Innovations in Women's Behavioral Health:

The Promise of the IBH Model

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Introduction

Across the country, millions of people are experiencing a devastating behavioral health* (BH) crisis.[1] Between 2021 and 2022, almost 60 million adults experienced a mental illness, and over 45 million had a substance use disorder (SUD).[2] This crisis disproportionately impacts women and people of color due to risk factors associated with societal inequities and barriers to accessing care, such as discrimination and stigma.[3] Mental health conditions are also the leading underlying cause of maternal deaths during the first year after birth, with these rates especially high among women of color.[4] Current treatments and support systems have failed to meet women's BH needs, contributing to poor physical health outcomes, difficulty accessing adequate care, and unmet health-related social needs (HRSNs).[5]

The new Innovation in Behavioral Health (IBH) model from the Center for Medicare and Medicaid Innovation (CMMI) offers significant potential to improve the way care is provided to people with BH conditions.[6] The model tests a new payment-and-delivery approach to integrate care for physical health, BH, and HRSNs within BH practices already trusted by the community, such as federally qualified health centers and community mental health centers.

The IBH model is designed to provide the necessary resources for BH practices to adopt a "no wrong door" approach in accessing and delivering whole-person care. Historically, community-based BH practices have experienced systemic underinvestment and have had insufficient investment in health IT and infrastructure compared to physical health providers.[7] This is exacerbated by the traditional fee-for-service (FFS) payment system that restricts providers from investing in the resources needed to provide comprehensive care. The IBH model is designed to address this gap; practices will receive payment for care integration, care management services, and health IT infrastructure support.

The IBH model has potential to enhance women's health and outcomes. This brief provides an overview of the model and highlights key opportunities to better support women's health needs.

* Behavioral health (BH) conditions encompass mental health and substance use disorders (SUD).

Summary of the Innovation in Behavioral Health Model

Goal	Develop and enhance infrastructure of specialty BH organizations to provide person-centered care to beneficiaries with moderate to severe BH conditions
Model Participants	Up to eight state Medicaid agencies (voluntary)
Practice Participants	Specialty BH practices providing outpatient mental health and/or SUD treatment services
Metrics of Success	• Improved health outcomes for diabetes, hypertension, and tobacco use • Improved health IT capabilities to support care coordination • Reduction in hospitalizations • Increased use of referred services (e.g., HRSNs, primary care) • Patient-reported outcome measures
Care Delivery Transformation Areas	**Care Integration:** Address BH and physical health care in one setting. Screen, assess, treat, and refer patients as needed for both BH and selected physical health conditions. **Care Management:** Provide self-management support and person-centered care planning. **Health Equity:** Conduct HRSN screenings, population needs assessment, and a health equity plan. **Health IT:** Support data sharing between providers and patients. Help to track HRSNs referral and follow up.
Innovative Payment Approach	**Medicaid:** States will develop and implement their own Medicaid payment arrangement complementing existing payment approaches. **Medicare:** Practices will have the option to participate in the alternative Medicare payment arrangement. They will receive infrastructure funding to support health IT investments and practice transformations. They will also receive risk-adjusted, per-member-per-month payments for screening and care coordination. Both approaches will incorporate performance-based payments using specified quality measures and must be directionally aligned†.
Duration	January 2025–December 2032

† This would include alignment in areas of the model that reduce provider burden and are essential to the model's goals, the type and format of data provided, and learning priorities. CMS will not require recipients to build identical payment arrangements to what is proposed in the Medicare infrastructure support payments or population-based payments.

Practice Participants

Participants include specialty BH practices who offer longitudinal BH services on an outpatient basis. These providers must serve Medicaid – and optionally Medicare – beneficiaries over the age of 18 with significant BH challenges. A wide variety of provider types may participate, including, but not limited to:

- Community mental health centers
- Tribal health organizations
- Opioid treatment programs
- Federally qualified health centers
- Independent practitioners
- Critical Access Hospitals' outpatient BH clinics
- Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs are BH practices that have been doing this comprehensive, integrated care work since 2017.[8] **The IBH model provides a pathway for CCBHCs to receive payment under Medicare for the first time**; previous payments have been limited to Medicaid demonstration waivers and grant funding.

Care Integration

The IBH model aims to build and strengthen the BH infrastructure to support state Medicaid agencies (SMAs) and specialty BH practices in advancing care integration and management using health IT systems for efficient care coordination. To measure the impact, the model requires participants to screen for diabetes, hypertension, and tobacco use. **Although not required to treat these conditions, the BH practice must provide the necessary care management in collaboration with a physical health consultant to track related outcomes.** This consultant has the option to be in-house or contracted and plays a vital role in diagnosing and monitoring these physical health outcomes. The BH practices are required to execute data-sharing agreements and facilitate health information exchange between providers and patients, while also promoting patient privacy and confidentiality consistent with HIPAA and 42 CFR Part 2.[9]

Health Equity

BH practices are required to build interprofessional care teams to support screening, assessment, treatment, and referral for ongoing care management of BH and physical health needs.

These care teams, which may include partners like case managers, peer-support advocates, primary care providers, or community-based organizations (CBOs), must reflect the health, cultural and linguistic needs of the population using a population needs assessment. States must use infrastructure funding to strengthen health IT capabilities in BH practices, requiring the capture of demographic information such as race, ethnicity, language preference, sexual orientation, and gender identity. It is unclear whether self-reported demographic data will be required.

BH practices are also required to build health equity plans detailing the actions they will take to address health disparities within their population. These teams, in collaboration with patients, will co-create care plans that reflect each patient's specific concerns, including information from HRSN screenings. Practice participants will partner with CBOs to refer patients to necessary services that will address their needs indicated during screenings. States are encouraged to facilitate closed-loop referrals with social services agencies for HRSNs by providing the necessary data infrastructure and management. It is unclear whether demographic data or outcome data will be required to be reported.

Payment Strategy

A key factor in improving and innovating how care is provided is the shift from paying health care providers for the volume of services (fee-for-service) to paying for the quality and cost of care – otherwise known as value-based care. The traditional FFS system often leads to fragmented, uncoordinated care and limits BH practices from providing team-based care tailored to meet the needs of their patients.[10] Historically, BH providers have had few to no opportunities to participate in emerging value-based payment models.[11] The IBH model is designed to provide a glide path to value-based care for BH practices by providing essential investments, tying payment to performance, and ultimately creating accountability for patient care.

Since 2022, CMMI has launched six Medicaid-focused models, including the IBH model, aimed at advancing equitable, high quality, person-centered care for Medicaid and dually eligible beneficiaries. **This is the first CMMI model to focus on multi-payer alignment for beneficiaries with mental health and SUD conditions under both Medicaid and Medicare.**

Each SMA will be required to design and implement their own Medicaid alternative payment model that reflects their state's unique context and needs. However, each state will be required to use a performance-based payment approach – or a quality incentive payment – to encourage and reward improvement in quality. Practices who opt to participate in the Medicare payment model will also receive risk-adjusted integration support payments for identifying, addressing, and coordinating BH and physical health conditions, along with HRSN screenings and referrals.

How the IBH Model Addresses Patient and Consumer Priorities

Access to Care

The IBH model could profoundly impact access to care by meeting people where they are. It aims to address the need for greater access to physical health care for people with BH conditions by providing comprehensive services in a single integrated setting. The model reduces the need for patients to navigate separate systems to address concerns that are likely associated with their BH conditions. The integration of this care could minimize common barriers, such as transportation and child care, by reducing the number of appointments. This streamlined approach allows for greater convenience for patients and helps to build stronger, continuous relationships between patients and providers. Additionally, this model promotes early detection of conditions and timely intervention by screening for

Maternal Opioid Misuse (MOM) Model

The Maternal Opioid Misuse (MOM) model from CMMI is a five-year patient-centered care delivery model aiming to improve care and health outcomes of pregnant and postpartum Medicaid beneficiaries with opioid use disorder.[12] This model does not test an alternative payment approach but provides upfront infrastructure funding to provide coordinated and integrated care for enrollees. Providers must create comprehensive treatment plans that integrate mental health and SUD services with prenatal and postpartum care, as well as facilitate wraparound care with community and social services. Other key components include care coordination, health promotion, and family support. The Centers for Medicare & Medicaid Services (CMS) awarded funding to 10 states in 2021, who began implementation in 2023. Patients in the MOM model have reported a more positive labor and postpartum experience compared to pre-MOM pregnancies.[13] States should draw upon learnings from the MOM model on how to effectively integrate BH care, specifically SUD services, with women's health care and delivery.

both BH and physical health conditions, which is important toward addressing the full spectrum of women's health concerns. The model does not incorporate cost sharing requirements, but CMMI encourages states to waive cost sharing for patients through waivers or different Medicaid levers. The IBH model has significant potential to help people from underserved communities have better access to necessary care. However, it does not address workforce shortages that substantially impact the availability of this care in many rural and historically marginalized communities.

Patient, Family, and Community Engagement

CMS recognizes the need for diverse stakeholder participation in this model, requiring states to implement a convening structure that meets, at least, quarterly. The convening structure aims to enhance the model by aligning efforts of interested or impacted groups to establish priorities, facilitate shared learnings, and provide operational support for the model. SMAs are encouraged to recruit a variety of stakeholders, including beneficiaries with lived experience and caregivers, promoting the incorporation of patient experiences in the model's development and implementation. The model description lists several other entities as *essential* members, including practice participants, social services, and state mental health authorities. However, patient advocacy organizations and CBOs are listed only as *recommended* members.

Impact on Women's Behavioral Health

The IBH model aims to improve care delivery to individuals with BH conditions. Given that women face unique BH challenges throughout their life cycle, have more difficulty accessing adequate care, and experience stark socioeconomic inequities, the model has unique potential to improve quality of care and health outcomes for women.

For instance, in 2021, compared to male counterparts, women aged 18–25 were significantly more likely to:

- Have any mental illness across various U.S. regions, social statuses, employment situations, and racial and ethnic groups.
- Suffer from serious mental illness across all racial and ethnic groups.
- Experience a major depressive episode across all racial and ethnic groups.
- Have thoughts of suicide.[14]

Despite this, women with a mental illness, across all age groups, were more likely to feel that they had an unmet need for mental health support compared to men.

Women encounter a variety of barriers when seeking mental health services. These include economic constraints and a pervasive stigma associated with BH conditions – particularly around issues like SUD, which are often more stigmatized for women than for men.[15]

- Women typically earn less than men – only 75 cents for every dollar – a gap resulting in annual earnings disparities up to $14,170.[16]
- Women are more likely to take on caregiving responsibilities, spending on average 102 more hours annually on caregiving than men. This caregiving burden often prevents women from seeking care due to practical barriers such as inability to take time off work, inadequate child care, and insufficient transportation, further complicating access to necessary health services.[17]
- Women, especially pregnant people or mothers, face greater stigmatization for SUD due to the expectation of being more family-oriented than men.[18]

All of these barriers are attributed to women not receiving the care that they need when they most need it, which only exacerbates their BH conditions.

The IBH model has potential to reduce these challenges and improve health outcomes for women by fostering a person-centered and continuous care environment. There are opportunities for states to refine and target the IBH support structures to better meet the needs of women under both Medicaid and Medicare (see recommendations below). It is imperative to implement the IBH model in ways that address gaps in existing BH integration programs for women.[19] Previous integration programs offered in women's health settings have been limited to treating perinatal depression, often underutilizing the expertise of psychologists and other BH providers to treat conditions such as post-traumatic stress disorder and chronic pain.

Key Considerations: Substance Use, Pregnancy, and Health Privacy

Health information exchange across the care continuum is important to achieve effective care coordination for patients. However, amid the heightened threats of pregnancy surveillance and criminalization in the aftermath of the *Dobbs vs. Jackson Women's Health Organization* decision, safeguards to protect sensitive patient information are paramount. This is particularly important for pregnant and postpartum individuals dealing with SUD. The practice of drug-testing pregnant people and reporting the results of those tests to state authorities is the leading

reason why pregnant people face criminalization and other punitive state actions due to their pregnancy status or outcomes.[20]

Criminalizing pregnant people with SUD undermines patients' privacy and jeopardizes their health and well-being. These consequences are compounded for historically marginalized populations such as women of color and low-income women, who are more likely to face criminal charges related to reproductive health and pregnancy outcomes.[21] Fear of prosecution and stigma around pregnancy and SUD often deters pregnant individuals from seeking health care, increases the risk of complications for maternal and fetal health, and worsens health outcomes.[22]

Trust between patients and providers is fundamental to effective treatment and must be respected and promoted. SMAs and practice participants within the IBH model must ensure that practices for sharing this data prioritize patient privacy, risk mitigation, and patient-provider trust. Providers should have informed discussions with their patients about the risks, benefits, and protections associated with data sharing. The focus should always be on care and support, not penalization, and the implementation of this model should reflect broader societal and legal context.

Recommendations to Maximize Impact on Women's Health

To best support the BH care of women in this model, SMAs should consider the following when developing their care delivery framework and payment approach.

- **Prioritize a physical health consultant with experience in women's health**
  - Practice participants should hire or contract with a physical health consultant that will best serve their patient population. Women often feel more comfortable going to their ob-gyn for their primary care issues as they are more satisfied with care there than with a primary care provider.[23] A physical health consultant with a background in women's health can better consider the unique factors that could affect a woman's mental and physical health when co-developing patient care plans. Practices should, at minimum, require their physical health consultant to have training or background in women's health needs. The consultant, as well as the BH providers, should also receive training in trauma-informed, culturally congruent care, as history of trauma is a risk factor and consequence of

SUD for women in particular.[24] Providers should ensure they approach this population with empathy and foster a nonjudgmental environment to reduce perceived stigmatization and encourage SUD treatment.[25]

- **Co-locate primary care, BH, and ob-gyn providers**
  - To further aid care coordination and comprehensive care, SMAs should consider providing support for co-location of primary care, BH, and women's health services at one site. This approach facilitates closed-loop referrals and simplifies the care experience for patients by reducing the number of separate visits needed. Some Medicaid programs have billing restrictions that prohibit providers from billing for both a BH and physical health visit on the same day.[26] Although these restrictions are aimed at preventing unnecessary procedures, they can inadvertently limit patient access to care. This is a concern for co-located BH and physical health providers as it discourages same-day integrated care. States can lift these restrictions, which will help reduce barriers to care such as transportation challenges, child care needs, or lack of or limited sick leave.
- **Improve evaluation measures by requiring women's health screening and BH outcome measures**
  - This model includes the option for states to include a breast cancer screening measure in their evaluation based on each state's physical health priorities. We endorse the inclusion of a women's health screening measure in the model evaluation; however, we recommend CMS make this measure a requirement as it is the only measure tracking a women's health outcome. A women's health measure is necessary, given that women make up about half of the general population and are more likely to have a serious mental illness across all age groups.[27]

    In addition to the required health outcome measures tracking diabetes, hypertension, and tobacco use, the evaluation criteria should incorporate BH outcome measures, such as recovery or remission of depression. Measures that track recovery of BH conditions are especially important as this acknowledges improvements in health over time, not just a return to optimal well-being. Since providers do not always measure these outcomes, their inclusion would be helpful to understand whether there is a connection between the model's care delivery approach and successes in these outcomes.
- **Prioritize patient outcome and experience measures**
  - CMS is currently considering measures to evaluate practice performance and capture the patient's view of their health status over time. CMMI will

use at least one patient reported outcomes measure (PROM) in their quality strategy to monitor implementation and operation of the model. We recommend a strong emphasis on this measure during quality assessment and incorporation of patient experience as well, especially since BH has historically been excluded from CMS's patient experience surveys.[28] PROMs center patients' and caregivers' experiences and support person-centered care. We also urge consideration of goals and outcomes of importance to people with lived experience, including work and civic engagement, relationships, stable housing, and others. We recommend that participants be required to stratify these measures by race, ethnicity, age, and sex as a means to identify and address inequities. Finally, CMS should allow states some flexibility to tailor measure selection to their unique populations.

- **Emphasize patient/community engagement**
  - We commend CMMI for requiring a convening structure in each state where various impacted stakeholders can influence the development and implementation of the care delivery framework and Medicaid payment approach. Although CMMI identifies caregivers and beneficiaries with lived experiences as *essential* members of the convening structure, CMS does not explicitly require SMAs to commit to caregiver or beneficiary participation.

    Furthermore, CBOs are listed only as *recommended* members although their voice is crucial in providing equitable care. For example, CBOs should be consulted regarding the best platform to use for HRSNs referrals to ensure the loop is closed between services. Studies show that delayed or late engagement with CBOs as partners in addressing social needs leads to further obstacles in implementation, such as misaligned goals and lack of interest or capacity to fulfill the health system's needs.[29] It is important to note that, although partnership with CBOs is important to address HRSNs, CBOs need adequate funding and resources to account for the increased number of referrals and address the underlying barriers to accessing those services. States should work with CBOs to determine what resources they will need to be successful partners in this work. States should also be sure to track whether practice referrals to CBOs are closed to inform providers on whether their patients' social needs were met. We recommend CMS also include CBOs as *essential* members and require the recruitment of at least one of each type of *essential* member listed.

    Additionally, SMAs should leverage their beneficiary advisory councils (BAC) as well as the Medicaid Advisory Council (MAC) as finalized in the Ensuring Access and Eligibility in Medicaid regulation.[30] This required infrastructure

can serve as a good foundation for patient engagement for this model. For example, SMAs could have a BAC representative within these convening structures or consider establishing a subgroup in the BAC or MAC that focuses on the IBH model to ensure further alignment. States should also refer to the Substance Abuse and Mental Health Services Administration (SAMHSA) participation guidelines for individuals with lived experience.[31]

- **Promote secure data sharing and privacy**
  - The IBH model provides much needed funding to develop the health IT infrastructure in BH practices. As systems and processes for health information exchange are developed, robust training and education are necessary to account for the unique privacy protections and confidentiality challenges for people with BH conditions, including SUD. This is particularly important for pregnant or postpartum people. For example, there are additional protections in HIPAA for psychotherapy notes, as well as the confidentiality of SUD patient records under CFR Part 2, which could help protect patients from possible criminalization. Additionally, under the new HIPAA Privacy Rule from the Office of Civil Rights, providers are prohibited from disclosing protected health information for the purpose of criminalizing those who access, provide, or facilitate reproductive health care.[32] Providers should be educated and supported to have informed conversations with patients about the benefits and risks of data sharing and current data sharing policies. The focus must be on supporting patients in their BH care journey instead of criminalizing their conditions.

Conclusion

The IBH model represents a pivotal shift in delivering care to individuals living with BH conditions by integrating BH and physical health services. The model has great potential to improve the care and outcomes for women, who face unique challenges and barriers to accessing care. Incorporating measures that address conditions beyond perinatal health and prioritizing culturally competent care will help to strengthen its impact and realize this potential. Additionally, data sharing policies and privacy protections must be implemented with robust provider training and patient education, to build and maintain trust between patients and providers. The IBH model must evolve to bridge the gaps in service delivery and push to address the societal and systemic barriers that have long prevented women from receiving the care they deserve. The model could be a powerful tool in creating a more responsive and equitable health care system for women.

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About the National Partnership
The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to achieving equity for all women. We work to create the conditions that will improve the lives of women and their families by focusing on achieving workplace and economic equity, and advancing health justice by ensuring access to high-quality, affordable, and equitable care, especially for reproductive and maternal health. We are committed to combatting white supremacy and promoting racial equity. We understand that this requires us to abandon race-neutral approaches and center the intersectional experiences of women of color to achieve our mission.

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