Innovation in Behavioral Health (IBH) Model

Request for Applications (RFA) Webinar for Behavioral Health Practices in Cohort 1 States

April 30, 2026

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

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Agenda

1. Welcome and Introductions
2. IBH Model Overview
3. Practice Participant Eligibility and Requirements
4. Payment Design and Methodology
5. Application and Submission Information
6. Q&A Session
7. Closing and Resources

Welcome and Introductions

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Today's Presenters

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IBH Model Overview

IBH Model Purpose

The IBH Model tests a **value-based payment (VBP) approach** across Medicaid and Medicare that supports an **integrated Care Delivery Framework** in **specialty behavioral health settings** for adult Medicaid, Medicare, and dually eligible beneficiaries with moderate to severe **behavioral health conditions**.

PRIMARY OBJECTIVES

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

Promote **screening and referrals** for upstream drivers of health (e.g., 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 information technology (health IT)** products and infrastructure improvements

Reduce avoidable inpatient and emergency department utilization while reducing or maintaining program expenditures

IBH Model Overview

The IBH Model is an eight-year, voluntary service delivery and payment model promoting integrated care in behavioral health settings, with a period of performance from January 1, 2025, to December 31, 2032. **Cohort 1 states are Michigan (MI), New York (NY), and South Carolina (SC), and only practices in these Cohort 1 states are eligible to apply as Practice Participants.**

Specialty behavioral health practices participating in the IBH Model as a Medicaid Practice Participant in partnership with their state Medicaid agency (MI, NY, SC) **can apply and participate to become a Medicare Practice Participant annually** beginning in 2026 through 2029.

Adult Medicare, Medicaid, and dually eligible beneficiaries with moderate to severe behavioral health conditions are the target population. CMS and the Practice Participant identify eligible beneficiaries prospectively through a combination of claims-based and voluntary attribution methods.

This is an evidence-based integrated framework that is centered around the beneficiary's **whole-person care needs**, leverages an **interprofessional care team** to **deliver care coordination** that will **increase engagement with primary care and upstream drivers of health services**.

Overview of Care Delivery Framework

Practice Participants are required to deliver services outlined in the Care Delivery Framework. An overview of the framework is provided below, with specific requirements listed in the following slides.

CARE INTEGRATION

Practice Participants screen, assess, and refer patients for behavioral, physical, and upstream drivers of health needs, within the Practice Participants' scope of practice.

CARE MANAGEMENT

An interprofessional care team addresses the needs of the beneficiary and provides ongoing care management across the beneficiary's behavioral and physical health needs.

PREVENTIVE CARE AND HEALTH PROMOTION

Practice Participants engage in activities that improve health for all beneficiaries by managing and monitoring priority health conditions, including tobacco use, diabetes, and hypertension. States may add additional health conditions based on their population health needs assessment (PHNA).

Care Delivery Framework Requirements

The IBH Model's Care Delivery Framework includes three required core elements necessary to test a standard of integrated, person-centered care in specialty behavioral health practices. **The first core element is care integration**.

CARE INTEGRATION

- ✓ **Use evidence-based guidelines to screen and assess behavioral health, physical health, and upstream drivers of health needs** during the IBH Model Welcome or Reassessment Visit, and as part of ongoing patient care.
- ✓ **Confirm whether a beneficiary is engaged with a primary care provider (PCP).**
- ✓ **Develop a comprehensive care plan** with physical health consultant input as needed.
- ✓ **Consult with a physical health provider** on physical health (treatment initiation, care options and monitoring, interaction risks, and other needs).
- ✓ **Re-evaluate the care plan** based on patient outcomes.
- ✓ **Treat identified behavioral health and physical health conditions** within scope of practice or refer to appropriate providers or community-based resources.
- ✓ **Track beneficiary goals, treatment progress, and/or outcomes** using a standardized Patient-Reported Outcome Measure (PROM).
- ✓ **Implement certified health IT products** and infrastructure improvements.

Care Delivery Framework Requirements

The IBH Model's Care Delivery Framework includes three required core elements necessary to test a standard of integrated, person-centered care in specialty behavioral health practices. **The second core element is care management**.

CARE MANAGEMENT

- ✓ **Provide care management,** including person-centered planning, care coordination (e.g., scheduling and tracking referrals), utilization management, transitional care services, and health care navigation.
- ✓ **Provide beneficiary self-management support and conduct outreach and engagement activities** to promote beneficiary participation in behavioral and physical health care.
- ✓ **Establish care pathways** to track conditions over time, support progress toward care plan goals, and update the care plan as beneficiary needs change.
- ✓ **Coordinate care** for the beneficiary's behavioral health, physical health, and upstream drivers of health needs across providers and settings.
- ✓ **Track and monitor beneficiary progress** by documenting all care activities, goals, outcomes, and referrals.

Care Delivery Framework Requirements

The IBH Model's Care Delivery Framework includes three required core elements necessary to test a standard of integrated, person-centered care in specialty behavioral health practices. **The third core element is preventive care and health promotion**.

PREVENTIVE CARE AND HEALTH PROMOTION

- ✓ Focus these activities on the **prevention, management, and monitoring of priority physical health conditions**, specifically tobacco use, diabetes, and hypertension.
- ✓ **Discuss blood pressure, A1c, and/or tobacco use screening results** with the beneficiary.
- ✓ **Support medication adherence and self-management** strategies.
- ✓ **Referring beneficiaries** to preventive services or community-based programs.
- ✓ **Setting and reviewing** health goals with the beneficiary.
- ✓ **Promote prevention and health education strategies** that support whole-person health (e.g., lifestyle counseling, smoking cessation support, nutrition and physical activity guidance).
- ✓ **Leverage state and practice-level population health data to identify trends** and inform prevention and education strategies.

Technical Assistance and Education

CMS provides coordinated technical assistance (TA) and education to help state Medicaid agencies and Practice Participants **build the infrastructure, capacity, and competencies** needed to **deliver integrated behavioral and physical health care**.

NATIONAL-LEVEL SUPPORTS

CMS provides the following resources and activities to all states and Practice Participants:

- **Program guidance, accessible training, and a Help Desk** for policy and technical questions.
- **Peer learning** and performance improvement through **collaboration forums, office hours,** and **peer learning sessions.**

STATE-LEVEL SUPPORTS

CMS collaborates with state Medicaid agencies and partners to provide:

- **Practice transformation coaching** that enhances workflows, care-team coordination, and quality or reporting performance.
- **Health IT support and a state Convening Structure** to enable secure data sharing, interoperability, and stakeholder coordination.

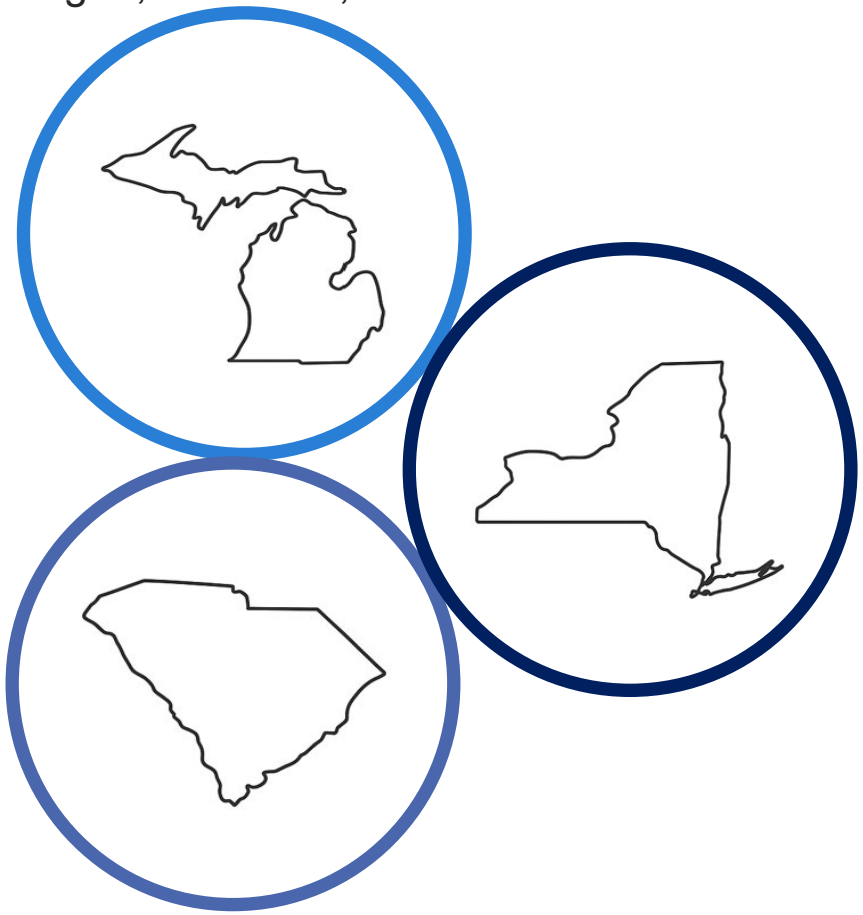
Implementation and Delivery: An **Implementation and Monitoring Contractor** provides individualized TA, peer learning, tools, and progress tracking for Practice Participants; **CMS Help Desk and Knowledge Platform** maintains FAQs, issue-tracking, and educational content; state **Convening Structure** serves as the hub for state-level collaboration and dissemination.

Continuous Learning and Improvement: CMS and its partners implement a structured TA and educational program to enable ongoing improvement across all IBH Model participants, including **quarterly feedback reports**.

Practice Participant Eligibility and Requirements

Practice Participant Eligibility

The RFA is open to **specialty behavioral health practices** in the three states selected for participation in **Cohort I (Michigan, New York, and South Carolina)** and includes the eligibility criteria below. A list of **sub-state geographic service areas** for Michigan, New York, and South Carolina can be found in the RFA in **Appendix A**.



PRACTICE ELIGIBILITY

- **Must be located in Michigan, New York, or South Carolina** in a region that has been designated by the state Medicaid agency.
- **Must be a Medicaid Practice Participant in the IBH Model that was chosen by the state.**[1] Medicare Practice Participant eligibility and participation are contingent on continued state participation in the IBH Model.
- **Must serve (or plan to serve) the Medicare population and be in good standing with CMS** and other applicable government oversight agencies.
- **Must provide mental health, substance use disorder (SUD) treatment, or both services at the outpatient level** of care to **at least 25 adult Medicaid beneficiaries per month**.
- **Must be able to adopt the IBH Model Care Delivery Framework** to care for their attributed patient population.
- **Must be accountable for quality, utilization, patient experience, and care integration** for their attributed patient population.

[1]If you are not currently a Medicaid Practice Participant in one of these three states and are interested in becoming one, please reach out to Leah Julian (MDHHS_IBH@michigan.gov) for Michigan practices, Joel Sodano (Joel.Sodano@omh.ny.gov) and Theresa Quinones (Theresa.Quinones@omh.ny.gov) for New York practices, and Margaret Garrett (Margaret.Garrett@scdhhs.gov) for South Carolina practices.

Requirements for Participation

Specialty behavioral health practices selected for participation **must demonstrate readiness to implement the IBH Model**, including meeting the criteria below.

REQUIREMENTS FOR PARTICIPATION

- **Serve Medicare beneficiaries** with Part A and Part B coverage.
- **Maintain specialty behavioral health practice enrollment and participation in the Medicare Program** through the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).
- **Adopt a Care Delivery Framework** that meets the requirements detailed in RFA Section 3: IBH Care Delivery Requirements.
- **Participate in both the Medicaid and Medicare Payment Approaches** described in RFA Section 4: Payment Design and Methodology.
- **Report on the performance measures** described in RFA Section 5: Performance Assessment.
- **Meet the health IT requirements** listed in RFA Appendix B: Certified Health IT Requirements by the beginning of model implementation (January 2028).

Payment Design and Methodology

IBH Model Funding and Payment Overview

The IBH Model Medicare Payment Approach includes **three different payment types to support the upfront infrastructure and sustainable investment** that will enable the ongoing provision of the IBH Model Care Delivery Framework.

	Infrastructure Funding	***Integration Support Payment (ISP)***	***Performance-Based Payment (PBP)***
Purpose	Support investments in health IT, interoperability, and other practice transformation needs.	Provide reimbursement for the cost of managing the care for patients attributed under the IBH Model.	Incentivize quality improvement based on the practice-based measures.
Timing	2026 – 2029 *(Model Years [MY] 2 – 5)*	2028 – 2032 *(MYs 4 – 8)*	2028 – 2032 *(MYs 4 – 8)*
Amount	Up to $200,000[1]	Paid prospectively on a quarterly basis	Paid annually and based on percentage of the earned ISP

[1]Determination of the actual amount of Infrastructure Funding disbursed, and timing and cadence, will be dependent on completion of Health IT and Practice Transformation Needs Assessment. Payment is distributed directly to Practice Participants from CMS.

Infrastructure Funding

Infrastructure Funding is designed to support Practice Participants in providing person-centered, integrated care, **improving health IT capabilities** at the clinician level, as well as **supporting practice transformation for model-aligned activities**.

Infrastructure Funding may be used for activities such as Health IT and Data Sharing Capacity Building, Telehealth Tools, and Practice Transformation.

Key Steps to Receive Infrastructure Funding

1. **Practices must complete the Health IT and Practice Transformation Needs Assessment (Health IT Needs Assessment)** on the IBH Model Salesforce Project Officer Support Tool (POST) Portal prior to submitting an application.
2. **CMS will determine Infrastructure Funding amount based on the Health IT Needs Assessment**, evaluating the following[1]:
   - Health IT capabilities, including the use of electronic health records (EHRs) and modular health IT tools
   - Use of technology that facilitates telehealth encounters
   - Capabilities for population health data capture and reporting, and associated capabilities
   - Connectivity to Health Information Exchanges (HIEs) or other Health Information Networks (HINs)
   - Commitment and capability to engage in the necessary transformation activities (e.g., based on Practice type and size, staffing requirements, regulatory adherence, etc.).
3. **Practice Participants will receive Infrastructure Funding on a yearly basis (MYs 2-5)**, after signing a Participation Agreement, and **disbursement amounts will be based on approved amounts and activities detailed in Spend Plans**.

[1]See RFA Appendix B for additional information on Certified Health IT Requirements.

Beneficiary Alignment

Eligible Medicare and dually eligible beneficiaries are **attributed to an IBH Model Practice Participant** through one of the **three mechanisms described below.**

BENEFICIARY ELIGIBILITY FOR ATTRIBUTION

- **Beneficiaries must have** Medicare Parts A and B, Medicare as the primary payer, must receive qualifying services from a Medicare Practice Participant, and be 18 years of age or older.
- **Beneficiaries must not be** enrolled in Medicare Advantage/other Medicare plans, in hospice or end-stage renal disease (ESRD) at time of initial attribution, institutionalized, attributed to certain overlapping CMS models (e.g., Psychiatric Collaborative Care Model), and fall within statutory Medicare payment exclusion criteria.
- **Beneficiaries are attributed only when services are reasonable and necessary** (i.e., the level of care required by the IBH Model Care Delivery Framework is needed).

ATTRIBUTION METHODOLOGY

- Beneficiaries are attributed **quarterly** through **voluntary attribution**, **prospective claims-based attribution**, and **on-the-spot attribution** using an IBH Model-specific billing code.
- Practices are paid prospectively, per-beneficiary per-month (PBPM), with annual reconciliation and continued freedom of choice for beneficiaries.

Integrated Support Payment

Integrated Support Payment (ISP) is a prospective, **PBPM payment that CMS pays quarterly to cover the IBH Model's care management, care integration, and whole-person integrated care services,** covering a broader set of services than what is currently covered under the Physician Fee Schedule (PFS).

Billing

- Practice Participants will use a **IBH Model-specific billing code to submit claims** and continue billing Medicare fee-for-service (FFS) for all other behavioral and physical health services.
- CMS will zero pay any prohibited claims billed by a Practice Participant based on the **IBH Model Prohibited Billing Codes list** (RFA Appendix).

Payment

- CMS anticipates the **average ISP payment to be $200 - $220 PBPM. When risk adjusted, CMS anticipates the range to be $175 - $250 PBPM.**
- ISP is **risk adjusted** based on clinical and upstream drivers of health, so beneficiaries with a greater level of clinical and upstream complexity receive higher payments aligned to their care needs.[1]
- Part B cost sharing or co-payments are not included in the ISP design to reduce participation barriers.

Reconciliation

- CMS will conduct **annual reconciliation** to account for the differences between payments provided for prospectively attributed beneficiaries and the final number of attributed beneficiaries based on the services rendered by participants.

[1]ISP amounts are risk adjusted using CMS methodology, that based on the Hierarchical Conditions Categories (HCC) and Community Deprivation Index (CDI), where all enrolled beneficiaries are assigned to one of four clinical risk tiers based on their CMS-HCC risk score, with further categorization based on their CDI percentile.

Performance-Based Payment

The Medicare Payment Approach includes a Performance-Based Payment (PBP) to encourage and **reward behaviors such as data reporting and the advancement of care quality and accountability** across multiple dimensions including care integration, care management, and population health outcomes.

PBPs will be based on performance on practice-based quality measures that focus on patient outcomes for priority health conditions, utilization of services, and includes a Patient-Reported Outcome Measure (PROM).

Year[1]	Payment Type	***Risk Structure***
2028 (MY4)	Pay-for-Reporting	3% Upside
2029 (MY5)	Pay-for-Reporting and Pay-for-Performance	4% Upside
2030 (MY6)	Pay-for-Performance	5% Upside
2031 (MY7)	Pay-for-Performance	5% Upside AND 2% Withhold
2032 (MY8)	Pay-for-Performance	5% Upside AND 5% Withhold

[1]PBP payments are based on Practice Participant activity during the prior year. PBP are expected to be made in Q3 of the year after the performance period..

IBH Model Performance Measures

The IBH Model's quality strategy uses quality measures to evaluate whether the model is achieving its underlying objectives.

PRACTICE-BASED MEASURES[1]

Practice Participants must report select practice-based measure data, for Medicare beneficiaries, directly to CMS:

- Preventive Care and Screening (Tobacco Use: Screening and Cessation Intervention)
- Controlling High Blood Pressure
- Glycemic Status Assessment for Patients with Diabetes
- Acute Hospital Utilization
- Emergency Department Utilization
- PROM (TBD)
- Upstream Drivers of Health[2]

STATE-BASED MEASURES

Practice Participants must submit aggregate level data to states for state-based measures that require more than claims data to calculate.[3] A complete list of state-based measures is listed below:

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

[1]Medicare Practice Participants submit Practice-based measures for beneficiaries directly to CMS and are not required to submit beneficiary-level data on state-based measures.
[2]Medicare Practice Participants will be required to attest to screening for upstream drivers of health.
[3]The process for this, as well as the specific measure(s) this applies to, will be outlined in the Medicare Participation Agreement.

Application and Submission Information

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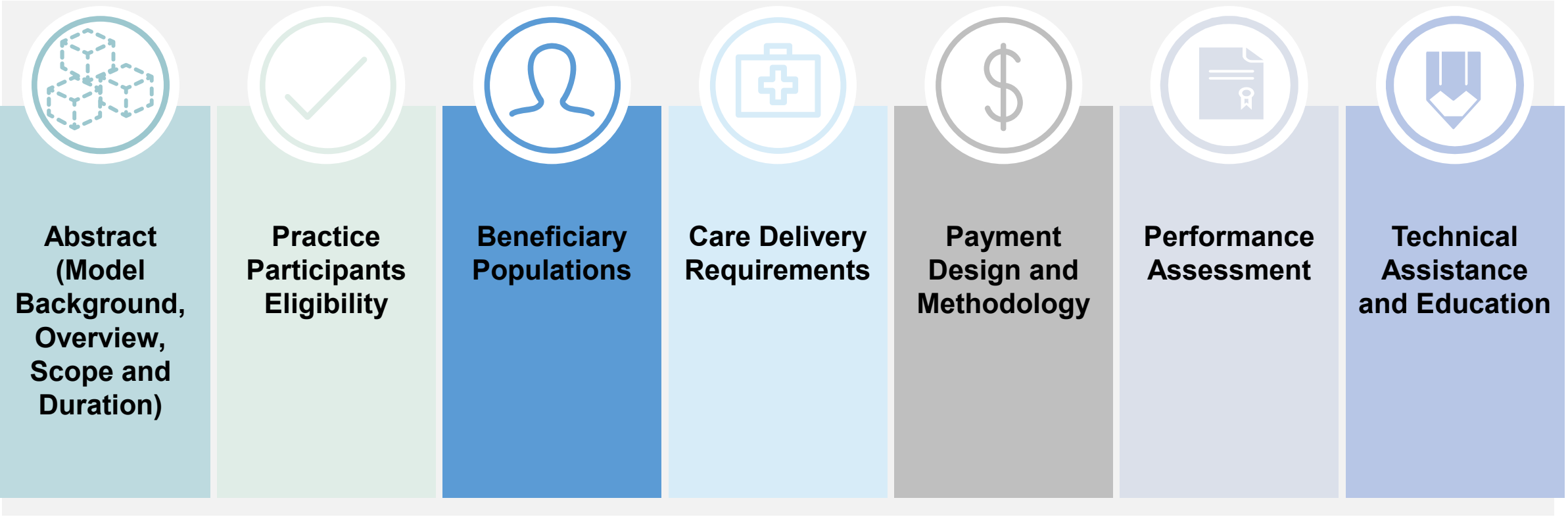
IBH Model RFA Contents

The **IBH Model RFA** includes **seven main sections**, outlined below.[1]



General application instructions, application checklist, and draft application questions can be found in the RFA in **Appendix D: Application Process**. To apply, visit https://app.innovation.cms.gov/IBH/IDMLogin.

[1]Other RFA sections include Data Reporting and Sharing, Participant Monitoring, Evaluation, Program Overlaps, and Appendices.

Application Information and Key Dates

The IBH Model RFA was released on April 16, 2026. Key application processes and deadlines are outlined below.

Key Application Steps:

- **Find the application online at https://app.innovation.cms.gov/IBH/IDMLogin.**
- **Submit an application** by answering all questions, completing the **Health IT Needs Assessment**, and attaching the required **Care Team Roster**[1].
- **Review the IBH Model Webpage** for more information about the IBH Model, including Frequently Asked Questions (FAQs).
- **Email IBHModel@cms.hhs.gov** with any questions related to the application.

Key Dates:

- **Request for Applications Period:** April 16 – May 26, 2026
- **Health IT Needs Assessment Due:** May 26, 2026
- **CMS Application Review Period:** May 27 – June 25, 2026
- **Participant Agreements (PA) Distributed:** *(Approximately)* June 26 – July 16, 2026
- **Infrastructure Funding Spend Plan Due:** July 1, 2026
- **PA Executed by Practice Participants / CMS:** *(Approximately)* July 23, 2026
- **Medicare Infrastructure Funding Disbursement:** Q3/Q4 of 2026
- **Implementation Period:** January 1, 2028 – December 31, 2032

[1]Please refer to Attachment 1 on the application portal to complete the Care Team Roster. This attachment is part of the application package and failure to submit it may result in the application being determined to be incomplete.

Application Portal Demo

Q&A Session

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Q&A

Please **submit questions via the Q&A box** to the right of your screen.

If we do not get to your question, we invite you to email the IBH Team at IBHModel@cms.hhs.gov.

Closing and Resources

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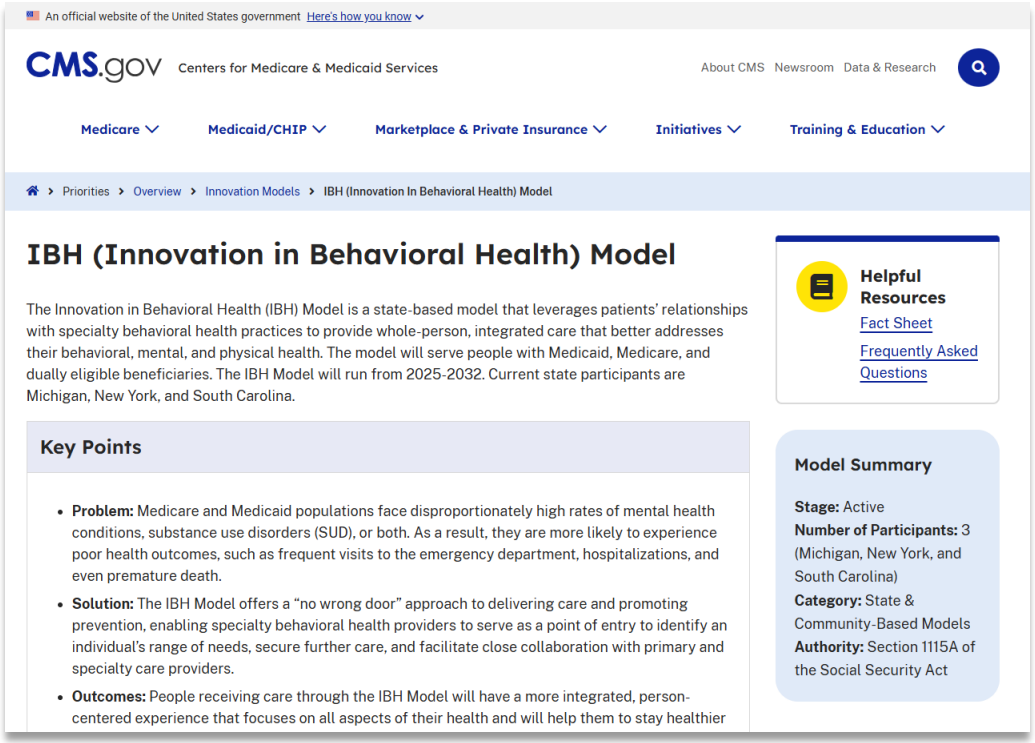
Application Resources

The resources below have been designed to support applicants.

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



Submit applications to the IBH Model at
https://app.innovation.cms.gov/IBH/IDMLogin
by May 26, 2026.

Thank You

We appreciate your time and interest!

Please share feedback via the post-event survey.

Questions? Email IBHModel@cms.hhs.gov.