Innovation in Behavioral Health (IBH) Cohort II Introduction Webinar

December 11, 2025

>>Jerrica Li, Deloitte: Hello everyone, and thank you for joining us. Next slide, please.

Before we get started, we would like to share some housekeeping remarks. During today's presentation, all participants will be in listen-only mode. We recommend that you listen via your computer speakers, but you also have the option to dial in from your phone. The dial-in information is available on the screen. Please feel free to submit any questions you have throughout today's presentation in the Q&A box on the right side of your Zoom window. Given today's time constraints we may not get to every question, but we will collect all the questions for future events and FAQs on our webpage. You can reach out to our helpdesk at IBHModel@cms.hhs.gov, which you'll find in the chat. There will be a brief survey at the end of the webinar, and we would welcome your feedback there.

Please note that this webinar is being recorded. This slide deck, along with the recording, and a transcript of today's webinar will be available on the IBH Model website in the coming weeks. For details about any of today's topics, please view the IBH Model website or the Notice of Funding Opportunity, NOFO, which will be the sole source of information about model details and the application process. Next slide, please.

Here is our agenda for today. We will begin with welcome and introductions, and an overview of the IBH Model. Next, we will provide an overview of funding and payment. Finally, we will close out with additional helpful resources. Next slide, please.

We have a couple of poll questions before we get started. The first one being: "Where are you calling from today?" Please type your response in the Zoom chat. Great, looks like we've got folks calling from across the country. That's awesome to see. Thank you all for joining us. All right, next slide, please.

Second polling question is: "How familiar are you with the IBH Model?" A) Very familiar B) Somewhat familiar C) Not familiar and D) Not familiar at all. Please indicate your response in the poll you see on your screen. Great, it looks like a majority of attendees are very familiar. That is amazing to see. Thank you all for participating in these polls. Next slide, please.

Now we will introduce today's speakers. Next slide, please.

Today we have the following presenters joining us: Karin Bleeg is the Director of the Division of Health Innovation and Integration at the CMS Innovation Center. Ally Marlatt and Aaron Hedquist are IBH Model Co-leads at the CMS Innovation Center. Ally will now provide an overview of the IBH Model. Next slide, please.

>>**Allison Marlatt, CMS:** Thank you, Jerrica. As mentioned, we will now provide a brief overview of the IBH Model. Next slide, please.

The IBH Model supports state Medicaid agencies and behavioral health practices in their efforts to improve quality of care and contain costs among adult Medicaid, Medicare, and dually eligible beneficiaries with moderate to severe behavioral health conditions. A complete list of diagnoses can be found in Appendix IX of the Notice of Funding Opportunity, or NOFO.

The IBH Model aims to complement and extend existing initiatives within each state. States don't have to start from scratch. A new behavioral health program can be developed, but states are also encouraged to build upon programs they already have in place, such as the Certified Community Behavioral Health Clinics, or CCBHCs, and Health Homes. We'll discuss these existing strategies in more detail later. A distinctive aspect of the IBH Model is the coordinated approach it offers for Medicaid and Medicare. Behavioral health practices in states that join the IBH Model will have the chance to take part in an integrated Medicare payment arrangement, which will be explained later on.

Notably, this is the first CMS Innovation Center model aimed at blending physical and behavioral health services specifically within behavioral healthcare environments, and for populations covered by both Medicare and Medicaid. This integrated care framework focuses on strengthening partnerships with physical health providers to better support beneficiaries' needs, encouraging the identification of, and response to, upstream drivers of health, such as nutrition, secure housing, and reliable transportation, utilizing care management and coordination to improve connections to primary care and community resources, and promoting adoption of certified health information technology, health IT, systems, and enhancing infrastructure to better serve patients. CMS will assess the effectiveness of this model, including how it improves the overall quality of care and expands access to needed care for beneficiaries. Next slide, please.

Let's take a closer look at the key collaborators who will play a vital role in the model. First, let's talk about the state Cooperative Agreement recipients, who we'll simply refer to here as "states." CMS will select up to five states through the NOFO process. Those chosen will receive funding through a Cooperative Agreement and will be responsible for leading the implementation of the IBH Model within their state or substate region. CMS strongly encourages states to team up with their agencies overseeing mental health and substance use disorders to implement the model. These partnerships will be crucial for bringing in Practice Participants and providing them with necessary technical support.

The IBH Model is intentionally structured to help states and their partners strengthen and expand existing Medicaid and state-level programs. This approach is meant to minimize administrative workload for states and boost the chances of the program's success and sustainability beyond the model's period of performance. In cases where a state's behavioral health services are managed by a managed care organization, a prepaid inpatient health plan, or a prepaid ambulatory health plan, CMS requires the state to obtain a Letter of Intent from at least one of these partners. These groups can assist in recruiting practices to participate and support them with technical guidance. Notably, states that do not have managed care organizations are still eligible to join the IBH Model. They can identify other organizations to serve in similar capacities.

With their partners, states will identify and onboard specialty behavioral health providers and help them build the infrastructure and skills they'll need for the program's success. These providers are referred to as Practice Participants. The next slide will provide more detail on the care delivery framework for the IBH Model. All adults covered by Medicare, Medicaid or both and who receive care from a Participating Practice can access IBH Model services, regardless of their specific diagnosis, so long as the provider determines the services are appropriate and medically necessary. Next slide, please.

Medicaid agencies in all 50 states, Washington D.C., and U.S. territories are eligible to apply for the IBH Model. US territories include American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. To be eligible, a state Medicaid agency must have both the authority and the capacity to accept Cooperative Agreement funding. Applicants must identify the geographic area or areas where they intend to implement the IBH Model. Agencies that are already taking part in Cohort I are not eligible for Cohort II. All applications must be submitted on www.grants.gov in response to the Notice of Funding Opportunity. The deadline is 11:59 PM Eastern Time on June 3, 2026. An optional, non-binding Letter of Intent is due by April 1, 2026.

Applicants may propose to implement the IBH Model across the entire state, or within a specific region, pending CMS approval during the application review. To receive funding each additional year, states must show that they are making satisfactory progress during the current budget period. This will be reviewed through the non-competing continuation process. I will now turn it over to Aaron who will go over practice eligibility information. Next slide, please.

>>Aaron Hedquist, CMS: Thank you.

Next, we will review the responsibilities and eligibility criteria for Practice Participants. Practice Participants are specialty behavioral health practices in settings that are located in the areas where the state has chosen to implement the Innovation in Behavioral Health Model. These practices will receive support from both the state and CMS in order to put the care delivery framework into action and to meet the other requirements of the model.

To qualify as a Practice Participant, the practice must provide outpatient care to an average of at least 25 Medicaid beneficiaries with moderate to severe behavioral health conditions per month. There must be at least one behavioral health provider affiliated with the practice. This provider can be a direct employee, a leased employee, or an independent contractor. The provider is required to have a state license to deliver behavioral health treatment services. The provider must meet all additional state-specific criteria that apply to behavioral health services. The provider must also be eligible for Medicaid reimbursement. More details about eligibility are available in Section A4.2.1 of the NOFO.

States need to recruit practices that primarily serve Medicaid beneficiaries. After enrollment, these Medicaid-serving practices can choose to apply for the Medicare component of the model by responding to a separate CMS Request for Applications, when it is released. Next slide, please.

As you can see here, the three core elements of the IBH care delivery framework are care integration, care management, and preventative care and health promotion. All states will recruit and support specialty behavioral health Practice Participants to deliver these core services.

To strengthen care integration, Practice Participants will screen, assess, and treat or refer patients for behavioral health and physical health conditions within the Practice Participant's scope of practice. Screening must also include evidence-based tools for behavioral health, physical health, and relevant upstream drivers of health such as food, housing and transportation needs. Screening results should be incorporated into individualized care plans and documented through appropriate billing mechanisms.

To support 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 management will include coordination and follow-up on referrals related to behavioral health, physical health, and upstream drivers of health.

To improve preventative care and promote improvements in health for all beneficiaries, Practice Participants will manage and monitor priority health conditions including tobacco use, diabetes, and hypertension. States may add additional health conditions based on the population health needs assessment, the PHNA. Practices should promote prevention and health education strategies and leverage existing state and practice-level population health data to inform these activities. Next slide, please.

This slide shows an example of a patient's experience with the Innovation in Behavioral Health Model. Julia experiences bipolar disorder and opioid use disorder, and she also needs help managing her diabetes. When Julia visits a behavioral health provider in her community who participates in the Innovation in Behavior Health Model, she is supported by a behavioral health team. This team includes a behavioral health provider, psychiatrist, peer support specialist, and a case manager.

The care team works closely with Julia and her family to create a care plan that fits her individual needs. Julia's behavioral health providers screen her physical health and social needs and bring together an interprofessional team. This team includes a primary care provider to help manage Julia's diabetes and a community program that delivers healthy food. Julia will partner with her primary care provider to create a specific plan for managing her diabetes. The primary care provider and the behavioral healthcare manager will regularly discuss Julia's progress and collaborate with her behavioral health providers to adjust the plan as needed. Outside of her clinical team she meets with a local organization that helps her develop a nutrition plan and connects her with a healthy food delivery program. Through the Innovation in Behavior Health Model, Julia benefits from a multidisciplinary care team that supports every aspect of her health. Next slide, please.

Now, we will share more information about the IBH Model's payment and funding. Next slide, please.

The Innovation in Behavioral Health Model provides funding through Cooperative Agreements, Infrastructure Funding, Integration Support Payments, as well as other value-based payments for carrying out the care delivery framework. As covered earlier, each state selected for the Innovation in Behavioral Health Model receives Cooperative Agreement funding every year. This funding helps states build the capacity needed to develop and run the Innovation in Behavior Health Model, and to support Practice Participants. Cooperative Agreement funding is intended to be used for state costs for developing and operationalizing the model. This funding may not be used to pay providers or services under Medicare, Medicaid, or CHIP.

Infrastructure Funding is aimed at helping Practice Participants grow their ability to implement the Innovation in Behavioral Health Model. Medicaid-only Practice Participants can receive this funding from 2027 through 2030. Those in the Medicare part of the model qualify for Infrastructure Funding from 2028 through 2031. States will use a standardized needs assessment to help distribute Cooperative Agreement funds to Medicaid-only Practice Participants. For planning purposes, states are expected to reserve around $100,000 of Cooperative Agreement funds for each Medicaid-only Practice Participant in the model. For Practice Participants involved in the Medicare track, CMS will provide Infrastructure Funding directly. States are not required to use their own or Cooperative Agreement funds for this purpose.

Beyond funding, Practice Participants can receive reimbursements known as Integration Support Payments. These payments cover the costs associated with care management for patients involved in the IBH Model. Practice Participants are also eligible for value-based payments in line with the Innovation in Behavioral Health Model's payment approach. The goal is to help practices gradually transition to value-based care. Next slide, please.

In addition to Cooperative Agreement funds for participating states, the IBH Model includes a payment approach that is aligned in both Medicaid and Medicare. Medicaid payment for model services flows from states and/or managed care organizations to Practice Participants. Practice Participants must, at a minimum, participate in their state's Medicaid payment approach to participate in the Innovation in Behavioral Health Model. Medicare payment for model services flows directly from CMS to Medicare and Medicaid Practice Participants. Next slide, please.

Now we will give an overview of the IBH Medicaid payment approach. States will begin by identifying a neutral party to host the Innovation in Behavioral Health Model convening structure by month six of Model Year 1, 2027. The convening structure will support development of the Medicaid payment approach and the care delivery framework among the relevant parties, with technical assistance from CMS, prior to the end of Model Year 2, 2028. The convening structure provides support to Practice Participants throughout the duration of the model, such as through providing technical assistance with data reporting and sharing best practices for improving behavioral health outcomes and operations.

Within the Medicaid payment approach, states will also develop an attribution methodology. States can use an existing attribution methodology, such as Health Homes, or create a unique attribution method that generally aligns with the Medicare alignment parameters. States will then use this to attribute beneficiaries to the model. The purpose of attribution and alignment is to

support key features of the IBH Model care delivery framework and introduce a two-sided risk structure for participants that rewards improvements in cost and quality. Next slide, please.

Now we'll go over the IBH Medicare payment approach. Medicare payments are provided to eligible 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 Request for Application.

The IBH Medicare Payment Approach includes two core elements: the Integration Support Payment, or ISP, and bonuses based on reporting and performance. The Medicare ISP is a prospective, per-beneficiary-per-month payment that Medicare-enrolled practices may receive starting in Model Year 3, 2029, for implementing the IBH Model care delivery framework. Specifically, this covers services such as screening, referral, and care management.

In Model Year 6 and 7, 2032 and 2033, a 2% and a 5% withhold will be introduced respectively. Practice Participants will have the opportunity to earn this withhold, based on their performance with quality measures. Medicare payment bonuses will also begin in Model Year 3, 2029. Upside payment bonuses will be based on reporting and performance on Medicare participants. These payments are designed to encourage and reward behaviors such as data reporting, care integration, efficiency, and patient-centered outcomes. Now I will pass it over to Karin who will go over a few brief closing remarks. Next slide, please.

>>Karin Bleeg, CMS: Great, thank you Aaron. As we wrap up our session today, we will highlight some ways that you can stay connected, along with some helpful resources. Next slide, please.

Please join us for an in-depth conversation about the IBH Model and its application requirements on January 15, at 2:00 PM Eastern. This was just a taste and a high-level overview, but at the webinar in January, we will provide an overview of what is in the NOFO, including a deeper dive into the model's care delivery framework, Medicaid and Medicare payment models and funding, including the funding that Aaron talked about for health IT and practice transformation, and how your state can leverage existing authorities and initiatives in your state to implement the model. And lastly, there will be information about the application nuts and bolts.

Please register for the January 15 NOFO webinar using the QR code on your screen. Also, an invitation will be sent out for the webinar in the coming weeks via e-mail. Next slide, please.

To learn more about the IBH Model, please visit the IBH Model webpage, which is in the chat. The IBH Model webpage has resources about the model including an FAQ that will also be updated in the coming months to address additional questions we've received. Also, to view application materials, start the application process, or submit an application, please visit www.grants.gov, also in the chat.

Lastly, you can also send questions to the IBH Model mailbox which is listed on this screen. Please stay posted for more information about the NOFO webinar, which we will send through our listserv next week, and then reminders in the coming weeks. For additional updates from CMS, sign up for the CMS listserv through the IBH Model webpage. Next slide, please.

This concludes today's webinar. Thank you so much for joining us today. We hope that the information was helpful. Please remember to complete the post-event survey to share your feedback on the webinar, which will appear on your screen at the end of the webinar. You can reach out to IBHModel@cms.hhs.gov with the subject line “IBH Model NOFO” with any additional questions.

We look forward to seeing all of you at our IBH Model NOFO webinar on January 15. Thank you so much. Have a great day.

###