Innovation in Behavioral Health (IBH) Model

Notice of Funding Opportunity (NOFO) Webinar

March 5, 2026

Centers for Medicare & Medicaid Services | Center for Medicare & Medicaid Innovation

Housekeeping and Logistics

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Agenda

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2 | IBH Model Overview

3 | Cohort I Participant Experiences

4 | Model Funding and Payment Overview

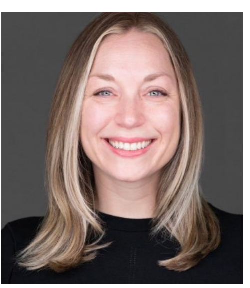
5 | Application and Submission Information

6 | Closing and Resources

Welcome and Introductions

Today’s Presenters

Abe Sutton
Director, *CMS Innovation Center*
Deputy Administrator, *Centers for Medicare and Medicare Services*



Ally Marlatt
IBH Model Co-Lead
CMS Innovation Center

Aaron Hedquist
IBH Model Co-Lead
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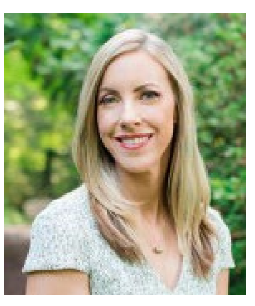


Karin Bleeg
Director, Division of Health Innovation and Integration
CMS Innovation Center

Jamie Atwood
Grants Management Officer
CMS Office of Acquisition and Grants Management

IBH Model Overview

IBH Model Overview

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

THEORY OF CHANGE

Build and strengthen connections to **physical health care** for beneficiaries

Promote **screening and referrals** upstream drivers of health, such as food, housing, and transportation needs

Leverage **care management and care coordination** to increase access to and engagement with primary care and community services

Encourage investments in certified **health IT** products and infrastructure improvement for practices and patient populations

CMS will evaluate the IBH Model's ability to:

Achieve higher quality, whole person care

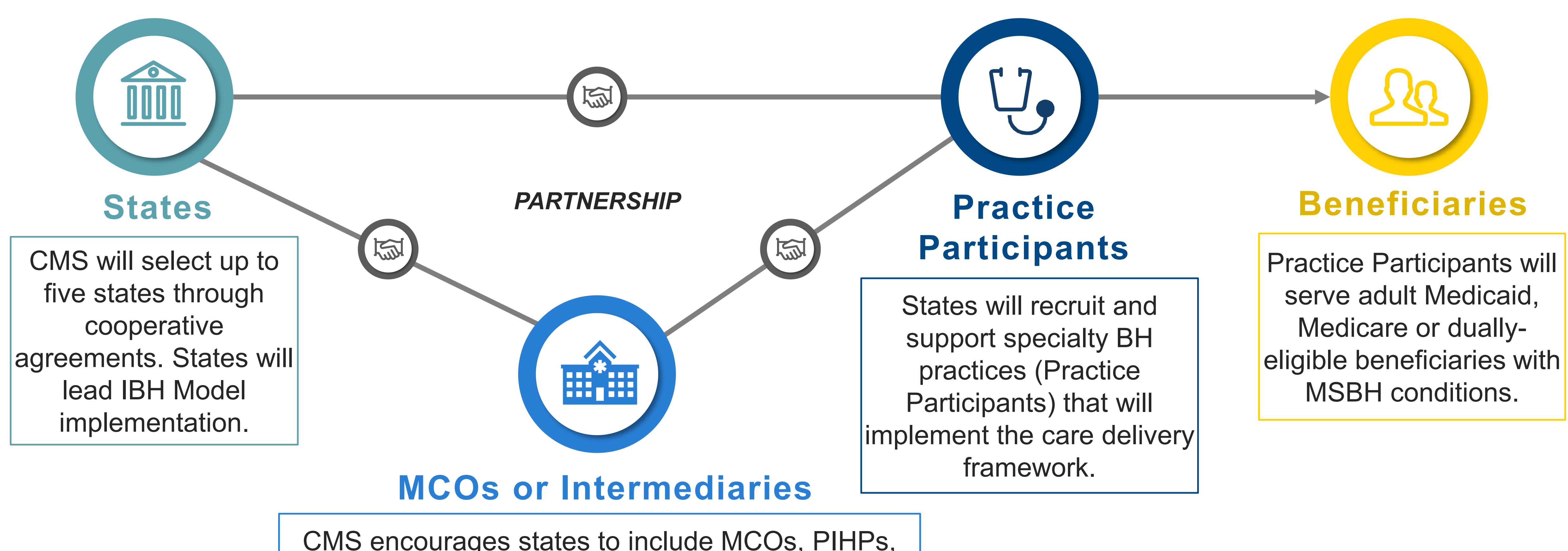
Increase access to care

Strengthen health IT systems capacity

Reduce avoidable emergency department and inpatient utilization, and thereby reduce Medicare and Medicaid expenditures

Overview of IBH Model Partners

States, Practice Participants, and managed care organizations (MCOs) or other intermediaries will collaborate to implement the IBH Model.



CMS encourages states to include MCOs, PIHPs, PAHPs, or other intermediaries, as applicable**, in recruiting and providing technical assistance to Practice Participants.**

Award Information and Key Model Dates

CMS plans to award up to five cooperative agreements, offering up to $7.5 million. Additional funding for Medicare practices in participating states will be available directly from CMS.

AWARD INFORMATION

The IBH Model uses a **cooperative agreement as its funding mechanism.** A cooperative agreement provides for **substantial involvement between the federal awarding agency and the non-federal entity** (e.g., state) in carrying out the requirements described in the federal award.

The IBH cooperative agreement will require significant CMS programmatic support, including technical assistance (TA) with each state throughout the model years (MY).

KEY MODEL DATES

Application due June 3, 2026

Application Period

Implementation Period

2025 | 2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | 2033

MY 3 | MY4 | MY5 | MY6 | MY7

Pre-Implementation Period

State Recipients Announced Fall 2026

Overview of Cooperative Agreement Requirements and Activities

States are expected to fulfill the requirements outlined in the cooperative agreement, listed below, over the seven-year performance period of the IBH Model.

NOTICE OF AWARD — 2026

MODEL IMPLEMENTATION — 2029

Recruit IBH Model Practice Participants	Design and Implement the Care Delivery Framework	Design and Implement the Medicaid Payment Approach	Infrastructure Development and Funding	Participate in the Convening Structure	Support Model Data, Quality, and Evaluation Efforts
Work with relevant parties (e.g., managed care organizations (MCOs), Prepaid Inpatient Health Plan (PIHPs), Prepaid Ambulatory Health Plans (PAHPs) to recruit eligible Practice Participants to the IBH Model.	Collaborate with CMS, Practice Participants, and others to design or adapt an existing BH initiative(s) in the state and implement the IBH care delivery framework.	Design, establish, and implement the IBH Medicaid Payment Approach, in partnership with CMS, including with the Center for Medicaid and Children's Health Insurance Program (CHIP) Services (CMCS).	Prepare and distribute cooperative agreement funding to eligible Practice Participants; implement health information technology (health IT) plans to support the IBH Model using a standardized needs assessment.	Help convene relevant parties to develop the care delivery framework and Medicaid Payment Approach and to improve model performance.	Enable the continuous flow of IBH Model data to Practice Participants and facilitate data sharing agreements between providers and payers.

Applicant Eligibility Information

Medicaid agencies in all 50 states, Washington, D.C., and eligible U.S. territories—including American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands—may apply to participate in Cohort II of the IBH Model.

WHO CAN APPLY?

State Medicaid agencies (SMAs), and **BH agencies** with the authority and capacity to accept cooperative agreement award on behalf of the SMA, are eligible to apply.

APPLICATION DEADLINE

Applications must be submitted in response to the NOFO on Grants.gov **by 11:59 PM Eastern on June 3, 2026.**

APPLICATION NOTES

Applicants may propose to implement their program state-wide or designate a sub-state region.

Practice Eligibility Information

Practice Participants are specialty BH practices and settings located in the service areas where the state has chosen to implement the IBH Model. With support from states and CMS, Practice Participants will implement the care delivery framework and carry out other model requirements. CMS' goal is for practices to participate in both Medicare and Medicaid.

PRACTICE ELIGIBILITY

Practice Participants can be existing practices that selected states are already working with and/or states may recruit additional practices. **Practice Participants must:**

- Serve at the **outpatient level of care**, an **average of at least 25 people per month who are enrolled in Medicaid** (age 18 or older) with **moderate to severe behavioral health (MSBH) conditions**.
- **Have at least one BH provider** who is an employee, leased employee, or independent contractor of the practice. **Provider must:**
  - **Be licensed by the state to deliver BH treatment services**.
  - **Meet all other state-specific requirements** to deliver BH services, as applicable.
  - **Be eligible for Medicaid reimbursement**.

MEDICARE PRACTICE ELIGIBILITY

IBH Model Medicaid practices may also opt to participate in the Medicare arm of the model by responding to a forthcoming CMS Request for Applications (RFA). CMS will be responsible for monitoring these Medicare practices for compliance, as well as providing TA and other support. Those practices participating in the Medicare arm of the model will be eligible for additional funding from CMS to help support health IT, practice transformation, and delivering model services.

Overview of Care Delivery Framework

States 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, preventive care and health promotion services. States are also encouraged to build on existing initiatives and may include additional care delivery services.

CARE INTEGRATION

Practice Participants will screen, assess, and refer patients for BH conditions, physical health conditions, and upstream drivers of health within the scope of practice of the Practice Participants' providers.

CARE MANAGEMENT

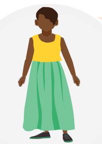
An interprofessional care team will address the needs of the beneficiary and provide ongoing care management across the beneficiary's behavioral and physical health needs. Care manage will include coordinating and following up on referrals related to BH, physical health, or upstream drivers of health.

PREVENTIVE CARE AND HEALTH PROMOTION

Practice Participants will engage in activities that improve health for all beneficiaries by managing and monitoring priority health conditions, including tobacco use, diabetes, and hypertension. Practices should promote prevention and health education strategies and leverage existing state and practice-level population health data to inform these activities.

IBH Patient Journey

The following illustration depicts a hypothetical patient journey within the IBH Model.



Julia is living with bipolar disorder and opioid use disorder (OUD) and needs support managing her diabetes. She visits a BH provider in her community who is participating in the IBH Model.

BEHAVIORAL HEALTH

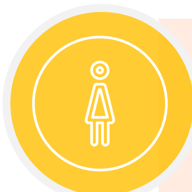
Julia's BH team—a BH provider, psychiatrist, peer support specialist, and case manager—works with her and her family to **develop and deliver a personalized care plan** for her bipolar disorder and OUD. Her BH provider **screens for physical health, BH, and social needs**, and **connects her to a Primary Care Provider (PCP) for diabetes management** and a community program for healthy food delivery.

PHYSICAL HEALTH CARE

Julia **develops a plan** for managing her diabetes with her PCP. Her **PCP and BH provider discuss** Julia's treatment plan so they can support her and help her adjust her plan as needed.

COMMUNITY SUPPORT

Julia meets with a **local organization that provides her with social supports.** They sign her up for a healthy food delivery program and maintain her nutrition plan.



Because of the IBH Model, Julia and her care team are better able to work together to manage her treatment plan and address her needs holistically. She and her family continue to partner with her BH provider and other care team members.

Cohort I Participant Experiences

Cohort I State Introductions

Melanie Hendricks
Director of Behavioral Health,
SCDHHS
South Carolina

Robert Myers
Integrated Care Advisor,
OMH
New York

Leah Julian
IBH Specialist,
MDHHS
Michigan

Cohort I State Discussion Questions

1. What motivated you to apply to the IBH Model?

2. What benefits have you experienced or expect to experience from participating in the IBH Model?

3. What advice would you give potential applicants?

Model Funding and Payment Overview

IBH Model Funding and Payment Overview

Outlined below are the key funding and payment arrangements available under the IBH Model.

	Cooperative Agreement Funding	***Infrastructure Funding***	***Integration Support Payment* (ISP)**	***Performance Based Payment***
Recipient	States	Practice Participants	Practice Participants	Practice Participants
Purpose	Enhance state capacity to develop and implement the IBH Model and support practices	Support investments in health information technology, interoperability, and other practice transformation needs.	Provide reimbursement for the cost of managing the care for patients attributed under the IBH Model	Transition BH practices with a glidepath towards value-based care
Timing	2027 – 2033 *(MYs 1 – 7)*	2028 – 2031 *(MYs 2 – 5)*	2030 – 2033 *(MYs 4 – 7)*	• **Pay-for-reporting:** 2029 (MY3) • **Pay-for-reporting & Pay-for-performance:** 2030 (MY4) • **Pay-for-performance with downside risk:** 2031 - 2033 (MYs 5 – 7)
Source	CMS	CMS	CMS	Existing Medicaid payment authority or mechanism

Funding Sources Considerations

CMS provides up to $200K per practice in Medicare Infrastructure Funding directly to Medicare Practice Participants.

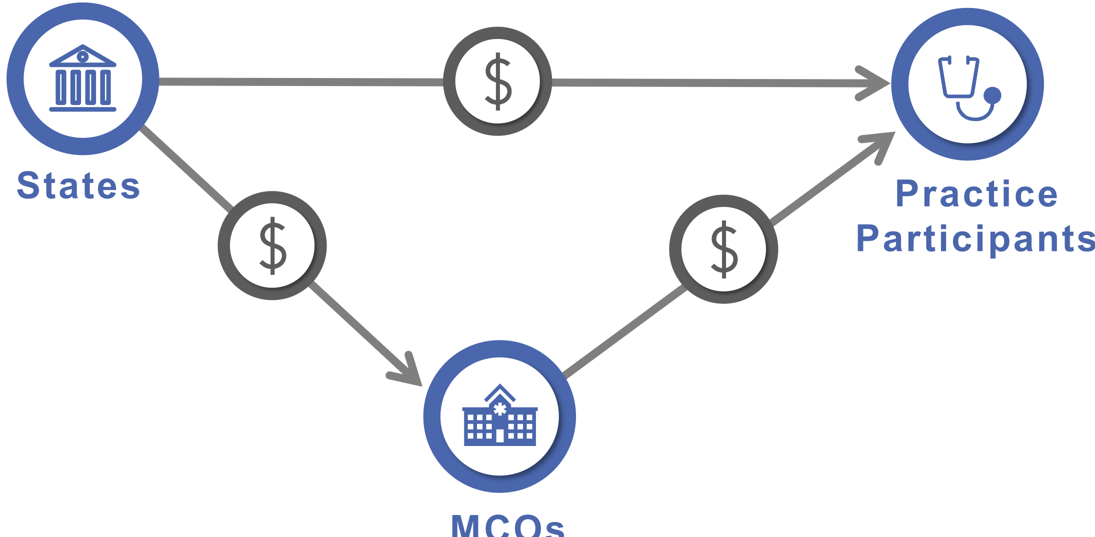
States are encouraged **to use up to $100K in cooperative agreement funding (per practice) for each Medicaid-Only practice.**

Medicare and Medicaid Payment Approach: Funding Flow

Along with cooperative agreement funds for participating states, the IBH Model offers an aligned payment approach across both Medicaid and Medicare.

Medicaid Payment Approach

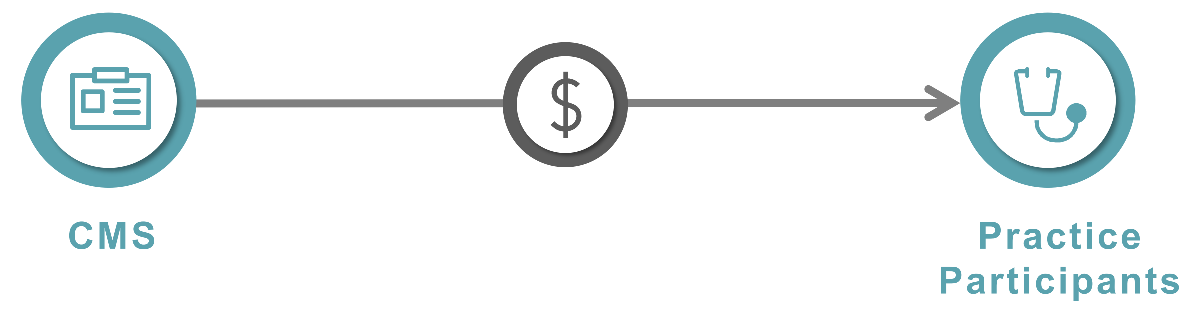
Medicaid payments for model services are made by states and/or MCOs directly to Practice Participants.



Practice Participants must at minimum participate in their state's Medicaid Payment Approach to participate in the IBH Model.

Medicare Payment Approach

Medicare payments for model services are made directly by CMS to Medicare Practice Participants.



Note: Payment approaches described here are distinct from cooperative agreement funding.

Overview of Infrastructure Funding

States, as Recipients, and/or CMS will distribute Infrastructure Funding to support investments in certified health IT products and infrastructure improvements for their practice and patient population. Funding will be made available based on results of a robust assessment tool of current capabilities and model priorities.

INFRASTRUCTURE FUNDING PURPOSE

Infrastructure funding supports and funds investments in certified health IT products and practice transformation, including:

1. Improving data infrastructure
2. Establishing quality goals
3. Supporting practice transformation activities
4. Supporting data collection efforts to advance towards accountable care and the development of an action plan to address needs specified in the population health needs assessment

INFRASTRUCTURE FUNDING EXAMPLE ACTIVITES

- Health IT, including electronic health records (EHRs) and interoperability improvement efforts
- Telehealth tools to support delivery of integrated care
- Practice transformation activities, including clinical workflow design, staffing and retention plans (e.g., hiring and training of care coordination staff such as peer support workers, community health workers, or other applicable staff)

Infrastructure Funding Sources

Practices Participants in the Medicare Payment Approach will receive Infrastructure Funding directly from CMS. Recipients must set aside a proportion of cooperative agreement funding for Medicaid-only Practice Participants. Infrastructure funding amounts will be determined by an Infrastructure Needs Assessment.

	Cooperative Agreement Infrastructure Funding *(For Medicaid-only practices)*	Medicare Infrastructure Funding Directly from CMS
Recipient	Practice Participants in the **Medicaid Payment Approach**	Practice Participants in the **Medicaid and Medicare Payment Approach**
Purpose & Allocation	Support the development and maintenance of infrastructure and practice transformation activities needed to deliver integrated, value-based care. Activities include health IT infrastructure, such as the use of certified electronic health record technologies, health information exchange and broader data interoperability upgrades, and population health management solutions	Support the development and maintenance of infrastructure and practice transformation activities needed to deliver integrated, value-based care. Activities include health IT infrastructure, such as the use of certified electronic health record technologies, health information exchange and broader data interoperability upgrades, and population health management solutions
Amount	SMAs can plan to set aside **~$100,000** in cooperative agreement funding per Medicaid-only practice for budgeting purposes.	Up to **$200,000 per practice.**
Timing	MY1 – MY4	MY2 – MY5

Medicare Payment Approach

Medicare payments are provided to Practice Participants who are enrolled in Medicare and have agreed to participate in the IBH Medicare Payment Approach. Details on Medicare participation will be available to practices through a forthcoming RFA. The IBH Medicare Payment Approach includes two core elements:

	Integration Support Payment (ISP)	**Performance-Based Payment**
WHEN	MY3 – MY7	• Pay-for-reporting **MY3 – MY4** • Pay-for-performance **MY4 – MY5** • Pay-for-performance with a withhold **MY6 – MY7**
HOW	Via prospective per-beneficiary per-month (PBPM) payment (~$200 - $220 PBPM)	Via annual Performance based Payment
PURPOSE	Cover the cost of managing care for patients attributed under the IBH Model.	Designed to encourage and reward behaviors such as data reporting, care integration and coordination, care efficiency, and patient-centered outcomes.

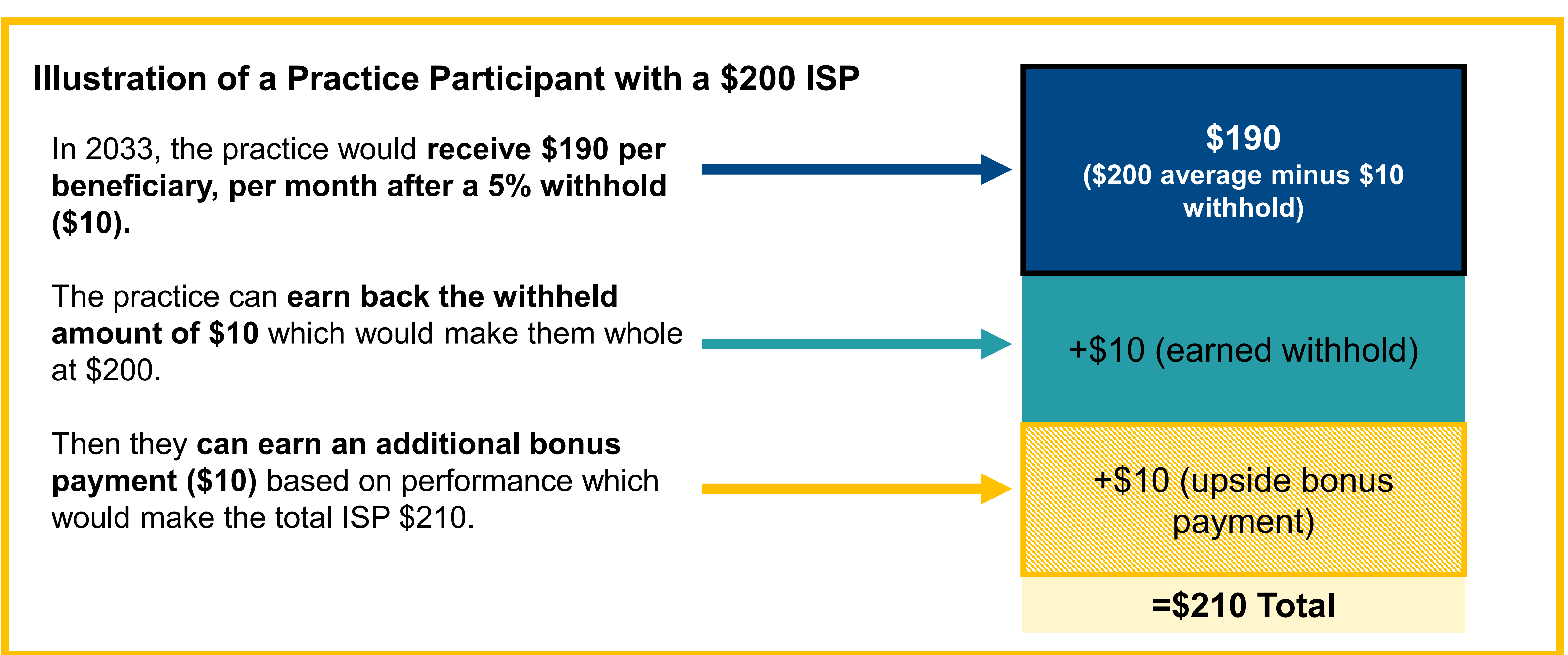
Performance Based Payments

CMS will adjust the ISP based on Practice-Based Performance measures. The Medicaid Payment approach must also include upside bonus and a withhold, however CMS is not prescriptive on the exact amount required.

Year	Payment Type	***Risk Structure***
2029 (MY3)	Pay-for-Reporting	3% Upside
2030 (MY4)	Blended, Pay-for-Reporting and Pay-for-Performance	4% Upside
2031 (MY5)	Pay-for-Performance	5% Upside
2032 (MY6)	Pay-for-Performance	5% Upside AND 2% Withhold
2033 (MY7)	Pay-for-Performance	5% Upside AND 5% Withhold

Medicare ISP Example

The Medicare ISP in 2033 (MY7) has two Medicare value-based payment components, a 5% withhold and a 5% bonus (i.e., upside payment). Practices can earn back the withhold and the additional bonus payment based on their performance on the Medicare quality measures, to be specified by CMS.



Medicaid Payment Approach

The IBH Model permits states to develop a new or leverage an existing Medicaid payment approach in collaboration with CMCS, subject to CMCS approval. State IBH Medicaid payment approaches must follow these guidelines:

CONVENING STRUCTURE

- Alongside CMS, states must identify a **neutral convener** to host model-related convening structure by month 6 of MY1; it is strongly recommended the convening structure meets **at least quarterly**, no later than the end of Q2 of MY1
- The convening structure will support **development** of the **Medicaid Payment Approach** and **care delivery framework** by working with relevant stakeholders and supported by technical assistance from CMS prior to the end of MY2
- **Implement the convening structure** to provide technical assistance (e.g., capturing and reporting data, implementing health IT) to Practice Participants and to troubleshoot data sharing challenges among partners
- Through the convening structure, exchange **best practices** for improving key BH outcomes and operational support among payers, Practice Participants, and others interested

ATTRIBUTION

- States will attribute beneficiaries to the IBH Model **using the state's own attribution methodology** (or using an existing attribution model) that generally adheres with the alignment parameters
- States will provide CMS, on a quarterly basis, **a list of all dually eligible and Medicaid-attributed beneficiaries**

MEDICAID AND MEDICARE ALIGNMENT

- **Rewards** improvements in **cost and quality**
- Supports key features of the IBH Model **care delivery framework**
- Introduces **state-based quality measures** for participants
- Introduces **performance-based quality incentives** for participants

IBH Quality Strategy Overview

The IBH Model's quality strategy uses claims-based measures to monitor the model's underlying objectives. Measures include those reported at the State- and Practice-level.

STATE-BASED QUALITY MEASURES

States will submit the following state-based quality measures:

- Acute Hospital Utilization
- Emergency Department Utilization
- Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older
- Follow up after Hospitalization for Mental Illness: Age 18 or older
- Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older
- Glycemic Status Assessment for Patients with Diabetes
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Medicaid Total Cost of Care

PRACTICE-BASED MEASURES[1]

States will develop a performance-based-payment approach using the following measures:

- Preventive Care and Screening (Tobacco Use: Screening and Cessation Intervention)
- Emergency Department Utilization
- Acute Hospital Utilization
- Controlling high blood pressure
- Glycemic Status Assessment for Patients with Diabetes
- Patient Reported Outcome Measure (PROM)

1. Medicare Practice Participants will submit Practice-based measures for Medicare beneficiaries directly to CMS.

State Quality Improvement Program (SQIP)

Prior to the start of MY6, CMS will analyze states' performance based on the performance measures from the period of January 2029 – June 2030 (Total Cost of Care, Acute Hospital Utilization, Emergency Department Utilization).

Prior to the Implementation Period, CMS, in collaboration with states, intends to establish state-specific performance benchmarks. If the state meets or exceeds the performance benchmarks, **the 10% withhold will not increase**.

Cooperative Agreement Funding			
Year (MY)	**Maximum Cooperative Agreement Funding**	**Proportion of Cooperative Agreement Funding Withheld**	
2027 (MY1)	$1,500,000	*Pre-Implementation cooperative agreement Funding is NOT dependent on SQIP Performance*	
2028 (MY2)	$1,250,000		
2029 (MY3)	$1,000,000	**CMS feedback on measure performance begins** $100,000 (10%)	
2030 (MY4)	$1,000,000	$100,000 (10%)	
2031 (MY5)	$ 1,000,000	$100,000 (10%)	
Performance Benchmark Analysis →		**Performance benchmarks met**	**Performance benchmarks not met**
2032 (MY6)	$750,000	$75,000 (10%)	$150,000 (20%)
2033 (MY7)	$500,000	$50,000 (10%)	$150,000 (30%)

Application and Submission Information

Application Submission Requirements

Applications must meet the requirements below; additional information can be found in the bolded NOFO sections.

Application Submission Requirements

- Valid Employer Identification Number (EIN) / Taxpayer Identification Number (TIN)
- Unique Entity Identifier (UEI)
- Active Login.gov account
- Registered in the System for Award Management (SAM) database (registration must be annually renewed)

Authorized Organizational Representative (AOR) Submission

- The AOR is the individual, named by the applicant/recipient organization, who is authorized to act for the applicant/recipient and to assume the obligations imposed by the federal laws, regulations, requirements, and conditions that apply to grant applications or awards
- The AOR must register with Grants.gov to obtain a username and password
- The AOR must submit the application to Grants.gov

Electronic Signature

- The electronic signature must match the AOR named on Standard Form 424

Key NOFO Sections

- **Application Instructions:** See **Section D** of the NOFO and our website (CMS Grants and cooperative agreements) for instructions on how to submit a complete application, including formatting requirements in **Section D2**.
- **Application Review Criteria:** See **Section E1** for application review criteria and see **Section E2** and our website (CMS Grants and cooperative agreements) for information on the merit review and selection process.

Application Standard Forms

All applications must include the following standard forms (SFs).

Project Abstract Summary

- One-page summary of the proposed project including the **purpose, outcomes, goals, total budget amount, and how funds will be used**
- For awardees, this will be used for information sharing and public information requests

SF 424: Official Application for Federal Assistance

- The AOR completes and signs this standard application form, which provides **essential data** about the applicant
- A strong award description will include specifics about the award **purpose**; **activities** to be performed; expected **deliverables and outcomes**; intended **beneficiaries**; and **subrecipient activities** (if known)

SF 424A: Budget Information Non-Construction

- Used to **budget and request grant funds** for non-construction programs
- Includes a detailed budget and narrative consistent with the **Project Narrative**

SF LLL: Disclosure of Lobbying Activities

- **All applicants must submit** this SF-LLL form
- If an entity does not engage in lobbying, please insert "Non-Applicable" on form fields 10a and 10b and include the required AOR name, contact information, and signature

Project / Performance Site Location

- **All applicants must submit** this Project/Performance Site Location form

Additional Application Forms (1 of 2)

All applications must include the following additional forms.[1]

Project Narrative
Maximum 60 pages

- Articulates in detail the **proposed goals, measurable objectives, and milestones**, including a practice recruitment strategy, health IT implementation plan, and other requirements

Budget Narrative
Maximum 15 pages

- Includes a **breakdown of costs**
- Provides detailed **justifications** for each proposed activity and cost
- Links each activity to the **goals** and milestones of the NOFO
- Identifies a **Project Director** who will dedicate sufficient time to the award

Letter of Intent (LOI)
No maximum

- **Optional LOI due April 1, 2026, via email** that will not impact application scoring
- Must include an **expression of interest, including the proposed regions of participation; a brief description of the interested organization; and contact information**

Program Duplication
Maximum 5 pages

- Explains how to use IBH Model funds
- Identifies how to **build upon current programs**, if applicable, while **avoiding duplication** with Medicaid, Title V, and any other federal/state/local funding for the attributed population
- Describes strategy for **avoiding program duplication** if simultaneously participating in a similar program serving the region's Medicaid beneficiaries with MSBH conditions

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 2 CFR 200.206 (*Federal agency review of risks posed by applicants*)

[1]Refer to NOFO Section D.

Additional Application Forms (2 of 2)

Appendices include required and optional components, specified below.[1]

Required

- **LOI** from **at least one MCO, PIHP, or PAHP** indicating commitment 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 **single state agencies for SUDs**
- **Resumes** and/or curriculum vitae for identified managers, Project Director, and all other key personnel identified at the time of application
- **Job descriptions** for key model personnel (can be provided in the project narrative or appendix)
- **Organization chart** (can be provided in the project narrative or appendix)

Optional

- Letters of **support** from the applicant's **governor or state legislators, hospitals, primary care providers**, and/or others
- Letters of **interest** from **specialty BH practices**

[1]Refer to NOFO Section D.

Notice of Award Process

If successful, applicants will receive a Notice of Award (NoA) signed and dated by the CMS Grants Management Officer. Selected states will also follow regulatory and policy requirements that apply to cooperative agreements.

NoA Administration

- 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 on GrantSolutions.

If the application is unsuccessful, CMS will notify the applicant electronically via the email address listed on its SF-424, within 30 days of the award date.

Grant Regulation and Policy

Regulatory and policy requirements that apply to federal grant and cooperative agreement awards include:

- **Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards** (in 2 CFR 200, with HHS-specific additions included in 2 CFR 300)
- **HHS Grants Policy Statement**
- **SAM.gov**, which includes information about the entity, exclusions, responsibility/qualification, Reps/Certs

Application Timeline and Materials

The IBH Model follows the timeline below for the NOFO, Pre-Implementation Period, and Implementation Period. HHS strongly recommends that applicants do not wait until the application due date to begin the application submission process.

Application and Model Timeline

Key Activity	Timing
NOFO Publication	October 16, 2025
Non-Binding LOI	April 1, 2026
NOFO Application Due	June 3, 2026, at 11:59 PM Eastern
Application Issuance Notice(s) of Award	September 15, 2026
Pre-Implementation Period	January 1, 2027 – December 31, 2028
Implementation Period	January 1, 2029 – December 31, 2033

Application Materials

At http://www.grants.gov, applicants may:

View application materials

Start the registration process

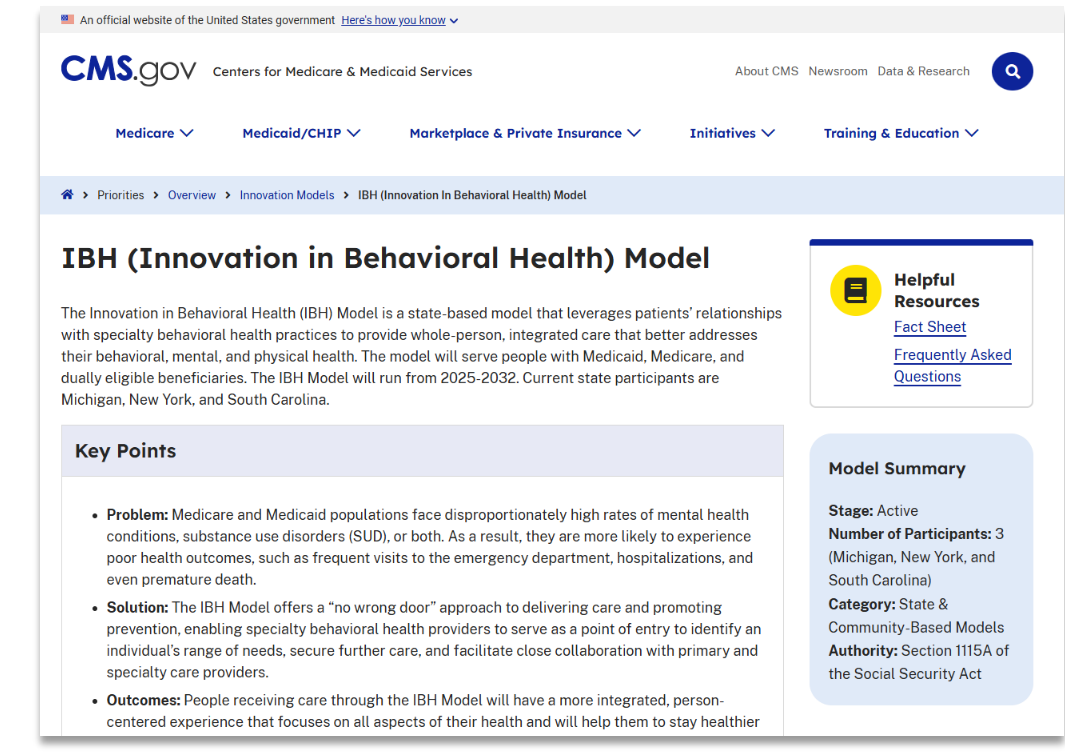
Submit applications

Closing and Resources

Application Resources

The below resources are designed to support applicants.

- IBH Model Webpage
- Frequently Asked Questions
- IBH Cohort II NOFO
- IBH Mailbox: IBHModel@cms.hhs.gov



All states interested in applying to the IBH Model will submit applications through https://grants.gov.

Thank You

We appreciate your time and interest!

Please share feedback via the post-event survey.

Questions? Email IBHModel@cms.hhs.gov.