Benefits Total $_____
Grant $_____
Recipient Share $_____*

*Cost sharing only.

Item(s)	**Rate**	**Cost**
All-in-one Printer, Copier, and Scanner (large scale)	1 @ $5,800	$5,800
X-Ray Machine	1 @ $8,000	$8,000
Total:		$13,800

Sample Justification

Provide complete justification for all requested equipment, including a description of how the program uses the equipment. For equipment and tools shared amongst programs, please cost allocate as appropriate. Applicant shall provide a list of hardware, software and IT equipment that will be needed to complete this effort. Additionally, they shall provide a list of non-IT equipment that will be needed to complete this effort.

E. Supplies

Supplies includes all tangible personal property with an acquisition cost of less than $5,000 per unit or an alternative lower limit set by Recipient policy. Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. Classify technology items such as computers that do not meet the $5,000 per unit threshold or an alternative lower limit set by Recipient policy as **supplies** and individually tag and record in an equipment or technology database. If appropriate, general office supplies may be shown by an estimated amount per month times the number of months in the budget category.

Sample Budget

Supplies Total	*$_____*
Grant	*$_____*
*Recipient Share**	*$_____*

*Cost sharing only.

Item(s)	**Rate**	**Cost**
Laptop Computer	2 @ $1,000	$2,000
Printer	1 @ $200	$200
General office supplies	12 months x $24/mo x 10 staff	$2,880
Educational pamphlets	3,000 copies @ $1 each	$3,000
Educational videos	10 copies @ $150 each	$1,500
Total:		$9,580

Sample Justification

General office supplies will be used by staff members to carry out daily activities of the program. The project coordinator will be a new position and will require a laptop computer and printer to complete required activities under this Notice of Funding Opportunity. The price of the laptop computer and printer is consistent with those purchased for other employees of the organization and is based upon a recently acquired invoice (which can be provided upon request). The pricing of the selected computer is necessary because it includes the following tools XXXX (e.g., firewall, etc.). The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. Usage of these pamphlets and videos will enable us to address components one and two of our draft proposal. Word Processing Software will be used to document program activities, process progress reports, etc.

F. Consultant/Subrecipient/Contractual Costs

F1. REQUIRED REPORTING INFORMATION FOR CONSULTANT HIRING[26]

This category is appropriate when hiring an individual who gives professional advice or provides services (e.g., training, expert consultant, etc.) for a fee and who is not an employee of the Recipient organization. Submit the following required information for consultants:

1. Name of Consultant: Identify the name of the consultant and describe the person's qualifications.
2. Organizational Affiliation: Identify the organizational affiliation of the consultant, if applicable.
3. Nature of Services to be Rendered: Describe in outcome terms the consultation to be provided including the specific tasks to be completed and specific deliverables.
4. Relevance of Service to the Project: Describe how the consultant services relate to the accomplishment of specific program objectives.
5. Number of Days of Consultation: Specify the total number of days of consultation.
6. Expected Rate of Compensation: Specify the rate of compensation for the consultant (e.g., rate per hour, rate per day). Include a budget showing other costs such as travel, per diem, and supplies.
7. Justification of expected compensation rates: Provide a justification for the rate, including examples of typical market rates for this service in your area.
8. Method of Accountability: Describe how the applicant monitors progress and performance of the consultant. Identify who is responsible for supervising the consultant agreement.

F2. REQUIRED REPORTING INFORMATION FOR SUBRECIPIENT APPROVAL

The costs of project activities to be undertaken by a subrecipient is included in this category. Please use formats from "Sample Budget" and "Sample Justification" above. For more information on subrecipient and contractual relationships, please refer to HHS regulation 45 CFR 75.351 *Subrecipient and Contractor Determinations* and 75.352 *Requirements for pass-through entities*.

F3. REQUIRED REPORTING INFORMATION FOR CONTRACT APPROVAL

All Recipients must submit to CMS the following required information for establishing a contract to perform project activities.

1. Name of Contractor: Who is the contractor? Identify the name of the proposed contractor and indicate whether the contract is with an institution or organization.

[26] Consultants referenced here do not include Physical Health (PH) Consultants. Practice Participants who cannot provide identified Evaluation and Management (E&M) services within their scope of practice will be encouraged to: develop an annual care agreement or other relationship with PH providers outlining roles and shared accountability and submit a roster of their partnering PH providers to CMS. The roster would make the listed PH providers eligible to use a new or modified consult and/or care management code. If no roster is in place, the PH provider will use existing professional consult codes for payment. Referral to a specific PH care provider shall align with the beneficiary's preferences. If the beneficiary's physical health provider is not included on the IBH Model roster for their Practice Participant, the physical health provider shall use existing professional consult codes for payment.

2. Method of Selection: How was the contractor selected? State whether the contract is sole source or competitive bid. If an organization is the sole source for the contract, include an explanation as to why this institution is the only one able to perform contract services.
3. Period of Performance: How long is the contract period? Specify the beginning and ending dates of the contract.
4. Scope of Work: What will the contractor do? Describe in outcome terms, the specific services or tasks performed by the contractor as related to the accomplishment of program objectives. Clearly define the deliverables.
5. Method of Accountability: Describe the monitoring plan of the progress and performance of the contractor during and on close of the contract period. Name who will be responsible for supervising the contract.
6. Itemized Budget and Justification: Provide an itemized budget with appropriate justification. If applicable, include any indirect cost paid under the contract and the indirect cost rate used.

G. Construction (not applicable)

H. Other

This category contains items not included in the previous budget categories. Individually list each item requested and provide appropriate justification related to the program objectives.

Sample Budget

Other Total	*$_____*
Grant	*$_____*
Recipient Share $_____*	
Sources of Funding_____	

*Cost sharing only.

Item(s)	**Rate**	**Cost**
Telephone	$45 per month x 3 employees x 12 months	$1,620
Postage	$250 per quarter x 4 quarters	$1,000
Printing	$0.50 x 3,000 copies	$1,500
Equipment Rental *specify item	$1,000 per day for 3 days	$3,000
Internet Provider Service	$20 per month x 3 employees x 12 months	$720
Word Processing Software (specify type)	1 @ $400	$400
Total:		$8,240

[Some items are self-explanatory (telephone, postage, rent) unless the unit rate or total amount requested is excessive. If the item is not self-explanatory and/or the rate is excessive, include additional justification. For printing costs, identify the types and number of copies of documents to be printed (e.g., procedure manuals, annual reports, materials for media campaign).]

Sample Justification

We are requesting costs to accommodate telephone and internet costs for the 3 new hires that will be working on this project in the new space designated. We are also requesting printing and postage costs to support producing fliers to disseminate in the community and brochures to educate participants enrolled in the program. The word processing software will be used to help us track data and compile reports. To track and compile the data, we will need to rent _____. Without this equipment, we will not be able to produce this information in an accurate and timely manner.

I. Total Direct Costs

Show total direct costs by listing totals of each category.

J. Indirect Costs

To claim indirect costs, the applicant organization must have a current approved negotiated indirect cost rate agreement (NICRA) set up with the Cognizant Federal agency unless the organization has never established one (see 45 CFR §75.414 for more information). If a rate has been issued, a copy of the most recent indirect cost rate agreement must be provided with the application.

If the applicant organization has never received an indirect cost rate, except for those non-federal entities described in Appendix VII(D)(1)(b) to 45 CFR part 75, the applicant may choose to charge a de minimis rate of 10% of modified total direct costs (MTDC). If the applicant has never received an indirect cost rate and wants to exceed the de minimis rate, then costs normally identified as indirect costs (overhead costs) can be budgeted and identified as direct costs. These costs shall be outlined in the "other" costs category and fully described and itemized as other direct costs.

Sample Budget

The rate is ___% and is computed on the following direct cost base of $_____.

Personnel $_____
Fringe $_____
Travel $_____
Supplies $_____
Other $_____
Total $ x ____% = Total Indirect Costs

Appendix II. Application and Submission Information

Please CTRL/Click to access links or paste to your browser. Please note these are the most up-to-date directions and links at the time of NOFO publication. CMS recommends Applicants check the websites for any changes. Also, phone numbers are provided if additional assistance is needed as several websites have made recent changes to links and directions.

This NOFO contains all the instructions you need to apply. The application is written primarily as a narrative with the addition of standard forms required by the Federal government for all grants and cooperative agreements.

With respect to electronic methods for providing information about funding opportunities or accepting applicants' submissions of information, CMS complies with Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d).

How to Apply for CMS Grants

Register and Get Ready

Register and get ready at least one month before funding opportunity opens.

Every applicant organization and sub-recipient organization must have the following five registrations in place to submit a grant application:

1. Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN)
2. Unique Entity Identifier (UEI) registration;
3. System for Award Management (SAM.gov) registration;
4. Login.gov account; and
5. Grants.gov registration

All five registrations are free, but the process can take one month or longer. If you plan to apply for a CMS grant, do not delay. Get registered today!

If you have already completed registrations for SAM and Grants.gov, ensure that your accounts are still active.

Employer Identification Number (EIN)

You must have an Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN), to apply. **Begin the process of obtaining an EIN/TIN as soon as possible to ensure this information is received in advance of application deadlines. The process to obtain an EIN typically takes up to 5 weeks.**

Unique Entity Identifier (UEI)

All applicants must have a unique entity identifier (UEI) at the time of application submission. A Unique Entity Identifier (UEI) is a number that identifies your entity registration in SAM.gov. This identifier is assigned by SAM.gov. The Office of Management and Budget (OMB) requires the Unique Entity ID to be used across federal systems, governmentwide, for federal award purposes. Additional information is available on SAM.gov.

System for Award Management (SAM)

Initial registration on SAM.gov can take between three days and two weeks. Note that SAM.gov registrations must be updated every year, which can take five days. View user guides, frequently asked questions, and other support tools in the Support section of the SAM website.

You must register in the System for Award Management (SAM) database before you apply to Grants.gov. UEI and EIN/TIN numbers are required to complete the registration process. To register one or more domestic entities and appoint an entity administrator, you must send a notarized letter to SAM.

Begin the SAM registration process as soon as possible to ensure that it does not impair your ability to meet required submission deadlines. The process to register in SAM typically takes up to 2 weeks following receipt of the notarized letter (additional 5 weeks if an EIN must be established first).

After you register with SAM, you must update the information there every 12 months for your account to remain active. Grants.gov rejects electronic submissions from applicants with expired registrations. If your SAM account expires, the renewal process requires the same validation as required for a new account.

Primary awardees must maintain a current registration with the SAM database and **may make subawards only to entities that have UEI numbers.**

Grants.gov

Grants.gov is an online portal for submitting federal award applications. It requires a one-time registration to submit applications. All competitive Notice of Funding Opportunities must be submitted electronically through Grants.gov.

Search for the CMS application package in by entering the Federal Assistance Listings number. This number is shown on the Federal Assistance Listings website at SAM.gov and the cover page of the Notice of Funding Opportunity (NOFO).

For assistance with this process contact Grants.gov Support or 1-800-518-4726. Below is an overview of the instructions from the Grants.gov website. Applicants can access the site directly for more detailed information.

How to Register to Apply through Grants.gov

1. **Register to obtain a Grants.gov username and password.**
    - Click the Register link and complete the on-screen instructions.
    - The person submitting your application must be registered with Grants.gov as the Authorized Organizational Representative (AOR) for the specific UEI number cited on the SF-424 (first page). See the Applicant Training page for details.
2. **Link your Grants.gov account to a Login.gov account.**
3. ***Add a Profile to the Account*:**
    - The profile corresponds to a single applicant organization the user represents (i.e., an applicant) or an individual applicant. If you work for or consult with multiple organizations and have a profile for each, you may log in to one Grants.gov account to access all your grant applications. To add an organizational profile, enter the UEI (Unique Entity Identifier) for the organization in the field while adding a profile. For more detailed instructions about creating a profile click here.
4. ***Establish EBiz POC Authorized Profile Roles*:**
    - EBiz POCs will no longer use their UEI or DUNS Number during login. EBiz POCs will use an applicant account associated with their email address and UEI (Unique Entity Identifier) by using an existing applicant account or Creating a New Account.
    - EBiz POCs will login using multi-factor authentication through *Login.gov*. The Expanded AOR (Authorized Organizational Representative) role will be automatically assigned to the EBiz POC. Users with the Expanded AOR can control organization preferences, user access, and apply for grants with the same account. To be recognized as EBiz POC in Grants.gov, users will need to use an applicant account with an email address that matches the SAM.gov account email address for their organization.
        - Click here for more details.
5. **Track *Your Application Status*:**
6. ***Electronic Signature*:**
    - The name of the organization applicant with the AOR role that submitted the application is inserted into the signature line of the application, serves as the electronic signature. The EBiz POC **must** authorize people who are able to make legally binding commitments on behalf of the organization as a user with the AOR role; **this step is often missed and it is crucial for valid and timely submissions.**

Getting Started in Workspace:

Workspace is the standard way for organizations to apply for federal grants in Grants.gov. Workspace allows a grant team to simultaneously access and edit different forms within an application.

Create a Workspace.

Mandatory Fields in Forms: In the forms, you will note fields marked with an asterisk and a different background color. These fields are mandatory fields that must be completed to successfully submit your application.

Complete SF-424 Fields First: The forms are designed to fill in common required fields across other forms, such as the applicant name, address, and UEI Number. Once it is completed, the information will transfer to the other forms.

Submit a Workspace: An application may be submitted through workspace by clicking the Sign and Submit button on the Manage Workspace page, under the Forms tab. **Grants.gov recommends submitting your application package at least 24-48 hours prior to the close date to provide you with time to correct any potential technical issues that may disrupt the application submission.**

Track a Workspace Submission: After successfully submitting a workspace application, a Grants.gov Tracking Number (GRANTXXXXXXXX) is automatically assigned to the application. The number will be listed on the Confirmation page that is generated after submission. Using the tracking number, access the Track My Application page.

Application Completion & Proof of Timely Submission

All grant and cooperative agreement applications must be submitted electronically and **received** through Grants.gov by **11:59 p.m. Eastern Standard or Daylight Time** (Baltimore, MD) by the applicable deadline date noted in the NOFO.

Proof of timely submission is automatically recorded and an electronic date/time stamp is generated within the system when the application is successfully received by Grants.gov. The AOR who submitted the application will receive an acknowledgement of receipt and a tracking number (GRANTXXXXXXXX) with the successful transmission of their application. The AOR will also receive the official date/time stamp and Grants.gov Tracking number in an email serving as proof of their timely submission.

Please note, you may incur a time delay before you receive acknowledgement that the application has been accepted by the Grants.gov system. **Applicants should not wait until the application deadline to apply.** Notification by Grants.gov that the application is incomplete may not be received until close to or after the application deadline. Consequently, you may not be able to correct errors and resubmit the application. Applications submitted after the deadline, because of errors on the part of the applicant, will not be reviewed.

Once CMS successfully downloads the application from Grants.gov, the AOR will receive an electronic acknowledgment of receipt of the application. Proof of timely submission will be the official date and time that Grants.gov receives your application. Applications received after the

established due date for the program will be considered late and may not be considered for funding by CMS.

Applicants using slow internet, such as dial-up connections, shall be aware that transmission can take some time before your application is received. The Support Center reports that some applicants end the transmission because they think that nothing is occurring during the transmission process. Please be patient and give the system time to process the application.

Grants.gov complies with Section 508 of the Rehabilitation Act of 1973. If an individual uses assistive technology and is unable to access any material on the site, including forms contained within an application package, the individual can e-mail Grants.gov at support@grants.gov or call 1-800-518-4726.

Appendix III. Business Assessment of Applicant Organization

You must complete the business assessment questions outlined below. There are eleven (11) topic areas labeled A-K, with a varying number of questions within each topic area. **You MUST provide a brief substantive answer to each question (and supporting documentation as applicable).** If the answer to any question is non-applicable, please provide an explanation. CMS cannot complete its review without contacting the applicant for additional clarification, the applicant risks selection for award.

A. General Information

1. Provide organization:
    a. Legal name:
    b. EIN (include PMS prefix and suffix, if applicable-ex. 1-12356789-A1):
    c. Organizational Type:
2. What percentage of the organization's capital is from Federal funding? (percentage = total Federal funding received in previous fiscal year / organization's total gross revenue in previous fiscal year).
3. Does/did the organization receive additional oversight (ex: Correction Action Plan, Federal Awardee Performance and Integrity Information System (FAPIIS) finding, reimbursement payments for enforcement actions) from a Federal agency within the past 3 years due to past performance or other programmatic or financial concerns with the organization)?
    a. If yes, please provide the following information: Name of the federal agency; reason for the additional oversight as explained by the federal agency
    b. If resolved, please indicate how the issue was resolved with the federal agency.
4. Does the organization currently manage grants with other U.S. Department of Health and Human Services components or other Federal agencies?
5. Explain your organization's process to ensure annual renewal in System for Award Management (to include FAPIIS).
6. Explain your organization's process to comply with (a) 45 CFR 75.113 Mandatory Disclosures and (b) your organization's process to comply with FFATA requirements.
7. Do you have conflict of interest policies? Does your organization or any of its employees have any personal or organizational conflicts of interest related to the possible receipt of these CMS award funds? If yes, please explain and provide a mitigation plan.
8. Does your organization currently, or in the past, had delinquent Federal debt in the last 3 years? If yes, please explain.

9. Has the organization obtained fidelity bond insurance coverage for responsible officials and employees of the organization in amounts required by statute or organization policy? What is that amount?
10. Do you have (and briefly describe) policies and procedures in place to meet the requirements below? If not, explain your plan and estimated timeline for establishing these policies and procedures if selected for award.
    a. make determinations between sub-Recipients versus contracts in accordance with 45 CFR 75.351?
    b. notify entities at the time of the award and agreement if they are a sub-Recipient in compliance with 45 CFR 75.352?
    c. manage, assess risk, review audits, and monitor the sub-Recipients as necessary to ensure that subawards are used for authorized purposes in compliance with laws, regulations, and terms and conditions of the award and that established subaward performance goals are achieved (45 CFR § 75.351–75.353)?

B. Accounting System

1. Does the organization have updated (last two years) written accounting policies and procedures to manage federal awards in accordance with 45 CFR Part 75?
    a. If no, please provide a brief explanation of why not.
    b. Describe the management of federal funds and how funds are separated (not co-mingling) from other organizational funds.
2. Briefly describe budgetary controls in effect to preclude incurring obligations more than:
    a. Total funds available for an award.
    b. Total funds available for a budget cost category.
3. Has any government agency rendered an official written opinion within the last 3 years concerning the adequacy of the organization's accounting system for the collection, identification, and allocation of costs under federal awards?
    a. If yes, please provide the name and address of the federal agency that performed the review.
    b. Provide a summary of the opinion.
    c. How did your organization resolve any concerns?
4. How does the accounting system provide for recording the non-federal share and in-kind contributions (if applicable for a grant program)?
5. Does the organization's accounting system provide identification for award funding by federal agency, pass-through entity, Assistance Listing (CFDA), award number and period of funding? If yes, how does your organization identify awards? If not, please explain why not.

C. Budgetary Controls

1. What are the organization's controls utilized to ensure that the Authorized Organizational Representative (AOR), as identified on the SF-424, approves all budget changes for the federal award?
2. Describe the organization's procedures for minimizing the time between transfer of funds from the U.S. Treasury (e.g. Payment Management System) and disbursement for grant activities (See 45 CFR §75.305, "Payment.").

D. Personnel

1. Does the organization have a current organizational chart or similar document establishing clear lines of responsibility and authority?
    a. If yes, please provide a copy.
    b. If no, how are lines of responsibility and authority determined?
2. Does the organization have updated (last two years) written Personnel and/or Human Resource policies and procedures? If no, provide a brief explanation.
3. Does the organization pay compensation to Board Members?
4. Are staff responsible for fiscal and administrative oversight of HHS awards (Grants Manager, CEO, Financial Officer) familiar with federal rules and regulations applicable to grants and cooperative agreements (e.g. 45 CFR Part 75)?
5. Please describe how the payroll distribution system accounts for, tracks, and verifies the total effort (100%) to determine employee compensation.

E. Payroll

1. In preparation of payroll is there a segregation of duties for the staff who prepare the payroll and those that sign the checks, have custody of cash funds and maintain accounting records? Please describe.

F. Consultants (See appendix I in the NOFO for relevant information)

1. Are there written policies or consistently followed procedures regarding the use of consultants which detail the following (include explanation for each question below)?
    a. Briefly describe the organization's method or policy for ensuring consultant costs and fees are allowable, allocable, necessary and reasonable.
    b. Briefly describe the organization's method or policy to ensure prospective consultants prohibited from receiving Federal funds are not selected.

G. Property Management

1. Briefly describe the system for property management (tangible or intangible) utilized for maintaining property records consistent with 45 CFR 75.320(d). **Refer to (45 CFR 75.2) for definitions of property to include personal property, equipment, and supplies.
2. Does the organization have adequate insurance to protect the Federal interest in equipment and real property (see 45 CFR §75.317, "Insurance coverage")? How does the organization calculate the amount of insurance?

H. Procurement

1. Describe the organization's procurement procedures (in accordance with 45 CFR §75.326--§75.335, "Procurement procedures")? If there are no procurement procedures, briefly describe how your organization handles purchasing activities.
    a. Include individuals responsible and their roles.
    b. Describe the competitive bid process for procurement purchases of equipment, rentals, or service agreements that are over certain dollar amounts.

I. Travel

1. Describe the organizations written travel policy. Ensure, at minimum, that:
    a. Travel charges are reimbursed based on actual costs incurred or by use of per diem and/or mileage rates (see 45 CFR §75.474, "Travel costs").
    b. Receipts for lodging and meals are required when reimbursement is based on actual cost incurred.
    c. Subsistence and lodging rates are equal to or less than current federal per diem and mileage rates.
    d. Commercial transportation costs incurred at coach fares unless adequately justified. Lodging costs do not exceed GSA rate unless adequately justified (e.g. conference hotel).
    e. Travel expense reports show purpose and date of trip.
    f. Travel costs are approved by organizational official(s) and funding agency prior to travel.

J. Internal Controls

1. Provide a brief description of the applicant's internal controls that will provide reasonable assurance that the organization will manage award funds properly. (see 45 CFR §75.303, "Internal controls")
2. What is your organization's policy on separation of duties as well as responsibility for receipt, payment, and recording of cash transactions?

3. Does the organization have internal audit or legal staff? If not, how do you ensure compliance with the award? Please describe.
4. If the organization has a petty cash fund how is it monitored?
5. Who in the organization reconciles bank accounts? Is this person familiar with the organization's financial activities? Does your organization authorize this person to sign checks or handle cash?
6. Are all employees who handle funds required to be bonded against loss by reason of fraud or dishonesty?

K. Audit

1. What is your organization's fiscal year?
2. Did the organization expend $750,000 or more in Federal awards from all sources during its most recent fiscal year?
3. Has your organization submitted:
    a. an audit report to the ***Federal Audit Clearing House (FAC)*** in accordance with the Single Audit Act in the last 3 years? (see 45 CFR §75.501, "Audit requirements" and 45 CFR §75.216 "Special Provisions for Awards to Commercial Organization as Recipient") **or**
    b. an independent, external audit? If no, briefly explain. If yes, address the following:
        i. The date of the most recently submitted audit report.
        ii. The auditor's opinion on the financial statement.
        iii. If applicable, indicate if your organization has findings in the following areas: 1) *internal controls, 2) questioned or unallowable costs, 3) procurement/suspension and debarment, 4) cash management of award funds, and 5) sub-Recipient monitoring*.
        iv. Include (if applicable):
            1. A description of each finding classified as Material Weakness.
            2. A description of each finding classified as Significant Deficiency.
4. Does the organization have corrective actions in the past two years for the findings identified above (3(iii))? If yes, describe the status (closed or open) and progress made on those corrective actions.

Appendix IV. Accessibility Requirements

CMS and its Recipients are responsible for complying with federal laws regarding accessibility as noted in the Award Administration Information/Administration and National Policy Requirements Section.

The Recipient may receive a request from a beneficiary or member of the public for information in accessible formats. All successful applicants under this Notice of Funding Opportunity must comply with the following reporting and review activities regarding accessibility requests, in accordance with applicable law:

Accessibility Requirements:

1. Public Notification: If you have a public facing website, you must post a message at a conspicuous location on the website no later than **30** business days after award that notifies your customers of their right to receive an accessible format. appropriate auxiliary aids and services or language assistance services. Sample language may be found at: https://www.medicare.gov/about-us/nondiscrimination/nondiscrimination-notice.html. Your notice shall be crafted applicable to your program, but must state that your program provides appropriate auxiliary aids and services and language assistance services free of charge when necessary for compliance with § 1557 or its implementing regulation, to participants, beneficiaries, enrollees, and applicants of the program, and to members of the public. The notice must be in English and at least the 15 languages most commonly spoken by LEP individuals within the State and be provided in alternative formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication. Note that § 1557 and its implementing regulation also require that this notice be provided on an annual basis to certain parties; upon request; and in a prominent physical location in at least 20-point san serif font, placed where it is reasonable to expect individuals seeking services to read or hear it; and in certain other electronic and written communications.
2. Processing Requests Made by Individuals with Disabilities:
    a. Documents:
        i. When receiving a request for information in an alternate format (e.g., Braille, Large print, etc.) from a beneficiary or member of the public, you must:
            1. Consider/evaluate the request according to civil rights laws.
            2. Acknowledge receipt of the request and explain your process within **2** business days.
            3. Process in a timely manner as required to fulfill the request.
        ii. If the Recipient believes it is unable to fulfill an accessible format request, CMS may work with the Recipient to provide the

accessible format as funding and resources allow. Recipient shall refer the request to CMS within **3** business days if unable to provide the request. Recipient shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:

1. The e-mail title shall read "Recipient (Organization) Alternate Format Document Request."
2. The body of the e–mail shall include:
    a. Requester's name, phone number, e-mail, and mailing address.
    b. The type of accessible format requested, e.g., audio recording on compact disc (CD), written document in Braille, written document in large print, document in a format that is read by qualified readers, etc.
    c. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
    d. The document that needs to be put into an accessible format shall be attached to the e-mail. CMS may respond to the request and provide the information directly to the requester.

iii. The Recipient must maintain record of all alternate format requests received including the requestor's name, contact information, date of request, document requested, format requested, date of acknowledgment, date request provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

b. Services

i. When receiving request for auxiliary aids and services (e.g., sign language interpreter) from a beneficiary or member of the public, you must:

1. Consider/evaluate the request according to civil rights laws.
2. Acknowledge receipt of the request and explain your process within **2** business days.
3. Establish a mechanism to provide the request.

ii. If the Recipient believes it is unable to fulfill an accessible service request, CMS may work with the Recipient to provide the accessible service as funding and resources allow. Recipient shall refer the request to CMS within **3** business days if unable to provide the service. Recipient shall submit the request, using

encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:

1. The e-mail title shall read "Recipient (Organization) Accessible Service Request ."
2. The body of the e–mail shall include:
    a. Requester's name, phone number, e-mail, and mailing address.
    b. The type of service requested (e.g., sign language interpreter and the type of sign language needed).
    c. The date, time, address and duration of the needed service.
    d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview, etc.)
    e. Contact information for the person submitting the e-mail – Organization (Grantee), name, phone number and e-mail.
    f. Any applicable documents shall be attached to the e-mail. CMS will respond to the request and respond directly to the requester.

iii. You must maintain record of all accessible service requests received including the requestor's name, contact information, date of request, service requested, date of acknowledgment, date service provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

3. Processing Requests Made by Individuals with Limited English Proficiency (LEP):
    a. Documents:
        i. When receiving a request for information in a language other than English from a beneficiary or member of the public, you must:
            1. Consider/evaluate the request according to civil rights laws.
            2. Acknowledge receipt of the request and explain your process within **2** business days.
            3. Establish a mechanism to provide the request as applicable.
        ii. If the Recipient believes it is unable to fulfill an alternate language format request, CMS may work with the Recipient to provide the alternate language format as funding and resources allow. Recipient shall refer the request to CMS within **3** business days if unable to provide the request. Recipient shall submit the request, using encrypted e-mail (to safeguard any personally identifiable

information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:

1. The e-mail title shall read "Recipient (Organization) Alternate Language Document Request ."
2. The body of the e–mail shall include:
    a. Requester's name, phone number, e-mail, and mailing address.
    b. The language requested.
    c. Contact information for the person submitting the e-mail – Organization (Recipient), name, phone number and e-mail.
    d. The document that needs to be translated shall be attached to the e-mail.
    e. CMS may respond to the request and provide the information directly to the requester.

iii. The Recipient must maintain record of all alternate language requests received including the requestor's name, contact information, date of request, document requested, language requested, date of acknowledgment, date request provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

b. Services

i. When receiving request for an alternate language service (e.g., oral language interpreter) from a beneficiary or member of the public, you must:

1. Consider/evaluate the request according to civil rights laws.
2. Acknowledge receipt of the request and explain your process within **2** business days.
3. Establish a mechanism to provide the request as applicable.

ii. If the Recipient believes it is unable to fulfill an alternate language service request, CMS may work with the Recipient to provide the alternate language service as funding and resources allow. Recipient shall refer the request to CMS within **3** business days if unable to provide the service. Recipient shall submit the request, using encrypted e-mail (to safeguard any personally identifiable information), to the AltFormatRequest@cms.hhs.gov mailbox with the following information:

1. The e-mail title shall read "Recipient (Organization) Accessible Service Request ."
2. The body of the e–mail shall include:

a. Requester's name, phone number, e-mail, and mailing address.
b. The language requested.
c. The date, time, address and duration of the needed service.
d. A description of the venue for which the service is needed (e.g., public education seminar, one-on-one interview, etc.)
e. Contact information for the person submitting the e-mail – Organization (Recipient), name, phone number and e-mail.
f. Any applicable documents shall be attached to the e-mail.
g. CMS will respond to the request and respond directly to the requester.

iii. The Recipient must maintain record of all alternate language service requests received including the requestor's name, contact information, date of request, language requested, service requested, date of acknowledgment, date service provided, and date referred to CMS if applicable. Forward quarterly records to the AltFormatRequest@cms.hhs.gov mailbox.

Please contact the CMS Office of Equal Opportunity and Civil Rights for more information about accessibility reporting obligations at AltFormatRequest@cms.hhs.gov.

Appendix V. Merit Review and Selection Process

Applications will be screened to determine eligibility for merit review using the criteria detailed in Sections C. Eligibility Information, and D. Application and Submission Information (with cross-reference to Appendix II. Application and Submission Information), of this NOFO. Applications that are received late or fail to meet the eligibility requirements as detailed in this NOFO or do not include the required forms will not be reviewed. However, CMS and OAGM, at their sole discretion, may continue the review process for an ineligible application if it is in the best interest of the government to meet the objectives of the program.

Applications will be evaluated by a merit review committee. The merit review committee may include federal and/or non-federal reviewers. Merit Reviewers use the criteria described in Section E1. Criteria of the NOFO, to evaluate each application. Applicants shall pay strict attention to addressing all these criteria, as they are the basis upon which the reviewers will evaluate their applications.

The results of the merit review of the applications are key in decision making, but not the only factor. Final award decisions will be made by a CMS approving official. In making these decisions, the CMS approving official will take into consideration:

- Evaluation of the merit review panel;
- the readiness of the applicant to conduct the work required;
- the scope of overall projected impact on the aims;
- reviews for programmatic and grants management compliance;
- the reasonableness of the estimated cost to the government and anticipated results;
- the geographic diversity of all applications;
- The diversity of the project types; and
- the likelihood that the proposed project will result in the benefits expected.

As noted in 45 CFR Part 75, CMS will do a review of risks posed by applicants prior to award. In evaluating risks posed by applicants, CMS will consider the below factors as part of the risk assessment (applicant shall review the factors in their entirety at §75.205).

1. Financial stability;
2. Quality of management systems and ability to meet the management standards prescribed;
3. History of performance (including, for prior Recipients of Federal awards: timeliness of compliance with applicable reporting requirements, conformance to the terms and conditions of previous federal awards, extent to which previously awarded amounts will be expended prior to future awards);
4. Reports and findings from audits performed under Subpart F of 45 CFR Part 75; and
5. Applicant's ability to effectively implement statutory, regulatory, and other requirements imposed on non-federal entities.

CMS reserves the right to conduct pre-award negotiations with potential Recipients.

Appendix VI. Application Check-off List

Required Contents

A complete application consists of the materials organized in the sequence below. Please ensure that the project and budget narratives are page-numbered and the below forms are completed with an electronic signature and enclosed as part of the application. **Everything listed below must be submitted through** https://www.grants.gov/. **Placeholders are designated in the application kit available on Grants.gov. Documents without specific placeholders shall be uploaded under "Other Attachments Form."**

- ☐ SF-424: Application for Federal Assistance
- ☐ SF-424A: Budget Information for Non-construction Programs
- ☐ SF-LLL: Disclosure of Lobbying Activities
- ☐ Project/Performance Site Location Form(s)
- ☐ Applicant's Application Cover Letter (optional, **excluded from page limitations**)
- ☐ Project Abstract
- ☐ Project Narrative
  - Characteristics of the proposed model service area and model population
  - Organizational capacity of applicant organization
  - Model intervention
  - Medicaid Payment Approach
  - Behavioral health practice recruitment strategy
  - Health IT implementation plan
  - Sustainability Plan
  - Budget impact analysis
  - Identify additional priority health conditions for inclusion in the Model
- ☐ Business Assessment of Applicant Organization
- ☐ Budget Narrative
  - Detailed budget
  - Program duplication documentation
- ☐ Appendices
- ☐ Negotiated Indirect Cost Rate Agreement (NICRA) or Cost Allocation Plan (CAP), if applicable (excluded from page limitations)

CMS will not review or consider applications that do not meet the application due date. Technical and other issues can occur. We recommend that you submit your application at least three to five days before the due date.

Grants.gov can take up to 48 hours to notify you of a successful submission.

Appendix VII: Health IT Capabilities and Support for Practice Participants

Supporting interoperability among providers, as well as patient engagement, will be important components to the IBH Model's care delivery framework. Health information exchange allows providers to securely and efficiently transmit and exchange patient health information at the point of care, often in real time; thereby enabling better follow-up care through electronic transmission of data. This system integration increases coordination and quality of care while improving efficiency in health care delivery. All Practice Participants will be eligible to participate in the Model even if they have not yet connected to a HIE; however, they will be encouraged to connect to an HIE or other Health Information Network (HIN) as part of their model participation. Additionally, all Practice Participants are required to adopt and use health IT certified under the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program over the course of the Model period, unless exempted through the process specified below.

Health IT Requirements Table

This table describes the health IT requirements for IBH Model Recipients. Recipients will also have to comply with certain interoperability requirements under the terms of the IBH Model cooperative agreements and Participation Agreements. The proposed requirements below provide the minimum necessary health IT capabilities, and participants are encouraged to further evolve capabilities over the course of the Model.

Table VII: Health IT Requirements for IBH Model Recipients and Practice Participants[27]

Requirement	Notes
Certified Health IT Capabilities	
Capture demographic information such as race, ethnicity, preferred language, sexual orientation and gender identity.	See certification criterion for "Patient demographics and observations."[28]
At a minimum, support care coordination by sending and receiving summary of care records.	See certification criterion for "Transitions of care."[29]
Provide people receiving services with timely electronic access to view, download, or transmit their health information or to access their health information via an API using a personal health app of their choice.	See certification criteria for "View, download, and transmit to 3rd party"[30] and "Standardized API for patient and population services."[31]
Utilize decision support tools.	See certification criterion for "Decision support interventions."[32]
Conduct electronic prescribing, if applicable.	See certification criterion for "Electronic prescribing."[33]
Exchange information in accordance with a current version or versions of the United States Core Data for Interoperability (USCDI) adopted for use in the ONC Health IT Certification Program[34]	Incorporated as part of health information exchange criteria.
Requirement	**Notes**
Information Blocking	
Practice participants in the model must comply with applicable law, including but not limited to, the information blocking provisions of the 21st Century Cures Act.	Under the definition of information blocking,[35] a health care provider that conducts information blocking must know that a practice is unreasonable and is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information. For more information about information blocking, see: https://www.healthit.gov/topic/information-blocking
Health Information Exchange	
Participate in health data exchange (e.g., by connecting to an HIE or health information network) to facilitate exchange of electronic health information for care coordination, including participating in arrangements in	The term "HIE" broadly refers to arrangements that facilitate the exchange of health information and may include arrangements commonly denoted as exchange "frameworks," "networks," or using

[27] CMS reserves the right to update Health IT requirements in future MYs.
[28] 45 CFR 170.315(a)(5), see https://www.healthit.gov/test-method/demographics
[29] 45 CFR 170.315(b)(1), see https://www.healthit.gov/test-method/transitions-care
[30] See https://www.healthit.gov/test-method/view-download-and-transmit-3rd-party
[31] 45 CFR 170.315(g)(10), see https://www.healthit.gov/test-method/standardized-api-patient-and-population-services
[32] 45 CFR 170.315(b)(11), see https://www.healthit.gov/test-method/decision-support-interventions
[33] 45 CFR 170.315(b)(3), see https://www.healthit.gov/test-method/electronic-prescribing
[34] Currently adopted versions of the USCDI are specified at 45 CFR 170.213. For more information about USCDI, see https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi
[35] See Public Health Services Act section 3022(a)(1)(B)(ii).

order to receive electronic notifications for patient transitions of care.	other terms. HIEs shall be capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs and shall not engage in exclusionary behavior when determining exchange partners.
Health Related Social Needs	
Track HRSN screening information and link to social service agencies for referral and follow up.	Practice participants may, but are not required to, use IBH Model upfront funding to update existing EHRs to be able to update existing EHRs to be able to track HRSN screening information and link to social service agencies for referral and follow up.

Exceptions

State Medicaid Agencies may exempt potential Practice Participants from these certified health IT requirements on a case-by-case basis if the state determines that certified health IT is not applicable to the BH services provided by the participant.

For these Practice Participants, the State Medicaid Agency shall define alternative requirements for these Practice Participants to ensure they are effectively coordinating care with other providers and capture these requirements in the initial Health IT Implementation Plan and/or in subsequent quarterly/annual reports. The Innovation Center will provide technical assistance, guidance, and best practices on how to address the health IT needs of these Practice Participants. Note that any Infrastructure Funding used for health IT technology by these Practice Participants must continue to meet the requirements below for use of HHS-adopted standards where applicable.

Infrastructure Funding

Recipients are expected to use a portion of the cooperative agreement funding to make Infrastructure Funding payments to Medicaid-only Practice Participants who participate in the Model and meet the eligibility criteria. These funds may be used to invest in health IT infrastructure, EHRs, and telehealth tools, which are required as part of the IBH Model's care delivery requirements.

CMS has developed the minimum guidelines above for participation in the IBH Model, which will be supported through funding described under Section A4.4.3 Practice Participant Infrastructure Funding. Where used for health IT activities, funding must meet the interoperability requirements described in Section F5. Health Information Technology (IT) Interoperability Language.

Appendix VIII: State-Based Quality Measure Data Reporting Burden

This appendix provides information on the potential data burden for participating in the state-based quality measure program under the IBH Model. CMS has included this information to respond to state requests to understand quality measure data reporting burden in the Model application phase. The estimates are informed by the Medicaid Program and CHIP; Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting Final Rule.[36] The table includes a range of cost estimates (lower and upper bounds) and serves as a resource for state planning. Please note, this table solely represents burden estimates associated with quality reporting and does not account for burden associated with other state reporting requirements under the Model. **Table 1** exhibits the estimated annual state burden for reporting 13 quality measures for the IBH population.

Table 1: *State-based quality measures annual reporting burden:*

Quality Reporting Staff	Activity	Model Hours Estimate	Wage Rate	Cost Estimate (Lower Bound)	Cost Estimate (Higher Bound)
Computer Programmer	Data programming and synthesis	115	$98.84	$10,798.27	$11,934.93
Statistician	Data sampling	20	$101.46	$1,927.74	$2,130.66
General operations manager	Data analysis	76	$118.14	$8,529.71	$9,427.57
Data entry / Information Processing Worker	Data input and aggregation and disaggregation across intermediaries, where applicable	212	$37.94	$7,641.12	$8,445.44

[36] 88 FR 60278. Centers for Medicare and Medicaid Services. Available at https://www.federalregister.gov/documents/2023/08/31/2023-18669/medicaid-program-and-chip-mandatory-medicaid-and-childrens-health-insurance-program-chip-core-set

Chief executive	Verification, certification, and approval	6.5	$236.96	$1463.23	$1,617.25
State Hours for Quality		429.5		$30,360.06	$33,555.86
Total*		**1718**		**$121,440.25**	**$134,223.43**

*Initial estimates are multiplied by four. This assumption is based on quarterly, individual patient-level data submission for the IBH Model population.

Table 2 Exhibits potential estimated burden with vendor contract modifications for the IBH Model. These estimates are not applicable for Recipients that do not use a vendor. Please note, Recipients may want to consider additional annual vendor related fees that are not accounted for in burden calculations.

***Table 2**: Quality measure vendor associated data burden.*

Vendor Contract Modifications for IBH (One-time fee)	**Activity**	**Model Hours Estimate**	**Cost Estimate (Lower Bound)**	**Cost Estimate (Higher Bound)**
General operations manager	Contract Modifications	6	$673.40	$744.28
Chief executive	Approval	2	$450.22	$497.62
Total		**8**	**$1,123.62**	**$1,241.90**

Appendix IX: Model context data templates

Table 1: Total number (and percent) of beneficiaries with MSBH conditions

	2020			2021			2022		
Subgroup	**With mental illness**	**With a SUD**	**With co-occurring mental illness and a SUD**	**With mental illness**	**With a SUD**	**With co-occurring mental illness and a SUD**	**With mental illness**	**With a SUD**	**With co-occurring mental illness and a SUD**
Age									
18-21									
21-26									
27-45									
46-64									
65+									
Sex									
Female									
Male									
Race									
American Indian or Alaska Native									
Asian									
Black or African American									
Native Hawaiian or Pacific Islander									
White									
Disability Status									
Disability category									
Non-disability category									
Total									

Table 2: Total number (and percent) of beneficiaries with MSBH with co-occurring chronic conditions

	2020				2021				2022			
Sub-group	**With one or more physical health conditions**	**With diabetes**	**With hypertension**	**With tobacco use or nicotine use disorder**	**With one or more physical health conditions**	**With diabetes**	**With hypertension**	**With tobacco use/nicotine use disorder**	**With one or more physical health conditions**	**With diabetes**	**With hypertension**	**With tobacco use/nicotine use disorder**
Age												
18-21												
21-26												
27-45												
46-64												
65+												
Sex												
Female												
Male												
Race												
American Indian or Alaska Native												
Asian												
Black or African American												
Native Hawaiian or Pacific Islander												
White												
Total												

Table 3: Utilization among MSBH population.

Year	30-day all-cause readmissions	**Emergency department visits with a** *principal* diagnosis of mental illness or a SUD.	All-cause emergency department visits.
2020			
2021			
2022			

Appendix X: Medicaid Payment Scenarios for Health Homes and CCBHCs

Appendix X is relevant for Recipients who intend to adapt their Medicaid Health Homes or CCBHCs to implement the IBH Model. Scenario 1 exhibits components for potential Medicaid health home practices, while Scenarios 2 and 3 exhibits components for potential CCBHC demonstration and grant participants, respectively.

Scenario 1: Medicaid Health home practice participation scenario

Opportunity for alignment	Solutions
Payment and billing	
• Is there potential alignment of services between health homes and the IBH Model?	• Existing health homes may have alignment of services with the IBH Model-required services, depending on what is currently covered by each state. Recipients shall use the below options to align their health home model to the IBH Model care delivery framework and payment model.
• How must states adjust their health home payment model, if it doesn't cover one or multiple IBH Model required services?	• The Recipient shall adjust their Medicaid Payment Approach to include the required IBH Model services that are not currently covered by the health home. Recipients will have two options for covering these services: - The Recipient exhibits how their existing or new health home payment model reaches directional alignment to cover the IBH Model's care delivery framework services, including the IBH Model priority health conditions; **OR** - The Recipient develops a new Medicaid Payment Approach. • Please note that for both options, states are required to meet all requirements laid out in Section A4.4 IBH Payment Strategy. • In either scenario, the payment model must align with the requirements detailed in Section D2.4 Program Requirements and Expectations to be considered an IBH Model Medicaid Payment Approach.
• How must existing health homes participate in the IBH Model if they already cover the required services?	• Health homes can still participate in the IBH Model if they already cover the services in their existing payment arrangement. However, health homes would make necessary adjustments to their care delivery framework to ensure they are in alignment with the IBH Model's care delivery framework, and ensure they are in alignment with the service

	definitions for the health home provision (where these services are not currently being completed). If the Recipient needs to add a service that is not part of the health home authority to align with the IBH Model, this needs to be paid separately from the health home authority as non-health home services cannot be paid under the health home authority. Examples include: - Complete HRSN screening and referral - Complete screening and referral for PH conditions, including the IBH Model target PH conditions. - Include the use of closed loop referrals. - Include the use of interprofessional care teams
Infrastructure Funding for Practice Participants	
• Can health homes receive Infrastructure Funding?	• Health homes are eligible for Infrastructure Funding. However, the Recipient and health home are responsible for ensuring that federal dollars are not duplicated. For example, IBH Model funding to procure an EHR could not be used if a health home has already received federal dollars to procure an EHR. However, health homes could use the IBH Model funding for upgrades or additions to the EHR system that would bolster the care team's ability to conduct IBH Model services.
Quality measurement	
Are health homes required to report on all IBH Practice-based quality measures?	• Health home providers will be required to report on all measures in the IBH Practice-based measures set.
Do existing or new health homes continue reporting on the Medicaid health homes measures?	• If the Recipient decides to use the existing health home authority or a new health home authority to implement the IBH Model, they must continue to report or begin reporting on all required health homes measures in addition to the IBH Model measures.
Are Recipients required to incorporate a performance-based payment for their health homes?	• The Recipient is required to include a performance-based payment component for participating health homes that includes all measures outlined in *Table A.4.5.2 – Practice-based measures*.

Scenario 2: CCBHC demonstration provider participation scenario

Recipients shall consider one of the following scenarios when including one or many of their CCBHCs as Practice Participants in the IBH Model. Please note that the CCBHC Demonstration is jointly administered by CMS and SAMHSA. Clinics given the CCBHC designation are required

to provide nine essential services and in states that participate in the Medicaid demonstration receive Medicaid reimbursement for service provision using a prospective payment system (PPS). Any IBH Model Recipients that also participate in the CCBHC Demonstration or grant program would need to sign a maintenance of effort (MOE) agreement with CMS and SAMHSA outlining that the Recipient will continue to comply with all requirements and services as part of the CCBHC Demonstration or grant programs. The IBH Model will require this documentation in the Recipient specific terms and conditions.

Recipients who wish to include their CCBHC Demonstration providers as IBH Model Practice Participants shall consider the following scenarios:

1. Recipients and CCBHCs in the IBH Model participate and demonstrate that the existing CCBHC payment demonstration in their state meets IBH directional alignment as is. Under this scenario, a state needs to ensure that the current CCBHC payment arrangement achieves directional alignment for reimbursing the required IBH care delivery framework services in Medicaid.
2. Recipients and CCBHCs participate in the IBH Model and develop a new payment, outside of their PPS rate for any IBH services they are not currently performing as part of the CCBHC demonstration. IBH model services that are already incorporated into the existing PPS do not receive duplicate payment.
3. The Recipient develops clear parameters for services provided under the IBH Model and exhibits how they differ services provided under the CCBHC PPS rate, where applicable.

Opportunity for alignment	Solutions
Payment and billing	
• Is there potential alignment of services between CCBHC services and IBH Model services provided by CCBHC Demonstration providers?	• Existing CCBHC Demonstration providers could have alignment of services with the IBH Model required services, depending on what is currently covered by each state. • Recipients have the option to require CCBHC Demonstration providers add any IBH Model services that are not already required under each state's demonstration scope.
• How must Recipients adjust their CCBHC Demonstration payment model, if it doesn't cover one or more IBH Model required services?	• The Recipient shall develop an IBH Model Medicaid Payment Approach to include the required IBH Model services that are not currently covered in the CCBHC Demonstration PPS rate. The payment approach shall be on top of or outside of the CCBHC Demonstration PPS rate. Recipients will need to ensure (with support from CMS) non-duplication of payment when developing their payment methodology.

• Can the Recipient include their CCBHC Demonstration providers in the IBH Model if they already cover the IBH Model required services?	• Yes, the Recipient and their CCBHC Demonstration providers would make necessary adjustments to their care delivery framework to ensure they are in alignment with the IBH Model's care delivery framework (e.g., adding IBH Model services that are not currently available). Examples include: - Complete HRSN screening and referral - Complete screening and referral for PH conditions, including the IBH-Model priority health conditions. - Include the use of closed loop referrals.
Infrastructure Funding for Practice Participants	
• Can Recipients provide CCBHC Demonstration providers with Infrastructure Funding?	• CCBHC Demonstration providers may be eligible for Infrastructure Funding at the Recipient's discretion. However, the Recipient and CCBHC Demonstration providers are responsible for ensuring that federal dollars are not duplicated. • For example, IBH Model funding to procure an EHR could not be used if a CCBHC Demonstration provider has already received federal dollars to procure an EHR. • However, CCBHC Demonstration providers could use the IBH Model funding for upgrades or additions to the EHR system that would bolster the care team's ability to conduct IBH Model services.
Quality measurement	
• Are CCBHC demonstration providers required to report on all IBH Practice-based quality measures?	• CCBHC Demonstration providers are required to report on all measures in the IBH Model Practice-based measures set. The IBH Model measure sets were intentionally designed to align with the CCBHC measures. • CCBHC Demonstration providers and their states must continue to report on all required and optional measures they have committed to as part of the CCBHC Demonstration.
• Can CCBHC Demonstration providers earn additional incentive payments for the IBH Model performance-based payments?	• Some Recipients and CCBHC Demonstration providers may already participate in the Quality Bonus Payment for required and optional CCBHC Demonstration measures. The Quality Bonus Payment component under the CCBHC Demonstration meets the directional alignment criteria for performance-based payments in the IBH Model.

	• Such Recipients will not receive additional performance-based payments (or quality improvement program payments) under the IBH Model if such payments would constitute a duplication of payment. • If the CCBHC is not currently participating in the Quality Bonus Payment component of the Demonstration, then the Recipient must develop an aligned performance-based payment component or participate in the Quality Bonus Payments. • CCBHCs must earn IBH Model Medicaid performance-based payments for measures that are unique to the IBH Model.
• Can CCBHC Demonstration providers earn performance-based payments for Medicare beneficiaries.	• CCBHC Demonstration providers can earn Medicare performance-based payments for all Practice-based IBH Model Measures for Medicare beneficiaries. CCBHC Demonstration providers that serve Medicare beneficiaries must participate in the Medicare Payment Approach via an executed participation agreement with CMS to be eligible for such payments.

Scenario 3: CCBHC Improvement and Advancement (CCBHC-IA) and CCBHC Community Behavioral Health Clinic Planning, Development, and Implementation Grant (CCBHC PDI) participation scenario

Opportunity for alignment	Solutions
Payment and billing	
• Is there potential alignment of services between CCBHC grant providers and the IBH Model?	• Existing and new CCBHCs grant providers could have alignment of services with the IBH Model required services, depending on what is currently covered by each state.
• How must Recipients adjust their CCBHC payment, if it doesn't cover one or multiple IBH Model required services?	• The Recipient shall develop an IBH Model Medicaid Payment Approach to include the required IBH Model services that are not currently covered by the CCBHC grant provider. • CCBHC grant providers will be required to deliver any new services that are part of the IBH Model's care delivery framework and covered by any such IBH Model Medicaid Payment Approach.
• Can CCBHC grant providers still participate in the IBH Model if they already cover the IBH Model required services?	• Yes, the Recipient would aid the grant provider in making necessary adjustments to their care delivery framework to ensure they are in alignment with the IBH Model's care delivery framework (where these services are not currently available).

	Examples include: - Complete HRSN screening and referral. - Complete screening and referral for PH conditions, including the IBH Model priority health conditions. - Include the use of closed loop referrals.
Infrastructure Funding for Practice Participants	
• Can CCBHC grant providers receive Infrastructure Funding?	• CCBHC grant providers are eligible for Infrastructure Funding. However, the Recipient and CCBHC are responsible for ensuring that federal dollars are not duplicated. • For example, IBH Model funding to procure an EHR could not be used if a CCBHC has already received federal dollars to procure an EHR. • However, CCBHC grant providers could use the IBH Model funding for upgrades or additions to the EHR system that would bolster the care team's ability to conduct IBH Model services.
Quality measurement	
• Are CCBHCs grant providers required to report on all IBH Practice-based quality measures?	• CCBHC grant providers will be required to report on all measures in the IBH Model Practice-based measures set.
• Are Recipients required to incorporate a performance-based payment for their CCBHC grant providers?	• The Recipient is required to include a performance-based payment component for participating CCBHC grant providers that includes all measures outlined in *Table A4.5.2 – Practice-based measures*.
• Can CCBHC grant providers earn performance-based payments for Medicare beneficiaries.	• CCBHC grant providers can earn performance-based payments for all Practice-based IBH Model measures for Medicare beneficiaries. • CCBHC grant providers that serve Medicare beneficiaries must participate in the Medicare Payment Approach via an executed participation agreement with CMS to be eligible for such payments.

Appendix XI: Medicare Payment Approach Details

This appendix includes an overview of the Medicare Payment approach for informational purposes; however, the methodology as described below is subject to change at CMS' sole discretion. This methodology will be detailed further by CMS prior to the start of the MY 1.

The IBH Medicare Payment Approach includes three core elements:

1. Infrastructure Funding
2. Integration Support Payment (ISP)
3. Pay-for-reporting and pay-for-performance bonuses

Infrastructure Funding

Infrastructure Funding is critical to building Practice Participants' capacity to develop and maintain the infrastructure necessary to deliver care thru the IBH Model's care delivery framework and to participate in VBP activities. Health IT is critical to promoting integration, enabling specialty BH providers to communicate with other providers on the care team and allowing for the exchange of information in real-time. The Medicare Infrastructure Funding is designed to address the resource gap between specialty BH and other providers, and for those who already have certified EHRs, it may provide funding to improve population management, data sharing, and interoperability features.

CMS will provide Infrastructure Funding to eligible Practice Participants who are enrolled in Medicare and agree to participate in the Medicare Payment Approach. These payments will be made in increments and amounts to be determined by CMS during MY 2 through MY 5. Infrastructure Funding for Medicare Practice Participants may be used for activities, including health IT capacity building, such as adopting EHRs and other HIT, and establishing connections with operating state HIEs. Additionally, funds could be used to enhance capacity through hiring and training practice staff in new IT and clinical workflows.

Examples of activities supported by Infrastructure Funding include, but are not limited to:

- Health IT infrastructure, such as obtaining, modifying, or maintaining EHRs
- Patient engagement IT solutions (e.g., portal adoption)
- HIE integration or efforts to advance interoperability of telehealth systems
- Health-IT enabled tools and supports to ensure referrals to address HRSNs are possible (closed loop referrals through interprofessional care teams)
- Population management tools
- Health IT enabling connections with other providers to enhance Practice Participants' ability to refer beneficiaries to PH Providers and/or social needs providers
- Additional staffing to support new clinical and IT workflows and change management

- Practice transformation activities including but not limited to, workflow development, staffing development and retention plans, systemic quality improvement, and strategies for outreach to beneficiaries and caregivers.

Integration Support Payment (ISP)

The IBH Model will support the package of services and activities under the care delivery framework through the development of the Integration Support Payment (ISP) that will be paid to Medicare Practice Participants via a prospective PBPM payment, beginning at the start of MY 4. The ISP will cover the cost of managing the care for patients attributed under the IBH Model.

The ISP will be calculated based on the values of the pre-existing CoCM model and billing codes (such as CPT codes 99492, 99493, 99494, and HCPCS code G2214), with adjustments made based on the IBH Model's care delivery framework's three core elements of care integration, care management, and health equity.

CMS has calculated the PBPM rate for the ISP based on the CPT and HCPCS codes, and respective payment amounts, that comprise the CoCM Model (such as CPT codes 99492, 99493, 99494, and HCPCS codes G0323 and G2214). The value of the ISP will be calculated using a variation on the CoCM Model codes that has been adjusted for time anticipated for implementing the care delivery framework, and adjusted based on the specific provider types who CMS anticipates delivering the IBH Model's care delivery framework services. That value will be further adjusted to account for geographic variation.

This NOFO includes an overview of the ISP financial methodology for informational purposes; however, the methodology as described below is subject to change at CMS' sole discretion. Detailed financial specifications will be provided by CMS during the IBH Model's Pre-Implementation period.

Alignment or Overlaps with Existing Codes
The Model's Medicare Payment Approach is specifically designed to avoid conflict with or duplicate payment of the FFS system. As a condition of entering the Model, Practice Participants must agree not to bill separately for the billing codes outlined in Table 1, below:

Table 1: IBH Model Prohibited Billing Codes

Category	HCPCS Code	Year Added to MPFS	Description	Justification
Chronic Care Management (CCM)	99490	2015	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: • multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; • chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; • comprehensive care plan established, implemented, revised, or monitored.	The CCM codes duplicate payment included in the IBH Integration Support Payment, including: • Care management • Care integration
CCM	99439	2021	Add-on code for 99490; additional 20 minutes per month	
CCM	99491	2019	Chronic care management services, provided personally by a physician or other qualified healthcare professional, at least 30 minutes of physician or other qualified healthcare professional time, per calendar month, with the following required elements: • multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; • chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; • comprehensive care plan established, implemented, revised, or monitored.	
CCM	99437	2022	Add-on code for 99491, additional 30 minutes per month	

Category	HCPCS Code	Year Added to MPFS	Description	Justification
Complex CCM	99487	2017	Complex chronic care management services, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, • Chronic conditions place the patient at significant risk of death, acute exacerbation / decompensation, or function decline, • Establishment of substantial revision of a comprehensive care plan, • Moderate or high complexity medical decision making, • 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	
Complex CCM	99489	2017	• Add-on code for 99487, additional 30 minutes per month	
Principal Care Management (PCM)	99424	2022	PCM services performed by a physician or QHP, initial 30 minutes per month, with the following required elements: • One complex chronic condition expected to last at least 3 months, • Chronic condition places the patient at significant risk of death, hospitalization, acute exacerbation / decompensation, or function decline, • Chronic condition requires frequent adjustments in the medication regimen and/or management that's unusually complex due to comorbidities, • Ongoing communication and care coordination between relevant practitioners furnishing care, which can be carried out via telehealth or virtual/remote devices,	The PCM codes duplicate payment included in the IBH Integration Support Payment, including: • IBH Model welcome visit – Initial screening, assessment, and treatment for BH and PH conditions. • Care management • Ongoing care management

Category	HCPCS Code	Year Added to MPFS	Description	Justification
			• Creation of a disease-specific care plan.	
PCM	99425	2022	• Add-on code for 99424, additional 30 minutes per month	
PCM	99426	2022	• Same as 99424 above, performed by clinical staff under the direction and guidance of a physician or QHP	
PCM	99427	2022	• Add-on code for 99426, additional 30 minutes per month	
Psychiatric collaborative care management services	99492		• A provider performs psychiatric collaborative care management (CoCM) for a patient receiving BH treatment and regular psychiatric inter-specialty consultation in collaboration and in conjunction with a patient's treating (or billing) primary care provider. Report 99492 for the initial 70 minutes of CoCM in the first calendar month.	Ongoing Psychiatric CoCM codes overlap with the IBH services covered by the ISP: • **IBH welcome visit** – Initial screening, assessment, and treatment for BH and PH conditions. • Care management
	99493		• A provider performs psychiatric collaborative care management (CoCM) for a patient receiving BH treatment and regular psychiatric inter-specialty consultation in collaboration and in conjunction with a patient's treating (or billing) primary care provider. Report 99493 for the first 60 minutes of CoCM in a	Psychiatric CoCM codes overlap with the IBH services covered by the ISP: • IBH ongoing screening assessment, treatment for BH and BH conditions.

Category	HCPCS Code	Year Added to MPFS	Description	Justification
			subsequent month after the first month of care.	
	99494		• A provider performs psychiatric collaborative care management (CoCM) for a patient receiving BH treatment and regular psychiatric inter-specialty consultation whose conditions are not improving in collaboration and in conjunction with a patient's treating (or billing) primary care provider. Report this code in addition to 99492 or 99493 for each additional 30 minutes of initial or subsequent psychiatric care management in a calendar month, in addition to the primary codes.	Psychiatric CoCM codes overlap with the IBH services covered by the ISP. • Care management
	G2214		• Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of BH care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified healthcare professional. Must contain the elements of 99492.	Psychiatric CoCM Model codes overlap with the IBH Model services covered by the ISP: • Ongoing care management.
	G0512		• Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of BH care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified healthcare professional. Must contain the elements of 99492.	
Behavioral Health Integration /Care management services for BH conditions	99484		• Clinical staff members spend at least 20 minutes each month coordinating and managing a patient's BH services under the direction of a physician or other qualified health care professional.	Duplicates services provided under the IBH ISP, including: • Ongoing screening, assessment, and treatment for BH and PH conditions. • Care management
	G0323	2023	• Describes general BHI that a clinical psychologist (CP) or clinical social worker (CSW) performs to account for monthly care integration	

Category	HCPCS Code	Year Added to MPFS	Description	Justification
			• A CP or CSW, serving as the focal point of care integration furnishes the mental health services • At least 20 minutes of CP or CSW time per calendar month	
	G0511		• HCPCS code G0511 for Rural health clinic for FQHC or RHC only, general care management, 20 minutes or more of clinical staff time for chronic care management services or BH integration services directed by an RHC or an FQHC practitioner (Physician, NP, PA, CNM), per calendar month as maintained by CMS.	
Community Health Integration Services	G0019	2024	• Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner, 60 minutes per calendar month, in the flowing activities to address social determinants of health that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit	Community health integration services duplicated services provided by the IBH ISP, including: • Social determinants of health (SDOH) services.
	G0022	2024		

Risk Adjustment Methodology

We anticipate that both clinical and social risk adjustment will be applied to the Medicare ISP. For clinical risk adjustment, CMS expects to use the prospective CMS-Hierarchical Condition Category (HCC) version 28 (V28) as it is expected to better-reflect the clinical risk of the priority population. By CY2026, CMS expects 100% of risk scores to be calculated with V28, aligning with the beginning of IBH's Medicare ISP. For social risk adjustment we expect to use an approach similar to that of the Accountable Care Organization Realizing Equity, Access, and Community Health Model (ACO REACH), by applying the Health Equity Benchmark Adjustment (HEBA), an adjustment permits increases or decreases to Practice Participants' financial benchmarks based on the characteristics of beneficiaries served. CMS may change the risk adjustment strategies discussed in this document based on further information and research.

Reporting and Outcome Based Payments

The Medicare payment structure will include a performance-based payment (PBP) paid annually for performance measured in MY4 - MY8. The PBP is upside-only and is designed to encourage

and reward behaviors such as data reporting, the advancement of care quality and accountability across multiple dimensions including care integration, care coordination, care efficiency, and patient centered-outcomes as demonstrated through performance on selected model quality measures. The PBP is designed to put specialty BH providers on the path to payment approaches with increased risk and accountability. During MY2 – MY5, Practice Participants will use Infrastructure Funding to establish the tools and capacity that are critical to supporting the data management and reporting necessary for measuring performance towards IBH Model goals.

The PBP will have two components:

1) Incentives for achieving reporting attainment thresholds (*pay for reporting*) (MY 4 – 5); and
2) Incentives for improvements in health outcomes and screenings *(pay for performance)* (MY 5 (to be determined on 1 – 2 specific measure(s)), and MY6 – 8 for all measures).

For the pay-for-reporting years of the PBP (MY4-MY5), Practice Participants must report data at the minimum reporting threshold for their beneficiary population to receive at least a partial PBP. For the pay-for-performance years (MY5-MY8), CMS will develop performance benchmarks using the prior MY data (e.g., benchmarks for MY 6 will be developed using data from MY 5). MY 5 will incorporate a small number of measures as to be determined as pay-for-performance, and MY6 will transition to using the full provider measure slate in pay-for-performance. The performance benchmarks will be calculated using data only from Practice Participants and will not include national or state averages outside of the states and providers participating in the Model. During the Implementation Period, CMS will use data to determine if it is most appropriate to calculate benchmarks at the Practice Participant, Recipient, or model-wide level.

As the PBP strategy shifts from pay-for-reporting to P4P pay-for-performance, the total amount of PBP available will increase as a percentage of the ISP, giving Practice Participants additional incentives to achieve quality outcomes and begin to move towards more sophisticated VBP arrangements. The PBP amount will be set at three percent of the ISP during MY 4, will scale up to four percent of the ISP during MY 5, and scale up a final time to five percent from MYs 6 – 8. Table 2 exhibits that each pay-for-reporting measure will be worth 20 percent of the total available PBP, giving Practice Participants the opportunity to earn a partial or full PBP. However, CMS is still exploring differential weighting of screening, process, and outcomes measures in the pay-for-performance period. For example, if the total PBP in MY 4 is worth three percent of the ISP, a Practice Participant that meets the attainment thresholds on three of the five measures would earn 60 percent of the available PBP funds, or 1.8 percent of the ISP (0.60 x 0.03=0.018).

Table 2: Practice participant performance-based payment structure

Measures	**Performance Benchmark (% of total PBP)**	**% of ISP available for PBP**
Pay-for-reporting: MY 4 - Practice participants can receive additional incentive payments for reporting on the specified attainment threshold.		

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	20%	3%
Emergency Department Utilization	20%	
Controlling high blood pressure	20%	
Screening for Social Drivers of Health	20%	
PROM	20%	
Pay-for-reporting and performance: MY 5 – Practice Participants can receive additional incentive payments for reporting on the specified attainment thresholds for pay-for-reporting attainment thresholds and for improvements in performance for quality measures. One measure during this period will be a pay-for-performance measure and will be specified at a later date.		
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	20%	4%
Emergency Department Utilization	20%	
Controlling high blood pressure	20%	
Screening for Social Drivers of Health	20%	
*PROM**	20%	
Pay-for-performance: Practice participants can receive additional incentives for improvements in performance on the below quality measures from MY 6 through 8.		
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	TBD%	5%
Emergency Department Utilization	TBD%	
Controlling high blood pressure	TBD%	
Screening for Social Drivers of Health	TBD%	
PROM[37]	TBD%	

[37] The PROM will continue to be a pay-for-reporting measure throughout the model lifecycle as PROMs are not suited for changes in performance.

Appendix XII: CMS Attribution Methodology for Medicare and Dually Eligible Beneficiaries

A primary goal of CMS' Medicare attribution methodology is to identify the beneficiaries who are affiliated with Medicare Practice Participants. Medicare beneficiaries with and without any dual eligibility[38] who receive qualifying services[39] from a Medicare Practice Participant will be eligible for Medicare attribution if they reside within a participating state where that Medicare Practice Participant is providing services. Practice Participants must be able to support and document the medical necessity of providing IBH Model services to the attributed beneficiary in order to bill Medicare under the IBH Model. The IBH Model will use a quarterly, prospective attribution of Medicare beneficiaries based on claims data from the previous six months and will also include an annual reconciliation component to allow Medicare Practice Participants to enroll new Medicare and dually eligible patients into the model in real-time as needed.[40]

To be eligible for attribution to a Medicare Practice Participant, beneficiaries must:

- Have Medicare Parts A and B;
- Have Medicare as the primary payer;
- Receive qualifying services from a Medicare Practice Participant;
- Reside in a region of the state where the IBH Model is being implemented;
- Not be attributed to another CMS Innovation Center model that provides comprehensive care coordination;[41]
- Not have end-stage renal disease (ESRD) or be enrolled in hospice at the time of initial attribution;
- Not be covered under Medicare Advantage or other Medicare health plan;
- Not be institutionalized;
- Not fall within statutory Medicare payment exclusion criteria; and
- Otherwise meet Medicare eligibility criteria, including requirements related to incarceration.

Eligible Medicare or dually eligible beneficiaries will be prospectively attributed to an IBH Model Medicare Practice Participant through one of three mechanisms.

First mechanism, the Model will permit voluntary alignment, as it may be a suitable approach for the Practice Participant and beneficiary population to be attributed based on their chosen alignment

[38] As the IBH Model's services are reimbursed under Medicare Part B, Medicare will cover IBH Model services for beneficiaries enrolled in both the Medicare and Medicaid programs. This follows the guiding principle that Medicare pays dually eligible beneficiaries' medical (and by extension, IBH Model's Part B) services first because Medicare is the primary payer for the items and services that both programs cover (42 U.S. Code § 1315b(f)).

[39] A qualifying service is a Medicare-covered behavioral health service, typically referred to as mental health and substance use services (as defined in https://www.cms.gov/files/document/mln1986542-medicare-mental-health.pdf).

[40] There will be a one- to two-month gap between the end of the six-month look-back period and the start of the quarter, to pull Medicare claims, conduct prospective attribution and send the attribution list to Medicare Practice Participants.

[41] See https://www.cms.gov/files/document/ibh-model-overlaps-fs.pdf for detail on the IBH Model's overlaps policy.

to a BH provider or Practice Participant. Under voluntary alignment, a beneficiary could choose a specific IBH Model Practice Participant on a quarterly basis, using Medicare.gov or paper format.

Second mechanism, claims-based attribution will be used for a Medicare or dually eligible beneficiary who has not voluntarily aligned to a Practice Participant. Under this mechanism, beneficiaries will be attributed to the Medicare Practice Participant who billed for the most outpatient mental health visits (including such visits using telehealth) or SUD services in the prior six months, based on claims data. In the case of multiple billing providers during the prior six months, the IBH Model will attribute the beneficiary according to a plurality of visits (i.e., the provider visited the most over that time period). If a beneficiary visited two or more providers an equal number of times over the past six months, the most recent visit would be used as the tiebreaker for Medicare attribution purposes. [42]

Whether attributed using voluntary alignment or claims-based mechanisms, CMS will conduct the beneficiary attribution algorithm and send each Medicare Practice Participant a list of its attributed Medicare and/or dually eligible patients on a quarterly basis during the Model's Implementation Period (MYs 4 – 8). CMS will also assess beneficiary provider selections quarterly in Medicare.gov and align these selections with the claims-based file. Note that attributed beneficiaries who transition in and out of higher levels of care (e.g., inpatient, partial hospitalization, etc.) and receive outpatient BH services between those stays remain attributed to the IBH Model unless they have a break of six months without receiving IBH Model services.

The third mechanism for attribution into the IBH Model will allow a Medicare Practice Participant to enroll new beneficiaries into the Model in real-time. Retrospective attribution will be used to determine how many beneficiaries met the attribution criteria during the prior quarter, regardless of whether they were on the preliminary attribution list. Annual reconciliation will be conducted for payment purposes (to reflect differences in the number of beneficiaries attributed prospectively and retrospectively), and for performance-based payments (based only on the beneficiaries who were retrospectively attributed).

CMS, its contractor(s), or both will develop a model implementation policy and guidance for Practice Participants regarding IBH Model covered services, patient eligibility requirements and documentation requirements. Model policy will state that for each beneficiary during a calendar month, only one BH provider can furnish IBH Model services and receive payment. Further, beneficiaries aligned with the Psychiatric Collaborative Care Model (CoCM) during a calendar month may not also receive IBH Model services, given that CoCM services overlap with IBH Model services.[43]

[42] Further, if a patient sees both providers on the same day, a second tiebreaker is conducted by randomly selecting the record of one of those two visits. For a beneficiary who visits two different providers the same number of times in six months, if one provider participates in the IBH Model and the other does not, the tie breaker still stands.

[43] Overlapping CoCM HCPCS codes include 99492, 99493, 99494, G2214 and G0512 and are included under Table 1: IBH Prohibited Billing Codes in Appendix XI: Medicare Payment Approach Details.

The model implementation guidance will also explain that as part of the initial beneficiary assessment, Medicare Practice Participants will discuss a beneficiary's preferences and care integration needs to determine whether IBH Model services are reasonable and medically necessary. Section 1862(a) (1) (A) of the Social Security Act (the Act) directs the following: "No payment may be made under Part A or Part B for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." An item or service is "reasonable and necessary" under §1862(a) (1) (A) of the Act if the service is:

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency in terms of whether the service or item is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve the function of a malformed body member;
    - Furnished in a setting appropriate to the beneficiary's medical needs and condition;
    - Ordered and furnished by qualified personnel; and
    - One that meets, but does not exceed, the beneficiary's medical need.

For any service reported to Medicare, it is expected that the medical documentation clearly demonstrates that the service meets all of the above criteria. All documentation must be maintained in the patient's medical record and be available to CMS or the contractor upon request.

This assessment will be conducted by a physician or other billing practitioner, exercising prudent clinical judgment. If services are not reasonable and medically necessary (i.e., the level of care required by the IBH Model's care delivery framework is not needed), the beneficiary would not be enrolled in the IBH Model. Consistent with current Medicare payment policy, Practice Participants will continue to assess at each encounter whether IBH Model services are reasonable and necessary for an IBH Model enrolled beneficiary. Practice Participants shall not provide IBH Model services for a beneficiary when those services are no longer reasonable and medically necessary. CMS will monitor and audit Medicare Practice Participants using standard program integrity best practices and will recoup payment for IBH Model services that are not reasonable and medically necessary for the beneficiary, as supported by clinical documentation. (See Section F6.1 Monitoring for more detail.)

Regardless of the attribution mechanism employed, Medicare Practice Participants will inform their patients in writing about their IBH Model participation. Recognizing the sensitive nature of this information and consistent with other Innovation Center models, patients may opt-out of data sharing. When Medicare beneficiaries are attributed to an IBH Model Practice Participant, they will continue to have freedom of choice; IBH Model attribution will not preclude them from seeing other providers (i.e., besides the provider to whom they are attributed). However, when a beneficiary is served by a non-participating practice, that non-participating practice would receive a claim denial for billing any IBH Model's care delivery framework services. Further, the IBH Model will not restrict or change Medicare fee-for-service benefits, though some of the services

currently paid through FFS will be incorporated into the per-beneficiary-per-month (PBPM) payment and will not be paid on a FFS basis to Practice Participants. The IBH Model team will not incorporate any cost sharing or co-payment as part of the model design, as it could obstruct model participation, especially for low-income beneficiaries.[44]

[44] As cost sharing requirements could potentially block the participation of low-income beneficiaries, the Model team is researching the possibility of including a Medicare cost sharing waiver in the model, and any levers to encourage participating states to waive cost sharing requirements on the Medicaid side.

Appendix XIII: Glossary of Acronyms

ADT	Admission, Discharge, Transfer
AHC	Accountable Health Communities
AOR	Authorized Organizational Representative
APMs	Alternative Payment Models
APR	Annual Progress Report
BCS-AD	Breast Cancer Screening
BH	Behavioral Health
CAH	Critical Access Hospital
CBE	CMS-contracted Consensus-Based Entity
CBO	Community-based Organization
CCBHC	Certified Community Behavioral Health Clinic
CEHRT	Certified Health Information Technology
CFDA	Catalog of Federal Domestic Assistance
CHIP	Children's Health Insurance Program
CMCS	Center for Medicaid and CHIP Services
CMHCs	Community Mental Health Centers
CMIT	CMS Measure Inventory Tool
CMS	Centers for Medicare & Medicaid Services
CoCM	Collaborative Care Model
COL-AD	Colorectal Cancer Screening
CPI	Center for Program Integrity
DHHS	Department of Health and Human Services
DOJ	Department of Justice
ED	Emergency Department
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
E/M	Evaluation and Management
ESRD	End-stage Renal Disease
F&A	Facilities & Administration
FAPIIS	Federal Awardee Performance Integrity Information System
FFA	Federal Financial Assistance
FFATA	Federal Funding Accountability and Transparency Act
FFP	Federal Financial Participation
FFR	Federal Financial Report
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
FSRS	FFATA Subaward Reporting System
FTR	Federal Travel Regulation
FUA-AD	Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older
FUM-AD	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older
GPS	Grants Policy Statement

HBD-AD	Hemoglobin A1c Control for Patients with Diabetes
HEP	Health Equity Plan
HHS	Health and Human Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HRSA	Health Resources and Services Administration
HRSNs	Health-Related Social Needs
IBH	Innovation in Behavioral Health Model
IRBs	Institutional Review Boards
ISP	Innovation Support Platform
IT	Information Technology
LAN	Health Care Payment Learning & Action Network
LOI	Letter of Intent
MCO	Managed Care Organization
MH	Mental Health
MOE	Maintenance of Effort
MOUMOU	Memorandum of Understanding
MSBH	Moderate to Severe BH
MTDC	Modified Total Direct Costs
MUC	Measures under Consideration
MY	Model Year
NCC	Non-competing Continuation
NCQA	National Committee for Quality Assurance
NICRA	Negotiated Indirect Cost Rate Agreement
NoA	Notice of Award
NOFO	Notice of Funding Opportunity
NPI	National Provider Identifier
OCR	Office for Civil Rights
OIG	Office of the Inspector General
ONC	Office of the National Coordinator for Health Information Technology
OP	Outpatient
OTP	Opioid Treatment Program
PAHP	Prepaid Ambulatory Health Plan
PBP	Performance-based Payments
PBPM	Per Beneficiary per Month
PCR-AD	Plan All-Cause Readmissions
PECOS	Provider Enrollment, Chain, and Ownership System
PH	Physical Health
PIHP	Prepaid inpatient health plan
PIPBHC	Promoting Integration of Primary and Behavioral Health Care
PMS	Payment Management System
PO	Project Officer

PPS	Prospective Payment System
PRAC	Pandemic Response Accountability Committee
PROMS	Patient Reported Outcome Measures
QPRs	Quarterly Progress Reports
RHC	Rural Health Clinic
SAM	System for Award Management
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SEC	Securities and Exchange Commission
SMA	State Medicaid Agencies
SMI	Serious Mental Illness
SSD-AD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications
SUD	Substance Use Disorder
TIN	Tax Identification Number
T-MSIS	Transformed Medicaid Statistical Information System
UEI	Unique Entity Identifier
VBP	Value-based Payment
USCDI	United States Core Data for Interoperability

Appendix XIV: Moderate to Severe Behavioral Health Conditions[45]

ICD 10 CODE	ICD-10 DIAGNOSIS
F10.10	Alcohol abuse, uncomplicated
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.121	Alcohol abuse with intoxication delirium
F10.129	Alcohol abuse with intoxication, unspecified
F10.14	Alcohol abuse with alcohol-induced mood disorder
F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
F10.151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
F10.159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10.1.80	Alcohol abuse with alcohol-induced anxiety disorder
F10.181	Alcohol abuse with alcohol-induced sexual dysfunction
F10.182	Alcohol abuse with alcohol-induced sleep disorder
F10.188	Alcohol abuse with other alcohol-induced disorder
F10.19	Alcohol abuse with unspecified alcohol-induced disorder
F10.20	Alcohol dependence, uncomplicated
F10.220	Alcohol dependence with intoxication, uncomplicated
F10.221	Alcohol dependence with intoxication delirium
F10.229	Alcohol dependence with intoxication, unspecified
F10.230	Alcohol dependence with withdrawal, uncomplicated
F10.231	Alcohol dependence with withdrawal delirium
F10.232	Alcohol dependence with withdrawal with perceptual disturbance
F10.239	Alcohol dependence with withdrawal, unspecified
F10.24	Alcohol dependence with alcohol-induced mood disorder
F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions
F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.26	Alcohol dependence with alcohol-induced persisting amnestic disorder
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.280	Alcohol dependence with alcohol-induced anxiety disorder
F10.281	Alcohol dependence with alcohol-induced sexual dysfunction
F10.282	Alcohol dependence with alcohol-induced sleep disorder
F10.288	Alcohol dependence with other alcohol-induced disorder
F10.29	Alcohol dependence with unspecified alcohol-induced disorder
F10.920	Alcohol use, unspecified with intoxication, uncomplicated

[45] The diagnoses listed in this Appendix are suggested for practice identification. However, they are not definitive, and not everyone with these diagnoses by default has moderate to severe BH conditions. These diagnoses shall not be used as doctrine, nor shall they use it for different purposes.

F10.921	Alcohol use, unspecified with intoxication delirium
F10.929	Alcohol use, unspecified with intoxication, unspecified
F10.94	Alcohol use, unspecified with alcohol-induced mood disorder
F10.950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions
F10.951	Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations
F10.959	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
F10.96	Alcohol use, unspecified with alcohol-induced persisting amnestic disorder
F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia
F10.980	Alcohol use, unspecified with alcohol-induced anxiety disorder
F10.981	Alcohol use, unspecified with alcohol-induced sexual dysfunction
F10.982	Alcohol use, unspecified with alcohol-induced sleep disorder
F10.988	Alcohol use, unspecified with other alcohol-induced disorder
F10.99	Alcohol use, unspecified with unspecified alcohol-induced disorder
F11.10	Opioid abuse, uncomplicated
F11.11	Opioid abuse, in remission
F11.120	Opioid abuse with intoxication, uncomplicated
F11.121	Opioid abuse with intoxication delirium
F11.122	Opioid abuse with intoxication with perceptual disturbance
F11.129	Opioid abuse with intoxication, unspecified
F11.14	Opioid abuse with opioid-induced mood disorder
F11.150	Opioid abuse with opioid-induced psychotic disorder with delusions
F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
F11.159	Opioid abuse with opioid-induced psychotic disorder, unspecified
F11.181	Opioid abuse with opioid-induced sexual dysfunction
F11.182	Opioid abuse with opioid-induced sleep disorder
F11.188	Opioid abuse with other opioid-induced disorder
F11.19	Opioid abuse with unspecified opioid-induced disorder
F11.20	Opioid dependence, uncomplicated
F11.21	Opioid dependence, in remission
F11.220	Opioid dependence with intoxication, uncomplicated
F11.221	Opioid dependence with intoxication delirium
F11.222	Opioid dependence with intoxication with perceptual disturbance
F11.229	Opioid dependence with intoxication, unspecified
F11.23	Opioid dependence with withdrawal
F11.24	Opioid dependence with opioid-induced mood disorder
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11.281	Opioid dependence with opioid-induced sexual dysfunction
F11.282	Opioid dependence with opioid-induced sleep disorder
F11.288	Opioid dependence with other opioid-induced disorder

F11.29	Opioid dependence with unspecified opioid-induced disorder
F11.90	Opioid use, unspecified, uncomplicated
F11.920	Opioid use, unspecified with intoxication, uncomplicated
F11.921	Opioid use, unspecified with intoxication delirium
F11.922	Opioid use, unspecified with intoxication with perceptual disturbance
F11.929	Opioid use, unspecified with intoxication, unspecified
F11.93	Opioid use, unspecified with withdrawal
F11.94	Opioid use, unspecified with opioid-induced mood disorder
F11.950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions
F11.951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
F11.959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
F11.981	Opioid use, unspecified with opioid-induced sexual dysfunction
F11.982	Opioid use, unspecified with opioid-induced sleep disorder
F11.988	Opioid use, unspecified with other opioid-induced disorder
F11.99	Opioid use, unspecified with unspecified opioid-induced disorder
F12.120	Cannabis abuse with intoxication, uncomplicated
F12.121	Cannabis abuse with intoxication delirium
F12.122	Cannabis abuse with intoxication with perceptual disturbance
F12.129	Cannabis abuse with intoxication, unspecified
F12.150	Cannabis abuse with psychotic disorder with delusions
F12.151	Cannabis abuse with psychotic disorder with hallucinations
F12.159	Cannabis abuse with psychotic disorder, unspecified
F12.180	Cannabis abuse with cannabis-induced anxiety disorder
F12.188	Cannabis abuse with other cannabis-induced disorder
F12.19	Cannabis abuse with unspecified cannabis-induced disorder
F12.220	Cannabis dependence with intoxication, uncomplicated
F12.221	Cannabis dependence with intoxication delirium
F12.222	Cannabis dependence with intoxication with perceptual disturbance
F12.229	Cannabis dependence with intoxication, unspecified
F12.23	Cannabis dependence with withdrawal
F12.250	Cannabis dependence with psychotic disorder with delusions
F12.251	Cannabis dependence with psychotic disorder with hallucinations
F12.259	Cannabis dependence with psychotic disorder, unspecified
F12.280	Cannabis dependence with cannabis-induced anxiety disorder
F12.288	Cannabis dependence with other cannabis-induced disorder
F12.29	Cannabis dependence with unspecified cannabis-induced disorder
F12.921	Cannabis use, unspecified with intoxication delirium
F12.922	Cannabis use, unspecified with intoxication with perceptual disturbance
F12.929	Cannabis use, unspecified with intoxication, unspecified
F12.93	Cannabis use, unspecified with withdrawal

F12.950	Cannabis use, unspecified with psychotic disorder with delusions
F12.951	Cannabis use, unspecified with psychotic disorder with hallucinations
F12.959	Cannabis use, unspecified with psychotic disorder, unspecified
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13.120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13.121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium
F13.129	Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
F13.14	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder
F13.150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.181	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder
F13.188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder
F13.19	Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13.220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13.221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
F13.229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13.231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13.232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13.239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F13.24	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder
F13.250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified

F13.26	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder
F13.288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder
F1.329	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13.90	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
F13.920	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, uncomplicated
F13.921	Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium
F13.929	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified
F13.930	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, uncomplicated
F13.931	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal delirium
F13.932	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal with perceptual disturbances
F13.939	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified
F13.94	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder
F13.950	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.951	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.959	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.96	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F13.97	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.980	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder
F1.3981	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.982	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sleep disorder

F13.988	Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorder
F13.99	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder
F14.10	Cocaine abuse, uncomplicated
F14.120	Cocaine abuse with intoxication, uncomplicated
F14.121	Cocaine abuse with intoxication with delirium
F14.122	Cocaine abuse with intoxication with perceptual disturbance
F14.129	Cocaine abuse with intoxication, unspecified
F14.14	Cocaine abuse with cocaine-induced mood disorder
F14.150	Cocaine abuse with cocaine-induced psychotic disorder with delusions
F14.151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
F14.159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14.180	Cocaine abuse with cocaine-induced anxiety disorder
F14.181	Cocaine abuse with cocaine-induced sexual dysfunction
F14.182	Cocaine abuse with cocaine-induced sleep disorder
F14.188	Cocaine abuse with other cocaine-induced disorder
F14.19	Cocaine abuse with unspecified cocaine-induced disorder
F14.20	Cocaine dependence, uncomplicated
F14.220	Cocaine dependence with intoxication, uncomplicated
F14.221	Cocaine dependence with intoxication delirium
F14.222	Cocaine dependence with intoxication with perceptual disturbance
F14.229	Cocaine dependence with intoxication, unspecified
F14.23	Cocaine dependence with withdrawal
F14.24	Cocaine dependence with cocaine-induced mood disorder
F14.250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14.259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14.280	Cocaine dependence with cocaine-induced anxiety disorder
F14.281	Cocaine dependence with cocaine-induced sexual dysfunction
F14.282	Cocaine dependence with cocaine-induced sleep disorder
F14.288	Cocaine dependence with other cocaine-induced disorder
F14.29	Cocaine dependence with unspecified cocaine-induced disorder
F14.90	Cocaine use, unspecified, uncomplicated
F14.920	Cocaine use, unspecified with intoxication, uncomplicated
F14.921	Cocaine use, unspecified with intoxication delirium
F14.922	Cocaine use, unspecified with intoxication with perceptual disturbance
F14.929	Cocaine use, unspecified with intoxication, unspecified
F14.94	Cocaine use, unspecified with cocaine-induced mood disorder
F14.950	Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions
F14.951	Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations

F14.959	Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified
F14.980	Cocaine use, unspecified with cocaine-induced anxiety disorder
F14.981	Cocaine use, unspecified with cocaine-induced sexual dysfunction
F14.982	Cocaine use, unspecified with cocaine-induced sleep disorder
F14.988	Cocaine use, unspecified with other cocaine-induced disorder
F14.99	Cocaine use, unspecified with unspecified cocaine-induced disorder
F15.10	Other stimulant abuse, uncomplicated
F15.120	Other stimulant abuse with intoxication, uncomplicated
F15.121	Other stimulant abuse with intoxication delirium
F15.122	Other stimulant abuse with intoxication with perceptual disturbance
F15.129	Other stimulant abuse with intoxication, unspecified
F15.14	Other stimulant abuse with stimulant-induced mood disorder
F15.150	Other stimulant abuse with stimulant-induced psychotic disorder with delusions
F15.151	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations
F15.159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
F15.180	Other stimulant abuse with stimulant-induced anxiety disorder
F15.181	Other stimulant abuse with stimulant-induced sexual dysfunction
F15.182	Other stimulant abuse with stimulant-induced sleep disorder
F15.188	Other stimulant abuse with other stimulant-induced disorder
F15.19	Other stimulant abuse with unspecified stimulant-induced disorder
F15.20	Other stimulant dependence, uncomplicated
F15.220	Other stimulant dependence with intoxication, uncomplicated
F15.221	Other stimulant dependence with intoxication delirium
F15.222	Other stimulant dependence with intoxication with perceptual disturbance
F15.229	Other stimulant dependence with intoxication, unspecified
F15.23	Other stimulant dependence with withdrawal
F15.24	Other stimulant dependence with stimulant-induced mood disorder
F15.250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15.251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations
F15.259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15.280	Other stimulant dependence with stimulant-induced anxiety disorder
F15.281	Other stimulant dependence with stimulant-induced sexual dysfunction
F15.282	Other stimulant dependence with stimulant-induced sleep disorder
F15.288	Other stimulant dependence with other stimulant-induced disorder
F15.29	Other stimulant dependence with unspecified stimulant-induced disorder
F15.90	Other stimulant use, unspecified, uncomplicated
F15.920	Other stimulant use, unspecified with intoxication, uncomplicated
F15.921	Other stimulant use, unspecified with intoxication delirium
F15.922	Other stimulant use, unspecified with intoxication with perceptual disturbance

F15.929	Other stimulant use, unspecified with intoxication, unspecified
F15.93	Other stimulant use, unspecified with withdrawal
F15.94	Other stimulant use, unspecified with stimulant-induced mood disorder
F15.950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions
F15.951	Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations
F15.959	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified
F15.980	Other stimulant use, unspecified with stimulant-induced anxiety disorder
F15.981	Other stimulant use, unspecified with stimulant-induced sexual dysfunction
F15.982	Other stimulant use, unspecified with stimulant-induced sleep disorder
F15.988	Other stimulant use, unspecified with other stimulant-induced disorder
F15.99	Other stimulant use, unspecified with unspecified stimulant-induced disorder
F16.10	Hallucinogen abuse, uncomplicated
F16.120	Hallucinogen abuse with intoxication, uncomplicated
F16.121	Hallucinogen abuse with intoxication with delirium
F16.122	Hallucinogen abuse with intoxication with perceptual disturbance
F16.129	Hallucinogen abuse with intoxication, unspecified
F16.14	Hallucinogen abuse with hallucinogen-induced mood disorder
F16.150	Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions
F16.151	Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations
F16.159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified
F16.180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16.183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)
F16.188	Hallucinogen abuse with other hallucinogen-induced disorder
F16.19	Hallucinogen abuse with unspecified hallucinogen-induced disorder
F16.20	Hallucinogen dependence, uncomplicated
F16.220	Hallucinogen dependence with intoxication, uncomplicated
F16.221	Hallucinogen dependence with intoxication with delirium
F16.229	Hallucinogen dependence with intoxication, unspecified
F16.24	Hallucinogen dependence with hallucinogen-induced mood disorder
F16.250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16.259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16.283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16.288	Hallucinogen dependence with other hallucinogen-induced disorder

F16.29	Hallucinogen dependence with unspecified hallucinogen-induced disorder
F16.90	Hallucinogen use, unspecified, uncomplicated
F16.920	Hallucinogen use, unspecified with intoxication, uncomplicated
F16.921	Hallucinogen use, unspecified with intoxication with delirium
F16.929	Hallucinogen use, unspecified with intoxication, unspecified
F16.94	Hallucinogen use, unspecified with hallucinogen-induced mood disorder
F16.950	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions
F16.951	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations
F16.959	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified
F16.980	Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder
F16.983	Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)
F16.988	Hallucinogen use, unspecified with other hallucinogen-induced disorder
F16.99	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder
F18.10	Inhalant abuse, uncomplicated
F18.121	Inhalant abuse with intoxication delirium
F18.14	Inhalant abuse with inhalant-induced mood disorder
F18.150	Inhalant abuse with inhalant-induced psychotic disorder with delusions
F18.151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations
F18.159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified
F18.17	Inhalant abuse with inhalant-induced dementia
F18.180	Inhalant abuse with inhalant-induced anxiety disorder
F18.24	Inhalant dependence with inhalant-induced mood disorder
F18.250	Inhalant dependence with inhalant-induced psychotic disorder with delusions
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18.259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F18.27	Inhalant dependence with inhalant-induced dementia
F18.280	Inhalant dependence with inhalant-induced anxiety disorder
F18.921	Inhalant use, unspecified with intoxication with delirium
F18.94	Inhalant use, unspecified with inhalant-induced mood disorder
F18.950	Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions
F18.951	Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations
F18.959	Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified
F18.97	Inhalant use, unspecified with inhalant-induced persisting dementia
F18.980	Inhalant use, unspecified with inhalant-induced anxiety disorder
F19.120	Other psychoactive substance abuse with intoxication, uncomplicated
F19.121	Other psychoactive substance abuse with intoxication delirium
F19.122	Other psychoactive substance abuse with intoxication with perceptual disturbances

F19.129	Other psychoactive substance abuse with intoxication, unspecified
F19.14	Other psychoactive substance abuse with psychoactive substance-induced mood disorder
F19.150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions
F19.151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations
F19.159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
F19.16	Other psychoactive substance abuse with psychoactive substance-induced persisting amnestic disorder
F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
F19.180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder
F19.181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
F19.182	Other psychoactive substance abuse with psychoactive substance-induced sleep disorder
F19.188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
F19.19	Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder
F19.20	Other psychoactive substance dependence, uncomplicated
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated
F19.221	Other psychoactive substance dependence with intoxication delirium
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19.229	Other psychoactive substance dependence with intoxication, unspecified
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19.231	Other psychoactive substance dependence with withdrawal delirium
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19.239	Other psychoactive substance dependence with withdrawal, unspecified
F19.24	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F1.9250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
F19.259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F19.26	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder

F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19.281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19.288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F19.29	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder
F19.90	Other psychoactive substance use, unspecified, uncomplicated
F19.920	Other psychoactive substance use, unspecified with intoxication, uncomplicated
F19.921	Other psychoactive substance use, unspecified with intoxication with delirium
F19.922	Other psychoactive substance use, unspecified with intoxication with perceptual disturbance
F19.929	Other psychoactive substance use, unspecified with intoxication, unspecified
F19.930	Other psychoactive substance use, unspecified with withdrawal, uncomplicated
F19.931	Other psychoactive substance use, unspecified with withdrawal delirium
F19.932	Other psychoactive substance use, unspecified with withdrawal with perceptual disturbance
F19.939	Other psychoactive substance use, unspecified with withdrawal, unspecified
F19.94	Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder
F19.950	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions
F19.951	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations
F19.959	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified
F19.96	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting amnestic disorder
F19.97	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia
F19.980	Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder
F19.99	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder
F20.0	Paranoid schizophrenia
F20.1	Disorganized schizophrenia
F20.2	Catatonic schizophrenia
F20.3	Undifferentiated schizophrenia

F20.5	Residual schizophrenia
F20.81	Schizophreniform disorder
F20.89	Other schizophrenia
F20.9	Schizophrenia, unspecified
F21	Schizotypal disorder
F22	Delusional disorders
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F25.0	Schizoaffective disorder, bipolar type
F25.1	Schizoaffective disorder, depressive type
F25.8	Other schizoaffective disorders
F25.9	Schizoaffective disorder, unspecified
F28	Other psychotic disorder not due to a substance or known physiological condition
F29	Unspecified psychosis not due to a substance or known physiological condition
F30.10	Manic episode without psychotic symptoms, unspecified
F30.11	Manic episode without psychotic symptoms, mild
F30.12	Manic episode without psychotic symptoms, moderate
F30.13	Manic episode, severe, without psychotic symptoms
F30.2	Manic episode, severe with psychotic symptoms
F30.3	Manic episode in partial remission
F30.4	Manic episode in full remission
F30.8	Other manic episodes
F30.9	Manic episode, unspecified
F31.0	Bipolar disorder, current episode hypomanic
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
F31.70	Bipolar disorder, currently in remission, most recent episode unspecified

F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.74	Bipolar disorder, in full remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.76	Bipolar disorder, in full remission, most recent episode depressed
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.78	Bipolar disorder, in full remission, most recent episode mixed
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.81	Premenstrual dysphoric disorder
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.0	Cyclothymic disorder
F34.1	Dysthymic disorder Y
F34.8	Other persistent mood [affective] disorders
F34.81	Disruptive mood dysregulation disorder
F34.89	Other specified persistent mood disorders
F34.9	Persistent mood [affective] disorder, unspecified
F39	Unspecified mood [affective] disorder
F41.0	Panic disorder [episodic paroxysmal anxiety]
F41.1	Generalized anxiety disorder
F41.3	Other mixed anxiety disorders
F41.8	Other specified anxiety disorders
F41.9	Anxiety disorder, unspecified

F42	Obsessive-compulsive disorder
F42.2	Mixed obsessional thoughts and acts
F42.3	Hoarding disorder
F42.4	Excoriation (skin-picking) disorder
F42.8	Other obsessive-compulsive disorder
F42.9	Obsessive-compulsive disorder, unspecified
F43.0	Acute stress reaction
F43.10	Post-traumatic stress disorder, unspecified
F43.11	Post-traumatic stress disorder, acute
F43.12	Post-traumatic stress disorder, chronic
F44.0	Dissociative amnesia
F44.1	Dissociative fugue
F44.2	Dissociative stupor
F44.4	Conversion disorder with motor symptom or deficit
F44.5	Conversion disorder with seizures or convulsions
F44.6	Conversion disorder with sensory symptom or deficit
F44.7	Conversion disorder with mixed symptom presentation
F44.81	Dissociative identity disorder
F44.89	Other dissociative and conversion disorders
F44.9	Dissociative and conversion disorder, unspecified
F45.0	Somatization disorder
F45.1	Undifferentiated somatoform disorder
F45.20	Hypochondriacal disorder, unspecified
F45.21	Hypochondriasis
F45.22	Body dysmorphic disorder
F45.29	Other hypochondriacal disorders
F45.41	Pain disorder exclusively related to psychological factors
F45.42	Pain disorder with related psychological factors
F45.8	Other somatoform disorders
F45.9	Somatoform disorder, unspecified
F48.1	Depersonalization-derealization syndrome
F50.00	Anorexia nervosa, unspecified
F50.01	Anorexia nervosa, restricting type
F50.02	Anorexia nervosa, binge eating/purging type
F50.2	Bulimia nervosa
F50.8	Other eating disorders
F50.81	Binge eating disorder
F50.82	Avoidant/restrictive food intake disorder
F50.89	Other specified eating disorder
F50.9	Eating disorder, unspecified

F53	Puerperal psychosis
F53.0	Postpartum depression
F53.1	Puerperal psychosis
F55.2	Abuse of laxatives
F55.3	Abuse of steroids or hormones
F60.0	Paranoid personality disorder
F60.1	Schizoid personality disorder
F60.2	Antisocial personality disorder
F60.3	Borderline personality disorder
F60.4	Histrionic personality disorder
F60.5	Obsessive-compulsive personality disorder
F60.6	Avoidant personality disorder
F60.7	Dependent personality disorder
F60.81	Narcissistic personality disorder
F60.89	Other specific personality disorders
F60.9	Personality disorder, unspecified
F63.81	Intermittent explosive disorder
F68.10	Factitious disorder imposed on self, unspecified
F68.11	Factitious disorder imposed on self, with predominantly psychological signs and symptoms
F68.12	Factitious disorder imposed on self, with predominantly physical signs and symptoms
F68.13	Factitious disorder imposed on self, with combined psychological and physical signs and symptoms

Appendix XV: References

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