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Innovation in Behavioral Health Model

Request for Applications

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Centers for Medicare & Medicaid Services (CMS)
Innovation in Behavioral Health (IBH) Model
Request for Application (RFA)

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Abstract

The Innovation in Behavioral Health (IBH) Model aims to reduce program expenditures and improve key measures of patient outcomes through more coordinated, integrated, whole-person care. The IBH Model provides a pathway for specialty behavioral health practices with varying levels of experience in value-based care (including practices new to value-based care, those supporting complex individuals, and small, independent, and rural practices) to gradually adopt prospective, capitated payments that support the integration of behavioral, physical, and community-based services.

The primary objectives of the IBH Model are to:

1. Build and strengthen connections between behavioral health and physical health care for individuals enrolled in Medicare, Medicaid, or both, with moderate to severe mental health conditions and/or substance use disorders (collectively referred to as behavioral health conditions).
2. Promote screening and referral for upstream drivers of health including nutrition, housing, and transportation needs.
3. Leverage care management and care coordination to increase access to and engagement with primary care and community services for high acuity individuals.
4. Incentivize investments in certified health information technology (health IT) products and infrastructure improvements.
5. Reduce avoidable inpatient and emergency department utilization while reducing or maintaining program expenditures.

Under the authority of Section 1115A of the Social Security Act, CMS designed the IBH Model as a voluntary eight-year multi-payer model, beginning in January 2025 and operating until December 2032 for Cohort I. The IBH Model is cooperatively implemented by the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies. Currently, the model operates in select counties in Michigan and Western New York, and statewide in South Carolina.

This Request for Applications (RFA) is an invitation to specialty behavioral health practices to apply for the Medicare arm of the IBH Model. This application is limited to practices that currently participate in the IBH Model in Michigan, Western New York, and South Carolina as a Medicaid Practice Participant. Practices that are approved for the Medicare arm of the model will be eligible for up to $200,000 in Infrastructure Funding, an average of $200 – $220 per beneficiary per month of Integration Support Payment (ISP), and the opportunity to receive performance-based payments for improving patient outcomes.

Although CMS is implementing the IBH Model first among beneficiaries who are enrolled in Traditional Medicare (fee-for-service, or FFS) and Medicaid; other payers, including Medicare Advantage Organizations, are encouraged to align with CMS to realize the goals of improved physical and behavioral health integration.

A. Model Background

The United States is currently facing an unprecedented behavioral health crisis with an increasing number of Americans experiencing mental health challenges or difficulties with substance use disorders (collectively referred to as "behavioral health"). The behavioral health system has long been uncoordinated and under-resourced, resulting in long-standing challenges.

1. **Poor Clinical Outcomes:** People with behavioral health conditions more frequently report co-occurring health conditions, such as diabetes, cardiovascular disease, and metabolic conditions, and higher rates of tobacco use,[1] and alcohol. Without adequate attention to physical health needs, adults with mental health conditions, substance use disorders (SUDs), or both, often have more emergency department (ED) visits and potentially preventable acute hospitalizations resulting from uncontrolled chronic conditions.[2] Adverse upstream drivers of health (e.g., nutrition, housing, or transportation challenges) further contribute to the medical comorbidity of people with behavioral health conditions. Due in part to these factors, people with behavioral health conditions experience worse health outcomes and have a significantly increased risk of premature mortality.
2. **Increased Expenditures:** CMS spends substantially more on care for beneficiaries with behavioral health conditions compared to spending on beneficiaries without.[3] These higher costs are not only attributable to the costs of needed behavioral health treatment, but also to the lack of coordinated, accessible care for both behavioral health and physical health conditions that can often result in poorly managed behavioral and physical health conditions. There is an opportunity for an intervention that aims to increase access to the appropriate levels of prevention and treatment, coordinated care, improved outcomes, and reduce unnecessary spending.
3. **System Challenges:** Preventive care and overusing emergency and medical inpatient care remains a challenge among the IBH Model's target population.[4] Individuals with SUDs often experience difficulties navigating the complex SUD treatment system due in part to structural barriers within the system itself such as limited access to specialty behavioral health practices and treatment, insufficient team training, and policy and legal constraints.[5] The behavioral health care delivery system is often fragmented from physical health care and lacks the integrated structures of care that promote long-term recovery.[6] While care in acute clinical settings remains important, there is a need for clinically appropriate, community-based integrated services to meet people in the settings in which they are already actively engaged.

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[1] Substance Abuse and Mental Health Services Administration (SAMHSA). Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health. 2020. p. 1-56.

[2] Chen LS, Baker TB, Korpecki JM, Johnson KE, Hook JP, Brownson RC, et al. Low-Burden Strategies to Promote Smoking Cessation Treatment Among Patients With Serious Mental Illness. Psychiatr Serv. 2018;69(8):849-51.

[3] Melek S. Potential economic impact of integrated medical-behavioral health care Milliman; 2018 January 2018.

[4] Ward MC, Druss BG. Reverse Integration Initiatives for Individuals With Serious Mental Illness. Focus (Am Psychiatr Publ). 2017;15(3):271-8.

[5] Farhoudian A, Razaghi E, Hooshyari Z, Noroozi A, Pilevari A, Mokri A, et al. Barriers and Facilitators to Substance Use Disorder Treatment: An Overview of Systematic Reviews. Subst Abuse.

[6] MACPAC. Behavioral Health in the Medicaid Program - People, Use, and Expenditures. 2015. Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality. Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). 2022.

4. **Health IT Barriers:** Many specialty behavioral health practices were not eligible for financial incentives for electronic health record (EHR) adoption that were provided to other categories of providers as part of the Health Information Technology for Economic and Clinical Health Act (HITECH Act), further exacerbating low uptake rates.[7] Interoperability across different provider types and settings of care is critical to facilitate the collaboration and communication necessary for integrated, whole-person care.

The challenges described above demonstrate the need for a broader, federally coordinated effort to advance behavioral health and physical health care integration, improve the quality of care, and test innovative payment models within Medicare and Medicaid to achieve better outcomes for beneficiaries with behavioral health needs and reduce program expenditures.

B. Model Overview

The IBH Model is an eight-year, voluntary service delivery and payment model promoting integrated care in behavioral health settings. The IBH Model will test the impact of a VBP model aligned across Medicaid and Medicare that supports an integrated Care Delivery Framework for adult Medicaid, Medicare, and dually eligible beneficiaries with behavioral health conditions.

Practice Participants: Specialty behavioral health practices participating in the IBH Model in partnership with their state Medicaid agency (MI, NY, and SC) can also apply and participate to become a Medicare Practice Participant annually beginning in 2026 through 2029. By the start of 2028, Practice Participants must meet the Care Delivery Framework requirements to receive payment from the Medicare Payment Approach (outlined in Section I. Practice Participants Eligibility).

Target Population: The IBH Model target population includes adult Medicare, Medicaid, and dually eligible beneficiaries with moderate to severe behavioral health conditions.[8] CMS and the Practice Participant identify eligible beneficiaries prospectively through a combination of claims-based and voluntary attribution methods. Practice Participants may also attribute beneficiaries into the model with on-the-spot enrollment (i.e., voluntary alignment) (Section II. Beneficiary Population(s)).

Care Delivery Framework: The IBH Model will test aligned Medicare and Medicaid Payment Approaches in select states that support an evidence-based integrated Care Delivery Framework. The framework 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. The core elements of the Care Delivery Framework include care integration, care management, preventive care, and health promotion (see Section III. IBH Care Delivery Requirements).

Medicare and Infrastructure Support Payments: The Medicare arm of the IBH Model offers an Integration Support Payment (ISP) to cover services outlined in the Care Delivery Framework. This is a prospective, risk adjusted payment that will average around $200 – $220 per beneficiary per

[7] Cohen D. Effect of the Exclusion of Behavioral Health from Health Information Technology (HIT) Legislation on the Future of Integrated Health Care. J Behav Health Serv Res. 2015;42(4):534-9.

[8] While CMS will not include Medicare Advantage beneficiaries in the prospective or retrospective attribution methodology, CMS is pursuing opportunities to engage Medicare Advantage Organizations to align their products to the IBH payment model and Care Delivery Framework.

month and will be paid quarterly to Practice Participants. The ISP will be modified by pay-for-reporting and pay-for-performance incentives. Additionally, Medicare Practice Participants will be eligible for up to $200,000 in direct funding to support health IT investments and other practice transformation activities required to implement the IBH Model Care Delivery Framework (see Section V. Payment Design and Methodology).

Performance Evaluation: The IBH Model will be evaluated on a series of practice-based performance measures. These measures will include a combination of health outcomes for priority health conditions, service utilization metrics, and patient-reported outcome measures. Practice participants will be required to report this information during the pre-implementation and implementation periods (see Section V. Performance Assessment).

C. Scope and Duration

The IBH Model is an eight-year voluntary state-based model for which all states, U.S. territories, and the District of Columbia are eligible to apply. The IBH Model will have two cohorts: Cohort I, comprised of states that CMS selected through a competitive Notice of Funding Opportunity (NOFO) in 2024 (Michigan, New York, and South Carolina) and up to five additional Cohort II states that CMS anticipates selecting through a second competitive NOFO in 2026. The model's period of performance for Cohort I states began on January 1, 2025, and will end on December 31, 2032.

Table 1. IBH Model Timeline for Medicare Practice Participants displays important milestones and target dates for the IBH Model's Cohort I. Additional information regarding prospective Cohort II states will be shared at a later date.

Table 1. IBH Model Timeline for Medicare Practice Participants

Milestone	Estimated Target Date
Request for Applications Period	April 15 to May 26, 2026
CMS Application Review Period	May 27 to June 25, 2026
Participant Agreements (PA) distributed to Practice Participants for execution	June 26 to July 16, 2026
PA is fully executed by Practice Participants and CMS	July 23, 2026
Practice Participant Pre-Implementation Period.	July 24, 2026, to December 31, 2027
Medicare Infrastructure Funding	After Participant Agreement Execution
Implementation Period	January 1, 2028, to December 31, 2032

I. Practice Participants Eligibility

A. Eligibility Requirements

This RFA is open to specialty behavioral health practices in the three states selected for participation in the IBH Model's Cohort I: Michigan, New York, and South Carolina. Eligibility criteria for specialty behavioral health practices in Cohort I includes:

- Must be located in Michigan, New York, or South Carolina in a region that has been designated by the state Medicaid agency. (See Appendix A, List of sub-state geographic service areas for Michigan, New York and South Carolina).
- Must be a Medicaid Practice Participant in the IBH Model that was chosen by the state. 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.[9]
- Must provide mental health, SUD treatment, or both services at the outpatient level of care to at least 25 adult Medicaid beneficiaries per month. This does not include the intensive outpatient level of care.
- 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.

The IBH Model targets specialty behavioral health practices that primarily serve patients with moderate to severe mental health or SUD conditions. Examples of specialty behavioral health practices who may be eligible to become Practice Participants could include but are not limited to the following.

- Community Mental Health Centers (CMHCs)
- Rural Health Clinics (RHCs) that provide specialty behavioral healthcare services
- Federally Qualified Health Centers and Look- a-Likes that are dually certified as a BH provider
- Critical Access Hospital (CAH) outpatient behavioral health clinics
- Independent health care providers with and without clinic affiliations
- Certified Community Behavioral Health Clinics (CCBHCs)
- Opioid Treatment Programs (OTP)
- Private specialty behavioral health clinics with and without medical center affiliations
- Specialty substance use disorder provider organizations
- Tribal health organizations and clinics

[9] Good standing includes, but is not limited to, that the practice is fully compliant with all state and federal regulations and licensing requirements, able to bill Medicare, that their Medicare Provider Enrollment, Chain, and Ownership System (PECOS) record is up to date, and that there is no outstanding fraud and abuse investigation or litigation involving the provider.

- Local and territorial health departments and governments or other entities that are part of a local government behavioral health authority where a locality, county, region, or state maintains authority to oversee behavioral health services at the local level and uses the entity to provide those services.

B. Requirements for Continued Participation

Specialty behavioral health practices selected for participation must show readiness to implement the IBH Model, including:

- 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 **Section III**. **IBH Care Delivery Requirements**
- Participate in both the Medicaid and Medicare Payment Approaches described in **Section IV. Payment Design and Methodology**
- Report on the performance measures described in **Section V. Performance Assessment**
- Meet the health IT requirements listed in **Appendix B: Certified Health IT Requirements** by the beginning of model implementation (January 2028)

C. Ineligible Applicants

Practice Participants will not be permitted to participate in the IBH Model as Medicare-only practices. At a minimum, Practice Participants must participate in their IBH Model's state Medicaid Payment Approach.

Specialty behavioral health practices that provide only case management,[10] or only recovery services, or do not provide direct delivery of diagnostic or treatment services for behavioral health, are ineligible to be Practice Participants.

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

[10] The Social Security Act, § 1915(g)(2), defines case management services as those assisting individuals eligible under the State plan in gaining access to needed medical, social, educational, and other services. Case management services do not include the direct delivery of an underlying medical, educational, social, or other service for which an eligible individual has been referred.

II. Beneficiary Population(s)

The IBH Model serves both Medicare and Medicaid beneficiaries, and beneficiaries who are dually enrolled in both programs. The population(s) served are adult Medicaid and Medicare beneficiaries with moderate to severe mental health or SUD conditions, or both. If services are not reasonable and necessary (i.e., the level of care required by the IBH Model Care Delivery Framework is not needed), the beneficiary will not be attributed in the IBH Model. Practice Participants are required to educate beneficiaries regarding IBH Model services and develop standardized practices to assess a beneficiary's need for the IBH Model Care Delivery Framework services.

A. Attribution Methodology for Medicare and Dually Eligible Beneficiaries

The primary goal of the attribution methodology is to identify beneficiaries who are affiliated with Practice Participants. This includes Medicare beneficiaries with and without any dual eligibility[11] and who receive qualifying services.[12] Practice Participants must be able to support and document the necessity of providing IBH Model services to the attributed beneficiary. Further, to be eligible for attribution to a Medicare Practice Participant, beneficiaries must:

- Have Medicare Parts A and B;
- Have Medicare as the primary payer;
- Receive qualifying services from a Medicare Practice Participant;
- Be 18 years of age or older;
- Not attributed to a CMS Innovation Center model listed in Section XII. Program Overlaps and Synergies;
- Not have end-stage renal disease (ESRD) or be enrolled in hospice at the time of initial attribution;
- Not be enrolled in Medicare Advantage or another Medicare health plan;
- Not be institutionalized;
- Not fall within statutory Medicare payment exclusion criteria; and
- Otherwise meet Medicare eligibility criteria.

Those eligible Medicare beneficiaries will be attributed to an IBH Model Practice Participant through one of three mechanisms described in Table 2. Attribution Methodology Summary.

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

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

Table 2. Attribution Methodology Summary

Attribution Method	Description
Voluntary Alignment	A beneficiary may voluntarily attribute themselves with a Practice Participant. Using MyMedicare.gov, a beneficiary may log into their Medicare account and select a specialty behavioral health practice and the location where they receive care on a quarterly basis. The beneficiary's choice will supersede all other attribution methodologies.
Prospective Claims-based Attribution	CMS will prospectively attribute beneficiaries to each participant prior to the beginning of every quarter using Medicare claims data. CMS will use a six-month look back period to identify beneficiaries that were served by Practice Participants. In the event of a beneficiary visiting multiple Practice Participants, CMS will attribute the beneficiary according to a plurality of visits (i.e., the Practice the beneficiary visited the most over the lookback period). CMS will share the list of identified beneficiaries with Practice Participants prior to the start of every quarter. This list of attributed beneficiaries will be used in the calculation of the participant's ISP payments. Practice participants will be required to submit the IBH-specific G-code during the month of service to indicate that services have been rendered to individuals on the prospective attribution list.
On-the-Spot Attribution	During each quarter, participants will be able to indicate to CMS that new beneficiaries should be attributed to their practice by submitting a claim using an IBH specific G-code. Prior to the start of MY 3, CMS will provide additional guidance to participants on how to submit IBH related claims.

During a calendar month, only one specialty behavioral health practice may receive the ISP for a beneficiary under this model. In order to determine which participant a beneficiary is attributed to, first CMS will determine if a beneficiary has voluntarily aligned to a participant. Second, CMS will conduct claims-based analysis to prospectively attribute beneficiaries to a participant. Third, CMS will retrospectively review on-the-spot attributions from the participants as part of its annual reconciliation process. During the reconciliation process, if multiple Practice Participants bill submit IBH G-codes for the same beneficiary, CMS will attribute the beneficiary to the Practice Participant that furnished a plurality of qualifying services.

When Medicare beneficiaries are attributed to an IBH Model Practice Participant, they will continue to have freedom of choice; IBH Model attribution will not preclude them from seeing other specialty behavioral health practices (i.e., besides the Practice Participant to whom they are attributed).

Further, the IBH Model will not restrict or change Medicare FFS benefits, though some of the services currently paid through FFS will be incorporated into the ISP and will not be paid on an FFS basis to Practice Participants. See Table 13. IBH Model Prohibited Billing Codes and Table 14. IBH Model Permitted Billing Codes.

The IBH Model also has the potential to overlap with other CMS Innovation Center models, and the model's overlaps policies are described in Section 13*:* Program Overlaps and Synergies. Further, beneficiaries aligned with the Psychiatric Collaborative Care Model (CoCM) during a calendar month may not receive IBH Model services in addition, given that CoCM services overlap with IBH Model services.

B. Reconciliation

The IBH Model will conduct an annual reconciliation to determine if any payment adjustments need to be made to account for differences in the number of beneficiaries attributed prospectively and retrospectively. Final payments may be adjusted upwards or downwards depending on if the number attributed beneficiaries are greater or fewer than those identified prospectively.

C. Medicare Advantage and Multi-Payor Alignment

Although CMS will only provide direct payment for Practice Participants' Medicare fee-for-service (FFS) population, all beneficiaries served by Practice Participants, including those enrolled in commercial plans, Medicare Advantage, and those uninsured, can benefit from enhanced care delivery because of the IBH Model.

In addition to participating in the Medicare Payment Approach, Practice Participants are required to participate in the Medicaid Payment Approach designed by their respective state Medicaid agency. CMS, in collaboration with participating state Medicaid agencies, is pursuing opportunities for future engagement of Medicare Advantage organizations to implement the IBH Model's Care Delivery Framework and payment principles.

III. Care Delivery Requirements

The Care Delivery Framework is a foundational component of the IBH Model, aligning with the model's quality and payment strategies to drive improvements in patient outcomes. It is directly tied to the IBH Model's Medicare Payment Approach and is designed to support Practice Participants in delivering high-quality, integrated care. Practice Participants will be responsible for implementing the IBH Model Care Delivery Framework by January 2028.

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 three core elements of the Care Delivery Framework are:

1. **Care integration:** Practice Participants will screen, assess, and treat and/or refer patients as needed for behavioral, physical, and upstream drivers of health needs, within the Practice Participant's scope of practice. Screening must include evidence-based tools for behavioral health, physical health, and relevant upstream drivers of health needs such as food, housing, and transportation needs. Screening results should be incorporated into individualized care plans.
2. **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 coordinating and following up on referrals related to behavioral health, physical health, and upstream drivers of health needs.

3. **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. States may add additional health conditions based on their population health needs assessment (PHNA)[13] and priorities. Practices should promote prevention and health education strategies and leverage existing state and practice-level population health data to inform these activities.

The IBH Model Care Delivery Framework is flexible enough to be implemented across various practice settings and levels of capacity, including operational, staffing, infrastructure, and clinical capabilities, while ensuring that the burden on practices does not unnecessarily increase. For instance, screening for health conditions may include, but is not limited to, reviewing the beneficiary's medical history and medications to assess current diagnoses, risk factors, or symptoms and referring them to a physical health provider, or performing screening labs or tests in accordance with evidence-based guidelines. Additionally, the IBH Model does not require treatment of physical health conditions by the specialty behavioral health practice. For example, Practice A might use referral networks to ensure that the beneficiary receives physical health care, and Practice B might co-locate physical health services on-site. All these approaches would comply with the IBH Model Care Delivery Framework. This flexibility helps ensure that the Care Delivery Framework considers the local context while guaranteeing a minimum standard of care to meet the needs of beneficiaries.

Priority Health Condition Requirements: The IBH model will focus on two physical health conditions, diabetes and hypertension, and one behavioral health condition with significant impacts on chronic physical health conditions, tobacco use disorder, to measure care integration. These three conditions are collectively referred to as priority health conditions. At a minimum, Practice Participants must screen and assess for the three priority health conditions (diabetes, hypertension, and tobacco use).

Practice Participants should work with their participating state to understand any additional care delivery requirements for participation in their state.

The requirements for the IBH Model Care Delivery Framework by core element are detailed in Table 3. Core Practice Participant Requirements below. The first column lists the core element, and the second column of the table includes Practice Participant requirements.

Initiating Visit and IBH Model Welcome Visit: The IBH Model requires an initiating visit for all beneficiaries not seen within 1 year prior to the start of IBH Model services. This visit establishes the patient's relationship with the billing practitioner and ensures the billing practitioner assesses the patient prior to enrolling into the IBH Model. Practice Participants must complete the initiating visit prior to on-the-spot attribution of a beneficiary to the IBH Model. The initiating visit is not included in the IBH Model ISP and may be billed separately under standard Medicare services, as

[13] Population Health Needs Assessment (PHNA): A comprehensive analysis provided by the Recipient (i.e., the state Medicaid agency) that assesses patterns and variations in health outcomes and service utilization within a Practice Participant's service population. The PHNA includes cultural, linguistic, geographic, and technological needs; the impacts of public health emergencies (e.g., COVID-19); and behavioral, physical, and other needs that impact health (e.g., food, housing, transportation). For complete information, reference the Notice of Funding Opportunity (NOFO) at https://www.grants.gov/search-results-detail/354873

applicable. CMS will provide each Practice Participant with a quarterly/monthly beneficiary alignment file that lists all the beneficiaries to support accurate billing.

Following the initiating visit, the beneficiary must complete the IBH Model welcome visit, which marks the start of IBH Model services. Practice Participants must conduct a reassessment to ensure the IBH Model is still necessary and appropriate for each attributed beneficiary. Reassessment should occur at least every six months or upon re-engagement following a gap in care of six months or more.

Beneficiary Assessment: As part of the initial beneficiary assessment (IBH welcome and reassessment Visits), Practice Participants will discuss a beneficiary's preferences and care integration needs to determine whether IBH Model services are reasonable and necessary.[14]

This assessment will be conducted by a billing practitioner, exercising prudent clinical judgment. If services are not reasonable and necessary (i.e., the level of care required by the IBH Model Care Delivery Framework is not needed), the beneficiary would not be enrolled in the IBH Model. Consistent with current Medicare payment policy, Practice Participants will continue to assess at each encounter whether IBH Model services are reasonable and necessary for an IBH Model enrolled beneficiary. Practice Participants should not provide IBH Model services for a beneficiary when they are no longer reasonable and necessary. CMS will monitor and audit Practice Participants using standard program integrity best practices and will recoup payment for IBH Model services that are not reasonable and necessary for the beneficiary, as supported by clinical documentation.

Practice Participant Requirements: In addition to the Care Delivery Framework requirements that are detailed in Table 3. Core Practice Participant Requirements, CMS will provide additional guidance in the Participation Agreement, which will outline the specific requirements Medicare Practice Participants must meet to receive the ISP.

[14] 16 Section 1862(a) (1) (A) of the Social Security Act directs that no payment may be made under Part A or Part B for any expenses incurred for items or services "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." An item or service is "reasonable and necessary" under §1862(a) (1) (A) of the Act if the service is: Safe and effective; Not experimental or investigational; and, Appropriate, including the duration and frequency in terms of whether the service or item is: Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve the function of a malformed body member; and, Furnished in a setting appropriate to the beneficiary's medical needs and condition. Medicare Program Integrity Manual § 13.5.4.

Table 3. Core Practice Participant Requirements

Core Element	Practice Participant Requirements
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[15] (within 30 days of attribution) or Reassessment Visit (at least every six months or upon re-engagement after a six-month break in care). • Use evidence-based guidelines to screen and assess behavioral health, physical health, and upstream drivers of health needs as part of ongoing patient care. ○ At a minimum, physical health screenings must include diabetes, hypertension, and tobacco use. ○ Practices should also assess other relevant conditions based on the state's population health needs, such as hyperlipidemia, HIV, Hepatitis C, and co-occurring behavioral health conditions. ○ Screening for upstream drivers of health should address factors such as food, housing, and transportation needs. • Select a screening instrument from one of the following options: (1) a state-required screening instrument; (2) a validated tool from the Gravity Project's list in the National Library of Medicine Value Set Authority Center; or (3) a CMS-approved instrument. • Screen to determine if a beneficiary is engaged with a primary care provider; if not, facilitate a connection to one. • Build a comprehensive care plan with input from a physical health consultant. • Consult with a physical health provider on physical health treatment initiation, care options and monitoring for complications of physical health conditions, and negative interactions of physical health with behavioral health treatment and other needs that impact health. • Re-evaluate the care plan based on patient outcomes, with input from a physical health consultant if needed. • Treat identified behavioral health and physical health conditions within the Practice Participant's scope of practice or refer to appropriate providers or community-based resources to address identified conditions, upstream drivers of health needs, and other gaps in care. • Track beneficiary goals, treatment progress, and/or outcomes using a standardized Patient-Reported Outcome Measure. • The implementation and use of certified Health IT products and infrastructure improvements for their practice and patient population.

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

Core Element	Practice Participant Requirements
Care Management	• Provide care management that includes person-centered planning, care coordination, utilization management, transitional care services, and health care navigation for each beneficiary's behavioral health, physical health, and upstream drivers of health needs that impact health outcomes. • Provide beneficiary self-management support and conduct outreach and engagement activities to promote participation in behavioral and physical health care, with support from peer support workers or other clinical staff. • Establish care pathways to ensure that identified conditions are tracked over time, beneficiaries are receiving care included in the care plan, and that updates to the care plan occur when there are relevant changes in a beneficiary's status. • Coordinate care for the beneficiary's behavioral health, physical health, and upstream drivers of health needs across providers and settings. ○ Manage care transitions, including hospitalizations, emergency department use, and other admissions, discharges, and transfers. ○ Use certified health IT, whenever possible, to create, exchange, or share standardized care coordination data with other practitioners, as practicable. ○ Facilitate direct, coordinated referrals when connecting beneficiaries to behavioral health, physical health, or community-based providers. • Track and monitor beneficiary progress by documenting all care activities, goals, outcomes, and referrals. ○ Use validated rating scales and, when possible, a registry or health IT system. ○ Track and monitor behavioral and physical health conditions and treatment needs in coordination with interprofessional care team members. ○ Document referral follow-up for health care and community-based services to ensure beneficiaries receive recommended services and supports.
Preventive Care and Health Promotion	• Focus preventive care and health promotion activities on the management and monitoring of priority physical health conditions, specifically tobacco use, diabetes, and hypertension. (alcohol use, hepatitis, HIV, prediabetes, hyperlipidemia and obesity) • Promote prevention and health education strategies that support whole-person health. • States may add additional physical health conditions based on their PHNA and priorities. • Leverage state and practice-level population health data to identify trends and inform prevention and education strategies.

IV. Payment Design and Methodology

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 (described in Section III. IBH Care Delivery Requirements).

See Table 4. IBH Payment Type and Purpose for a description of Infrastructure Funding, the Integration Support Payment (ISP), and the Performance-Based-Payment (PBP).

Table 4. IBH Payment Type and Purpose

Payment Type	Purpose
Infrastructure Funding	Installment payments for eligible Practice Participants to develop and maintain the infrastructure necessary to execute the Care Delivery Framework and participate in a VBP approach. Each Practice Participant is eligible for a maximum of $200,000 in Infrastructure Funding distributed between Model Years 2-5. However, the amount of Infrastructure Funding provided to each Practice Participant will be contingent on the results of the Health IT and Practice Transformation Needs Assessment.
Integration Support Payment (ISP)	A per-beneficiary-per-month (PBPM) payment for providing the IBH Model services outlined in the Care Delivery Framework section to eligible Medicare beneficiaries. The ISP will be paid prospectively on a quarterly basis for attributed IBH Model Medicare beneficiaries. The ISP will be risk-adjusted to reflect the clinical risk level and upstream drivers of health need of attributed beneficiaries.
Performance-Based Payment (PBP)	A payment to incentivize quality improvement on the practice-based measures listed in Table 3 Practice Based Measures. The PBP is paid annually and is based on a percentage of the earned ISP. The PBP begins with pay-for-reporting on the relevant quality measures and will shift to pay-for-performance during later model years.

A. 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.

CMS will distribute Infrastructure Funding directly to Practice Participants who participate in the Medicare Payment Approach. The total maximum amount available per Practice Participant is expected to be up to $200,000. Determination of the actual amount of Infrastructure Funding disbursed, as well as timing and cadence (e.g., all upfront or incrementally distributed over the pre-implementation period) will be dependent upon completion of an initial and subsequent Health IT and Practice Transformation Needs Assessment evaluation by the Participants. Payments will begin at the start of the Practice Participant's model participation, beginning in 2026 through 2029. A Practice Participant will receive their first payment upon, or shortly after, signing a PA for their first year of participation.

This assessment will, in part, determine the amount and cadence of subsequent Infrastructure Funding. This assessment (broadly represented in Appendix B, Certified Health IT Requirements) will gather information regarding:

a) the Practice Participant's current HIT capabilities, including the use of electronic health records (EHRs), modular HIT tools (e.g., e-prescribing, clinical decision support, the use of "apps" to facilitate data exchange with community-based organizations),

b) the Practice Participant's current use of technology that facilitates telehealth encounters,

c) the Practice Participant's current capabilities for population health data capture and reporting and associated capabilities (e.g., use of data dashboards), and

d) the Participant's current level of connectivity to Health Information Exchanges (HIEs) or other Health Information Networks (HINs).

This assessment will also collect information on a Practice Participant's commitment and capability to engage in the necessary transformation activities (e.g., based on Practice type and size, staffing requirements, regulatory adherence, etc.).

While CMS may allocate funding for health IT infrastructure to practices that demonstrate limited health IT capabilities, and a need for infrastructure enhancement to meet model aims, CMS anticipates that all Practice Participants will be eligible to receive some limited funding for practice transformation activities, even if the information provided in their application demonstrates they have advanced health IT capabilities and subsequently do not require infrastructure funding for health IT. Examples of activities supported by Infrastructure Funding include but *are not limited to* those detailed in Table 5. Example Activities for Practice Participant's Infrastructure Funding.

Table 5. Example Activities for Practice Participant Infrastructure Funding

Category of Activity	Example Activities
Health IT and data sharing capacity building	• Adoption, maintaining, and upgrading of EHRs and other HIT infrastructure, including e-consult platforms and telehealth solutions • Patient engagement IT solutions (e.g., portal adoption) Health-IT enabled tools and supports to ensure referrals to address other related health needs and physical health integration (closed loop referrals through multidisciplinary care teams) • Additional staffing to support new clinical and IT workflows and change management • Connections to state HIEs • Adoption, use and maintenance of interoperability solutions, including legal and technical costs associated with engaging in data exchange activities. • Use of standards, including support for piloting of priority emerging data standards for behavioral health.[16] Training on relevant privacy and confidentiality regulations such as 42 CFR Part 2 to promote secure and appropriate data sharing practices, population management and quality reporting.
Telehealth Tools	• Telehealth needs assessment, tools, and in-practice support and accessibility capabilities to connect the patient to a primary care or specialty behavioral health practice, including use of audio-only telehealth as appropriate. • Training and technical assistance to enhance knowledge around telehealth rules, regulations, and best practices.

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

Category of Activity	Example Activities
Practice Transformation Activities	• Developing new clinical and payment infrastructure, policies, procedures, and workflows for systematic screening and tracking of physical health conditions and other needs that impact health, referrals, or social service agency referrals as well as ongoing clinical coordination. • Implementing organization change management activities to facilitate Practice behavior change, mastery, and self-efficacy in providing integrated care. • Hiring and training care coordination staff such as peer support workers, community health workers, or other applicable staff. • Training staff on integration, goals, and new clinical workflows. • Collaborating with physical health consultants to establish care protocols. • Establishing formal or informal agreements with primary care specialty behavioral health practice and formal or informal agreements with social service organizations for enhanced referral. • Developing communication strategies to notify patients and caregivers regarding screening opportunities and clinical changes they may expect to see, such as added screenings for needs that impact health or peer support worker assistance. • Arranging for phlebotomy or increased availability of CLIA-waived laboratory testing, on site, including quality assurance and quality control standards.

Practice Participants that use Infrastructure Funding provided under the IBH Model for the type of technology investments must ensure that the technology purchased aligns with HHS-adopted standards that support interoperability, where applicable, as detailed in Table 6. IT Funding Requirements.

Table 6. IT Funding Requirements

Funding Category	Funding Requirement
Implementing, acquiring or upgrading health IT for activities by funded entity.	Use Health IT that meets applicable standards and implementation specifications adopted in 45 CFR Part 170, Subpart B, if such standards and implementation specification can support the activity. Visit Code of Federal Regulations - Title 45 to learn more.
Implementing, acquiring, or upgrading health IT for activities by eligible clinicians in ambulatory settings, or hospitals, eligible under Section 4101, 4102 and 4201 of the HITECH Act.	Use Health IT certified under the Office of the National Coordinator (ONC) for Health Information Technology (IT) Certification Program if certified technology can support the activity. Visit Certification of Health IT to learn more.

If standards and implementation specifications adopted in 45 CFR Part 170, Subpart B cannot support the activity, Practice Participants are required to use health IT that meets non-proprietary standards and implementation specifications developed by consensus-based standards development organizations. This may include standards identified by the Assistant Secretary for Technology Policy / Office of the National Coordinator for Health Information Technology (ASTP/ONC)[17], available at https://www.healthit.gov/isp/. See Appendix B, *Certified Health IT Requirements* for additional information.

Finally, in addition to the Health IT and Practice Transformation Needs Assessment, additional information provided by Practice Participants in annual spend plans and spend reporting will also contribute to determining infrastructure funding timing and cadence (for further detail, see Section. VIII. Participant Monitoring, Auditing, and Termination; this information will also be captured in the Participation Agreement "PA").

B. Integrated Support Payment (ISP)

The ISP is designed to provide Practice Participants with the necessary payment to support whole-person integrated care. The ISP will cover a broader set of services than what is currently covered for care management, care integration, and whole-person care under the Physician Fee Schedule (PFS). Practice Participants will continue to bill for all other behavioral health and physical health services under Medicare FFS. The IBH ISP will not incorporate any Part B cost sharing or co-payment as part of the IBH Model design as it could obstruct model participation.

Practice Participants must use the funding from the ISP to deliver all model services; however, they have flexibility to invest these dollars to enhance care for attributed Medicare beneficiaries

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

such as hiring new staff to carry out model activities. CMS will monitor spending of these investments and care delivery changes through regular required financial reporting.

- The ISP is designed to cover all care delivery services listed in Section III. IBH Care Delivery Requirements
- CMS will pay each Practice Participant a prospective PBPM ISP on a quarterly basis for Medicare FFS beneficiaries attributed to the IBH Model.
- Practice Participants will use a new G-Code developed for the IBH Model to submit claims.
- CMS anticipates the average PBPM payment to be $200 - $220; when risk adjusted, CMS anticipates the range to be $175 - $250 PBPM.
- CMS will conduct annual reconciliation to adjust payments 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. This adjustment may be upwards or downwards.

Table 13. IBH Model Prohibited Billing Codes, is a list of billing codes and services that are duplicative of the ISP. Medicare FFS payments for these services for the same beneficiaries would be duplicative payments to the ISP Practice Participants. CMS will zero pay any prohibited claims billed by a practice participant for an IBH attributed beneficiary.

Risk Adjustment Methodology: The ISP will be risk adjusted using a combination of clinical and upstream drivers of health information. The intention is to provide a higher payment in line with the care for beneficiaries with a higher level of clinical and upstream complications. CMS reserves the right to update the payment and risk adjustment methodology, including variable selection, calculation, or other specifications during the pre-implementation and implementation period.

All enrolled beneficiaries will be assigned to one of four clinical risk tiers. A beneficiary's clinical risk tier will be calculated using their CMS Hierarchical Conditions Categories (CMS-HCC) risk score. Further, beneficiaries will be categorized by their Community Deprivation Index (CDI) percentile. CDI is an area-level measure that serves as an assessment of relative upstream drivers of health need. Included in CDI is information on area-level education attainment, income, employment, and other measures. CMS will use the beneficiary's CDI percentile to categorize individuals in the highest risk quartile. For more information on CDI, the census block group percentiles and documentation are publicly available.[18]

Given the epidemiology and risk profile of the potentially attributable IBH-beneficiary population, CMS will calculate clinical risk scores and CDI percentiles using an IBH-specific reference population. This reference population will include all Traditional Medicare beneficiaries eligible for the IBH Model. This will be calculated within each state to account for state-by-state variations in risk scores.

CMS may introduce a risk score growth cap to safeguard against the potential that Participants could be incentivized to capture diagnoses inappropriately to generate higher ISP revenue through higher CMS-HCC scores. CMS will monitor CMS-HCC growth in the Practice Participants' beneficiary population versus a comparable Traditional Medicare beneficiary population that is not

[18] ACO REACH CDI methodology is informed from this research (https://pmc.ncbi.nlm.nih.gov/articles/PMC11629994/) and outlined in (https://www.cms.gov/files/document/aco-reach-py25-fin-op-ovw.pdf).

in the IBH Model and may place a "cap" on how much risk scores can grow versus the comparison population.

Table 7. IBH Risk Adjustment Tiers outlines the risk adjusted payment scale. The minimum payment will be set at $175 PBPM. The payments will be tiered towards beneficiaries with higher combined clinical risk scores and CDI percentile. Therefore, the maximum payment will be $250 PBPM for individuals with the highest combined clinical and upstream drivers of health need. CMS will continue to monitor ISP payment amounts and may adjust this range so that the average payment is between $200 - $220 PBPM after risk adjustment.

Table 7. IBH Model Risk Adjustment Tiers

CMS-HCC Clinical Risk Tier (Risk Score Percentile)	CDI Risk Tier (CDI Percentile)	Payment Amount
Tier 1 (<25th)	Not Applicable±	$175.00
Tier 2 (25th – 49th)	Not Applicable±	$200.00
Tier 3 (50th – 74th)	Not Applicable±	$220.00
Tier 4 (≥75th)	Tier 1, Tier 2, Tier 3 (<75th)	$240.00
Tier 4 (≥75th)	Tier 4 (≥75th)	$250.00

± *Listed as Not Applicable, because payment for beneficiaries in HCC tiers 1-3 is only based on HCC status.*

C. Performance-Based Payment (PBP)

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.

PBP payments are based on Practice Participant activity during the prior year and will be processed annually. The PBP will begin in 2028 and run through 2032. Table 8. Practice Participant Performance-based Payment Structure, displays the percentage of the ISP available for each year of the Implementation Period. The PBP will start as upside-only in 2028 – 2030 before including a performance-linked withhold in 2031 – 2032. Practices can earn a partial PBP based on whether they meet the benchmark for individual measures or the full PBP for achieving the benchmark on all measures.

The PBP will include all quality measures described in Section V. Performance Assessment and Table 9. Practice-Based Measures. These measures focus on patient outcomes for priority health conditions, utilization of services, and will include a Patient-Reported Outcome Measure (PROM). CMS reserves the right to change these measures during the pre-implementation and implementation periods. The PBP will not include the state-based quality measures listed in Table 10, State-Based Measures. The PBP has two components to incentivize improved performance, including:

1. **Pay-for-reporting (P4R):** Incentivizes reporting of quality measures aligned with IBH Model goals.
2. **Pay-for-performance (P4P):** Incentivizes achieving clinical improvements in health outcomes and screenings that align with IBH Model goals.

Each measure will be associated with a percentage of the PBP. Table 8. Practice Participant Performance-based Payment Structure exhibits the pay-for-reporting and pay-for-performance requirements, the percentage of the total PBP for each measure in 2028 and 2029. In 2031 and 2032, five (5) percent of the ISP is available for the PBP with a two (2) percent and five (5) percent withhold, respectively. In those years, practices can earn back the withhold and up to an additional five (5) percent of the ISP based on performance on Practice-based measures.

Table 8. Practice Participant Performance-based Payment Structure

Measures	**% of total PBP**	**% of ISP available for PBP**
Pay-for-reporting: 2028 - Practice Participants can receive additional incentive payments for reporting on the specified attainment threshold.		
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	20%	3% upside
Controlling High Blood Pressure	20%	
Glycemic Status Assessment for Patients with Diabetes	20%	
PROM (TBD)	20%	
Emergency Department Utilization	10%	
Acute Hospital Utilization	10%	
Pay-for-reporting and performance: 2029 – Practice Participants can receive additional incentive payments for reporting on the specified attainment thresholds for pay-for-reporting attainment thresholds and for improvements in performance for quality measures. One measure during this period will be a pay-for-performance measure and will be specified in the participation agreement.		
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	20%	4% upside
Controlling High Blood Pressure	20%	
Glycemic Status Assessment for Patients with Diabetes	20%	
PROM (TBD)	20%	
Emergency Department Utilization	10%	
Acute Hospital Utilization	10%	

Measures	% of total PBP	% of ISP available for PBP
Pay-for-performance (upside only): 2030 - Practice Participants can earn up to a five percent bonus payment for improvements in performance on the below quality measures.		
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	TBD%	5% upside
Controlling High Blood Pressure	TBD%	
Glycemic Status Assessment for Patients with Diabetes	TBD%	
Acute Hospital Utilization	TBD%	
Emergency Department Utilization	TBD%	
PROM (TBD)*	TBD%	
Pay-for-performance with two-sided risk: 2031 and 2032 - Practice Participants can earn the two to five percent ISP withhold back and then up to a five percent bonus payment for improvements in performance on the below quality measures.		
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	TBD%	5% upside 2% withhold in 2031 5% withhold in 2032
Controlling High Blood Pressure	TBD%	
Glycemic Status Assessment for Patients with Diabetes	TBD%	
Acute Hospital Utilization	TBD%	
Emergency Department Utilization	TBD%	
PROM (TBD)*	TBD%	

* The PROM will continue to be a pay-for-reporting measure throughout the IBH Model lifecycle.

V. Performance Assessment

The IBH Model's quality strategy evaluates the IBH Model's ability to achieve the goals of improving quality of care, reducing avoidable emergency department and inpatient utilization (thereby reducing Medicare program expenditures), and strengthening health information technology (health IT) systems capacity. The IBH Model's quality strategy will measure several key areas, including:

- Health outcomes for priority health conditions
- Care coordination
- Utilization of services
- Upstream Drivers of Health
- Patient-Reported Outcome Measure (PROM)
- Physical health screening

The key areas noted above will be measured through a combination of practice-based measure and state-based measures. Further details about the measures are provided in the tables below. Practices will be required to report measure data for their IBH-attributed population in a form, manner, and time specified by CMS.

Practices should note that aggregate-level data will not be sufficient for a portion of the measures; beneficiary-level data will be required for a portion of the measures. While certain details on data submission are included in this document, CMS will provide additional details regarding data submission at least 60 days in advance of each model year.

Practice-Based Measures: Though certain practice-based measures may be calculated using claims data, Practice Participants must report select practice-based measure data, for Medicare beneficiaries, directly to CMS, via a template designed by CMS. Four of the six Practice-based measures may require Practice Participants to submit beneficiary-level data.

See Table 9. Practice-Based Measures*,* for a list of pertinent information regarding practice-based measures.

Practices will not be responsible for submitting beneficiary-level data on state-based measures listed below. State-based measures for Medicare beneficiaries will be calculated by CMS using claims data, when possible. However, using claims data for some of the state-based measures will not be sufficient. For the state-based measures that require more than claims data to calculate, Practice Participants will need to submit aggregate level data. The process for this, as well as the specific measure(s) this applies to, will be outlined in the Medicare Participation Agreement. See Table 10. State-Based Measures.

Table 9. Practice-Based Measures[19]

Measure	Description	Steward	CBE Endorsement number	CMIT Measure Family ID
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (TOB)	Percentage of patients aged 12 years and older who were screened for tobacco use one or more times within the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user.	NCQA	0028	596
Controlling High Blood Pressure (CBP)	Percentage of patients ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mmHg) during the measurement year.	NCQA	0018	167
Glycemic Status Assessment for Patients with Diabetes (GSD)[20]	The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: • Glycemic Status <8.0%. • Glycemic Status >9.0%.	NCQA	0059 and 0575	204/148

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

[20] The Diabetes Control measure is formerly Hemoglobin A1c Control for Patients with Diabetes.

Measure	Description	Steward	CBE Endorsement number	CMIT Measure Family ID
Acute Hospital Utilization (AHU)[21]	For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year.	NCQA	N/A	14
Emergency Department Utilization (EDU)[22]	For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected emergency department (ED) visits during the measurement year.	NCQA	N/A	1755
Patient-Reported Outcome Measure (PROM)	Measure to be selected by CMS.	N/A	N/A	N/A

Note: Practice Participants will be required to screen for upstream drivers of health and attest to completing this requirement in a form and manner and by the date(s) specified by CMS. Participants may use the Accountable Health Communities (AHC) Screening tool, the Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE) tool, or other Logical Observation Identifiers Names and Codes (LOINC)-encoded screening tool.

[21] Only the observed rate of this measure will be calculated.

[22] Only the observed rate of this measure will be calculated.

Table 10. State-Based Measures[23]

Measure	Description	Steward	CBE[24] Endorsement Number	CMIT[25] Measure Family ID
Total Cost of Care	CMS will develop a total cost of care measure specific for Medicaid.	CMS	N/A	N/A
Emergency Department Utilization	Reports the observed and expected ED utilization rates for the population.	NCQA	N/A	1755
Acute Hospital Utilization (AHU): Age 18 and Older	The risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year.	NCQA	N/A	14
Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD)	The percentage of emergency department (ED) visits among members age 18 years and older with a principal diagnosis of a substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported: (1) The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). (2) The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	NCQA	3488	264

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

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

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

Measure	Description	Steward	CBE[24] Endorsement Number	CMIT[25] Measure Family ID
Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	The percentage of emergency department (ED) visits for members 18 years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. Two rates are reported: (1) The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). (2) The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	NCQA	3489	265
Follow-Up After Hospitalization for Mental Illness: Age 18 or older (FUH-AD)	The percentage of discharges for members 18 years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. Two rates are reported: (1) The percentage of discharges for which the member received follow-up within 30 days after discharge. (2) The percentage of discharges for which the member received follow-up within 7 days after discharge.	NCQA	0576	268

Measure	Description	Steward	CBE[24] Endorsement Number	CMIT[25] Measure Family ID
Glycemic Status Assessment for Patients with Diabetes (GSD)[26]	The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: • Glycemic Status <8.0%. • Glycemic Status >9.0%.	NCQA	0059 and 0575	204/148
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	The percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA	N/A	202

CMS will keep Practice Participants abreast of any new measures that are developed or prioritized through the annual Measures Under Consideration list[27] and may modify the measure set as the IBH Model evaluation policy develops (adding, modifying, or removing measures). CMS reserves the right to consider changes should a measure need to be suspended, suppressed, or removed due to changes in standards of care or data evaluation considerations, and CMS will communicate any changes in the measures to Practice Participants with at least 60-days advance notice and will work with Practice Participants to modify reporting requirements.

***Performance Benchmarks*:** CMS will use an IBH Model Participant's outcomes on the practice-based measures in prior performance years to determine the Participant's performance benchmarks for the performance-based payments in the current year (e.g., 2030 benchmarks will be developed using 2028 and 2029 data). CMS will calculate performance benchmarks that are specific to the IBH Model (in other words, CMS will not use benchmarks from other programs, such as MIPS).

[26] The Diabetes Control measure formerly "Hemoglobin A1c Control for Patients with Diabetes"
[27] CMS Measures Under Consideration list: https://mmshub.cms.gov/measure-lifecycle/measure-implementation/pre-rulemaking/overview

To ensure that CMS is setting accurate and meaningful benchmarks for IBH Model Participants, the IBH Model will have a "pay for reporting" approach before the "pay for performance" period begins. Specialty behavioral health practices should see Section IV. Payment Design and Methodology, for more details on this.

VI. Technical Assistance and Education

The IBH Model team will provide coordinated national- and state-level technical assistance (TA) and education to support state Medicaid agencies and Practice Participants in developing the infrastructure, capacity, and competencies needed to deliver integrated behavioral and physical health care.

A. National-Level Supports

At a national level, CMS will provide the following resources and activities to all states and Practice Participants:

1. Program guidance and education to help ensure that Practice Participants have the information they need to understand how the IBH Model works and the expectations and requirements of participation. This will likely include orientation materials, guidance documents, webinars, and 508-compliant educational modules to explain model participation requirements, operational procedures, data reporting expectations, and Performance Milestones. CMS will also maintain a Help Desk to respond to policy and technical inquiries.
2. A collaboration platform to help Practice Participants share ideas, tools, and resources and learn from each other. CMS will facilitate virtual communities of practice, office hours, and peer learning sessions that enable participants to share promising strategies, challenges, and tools to improve care integration and delivery.
3. Actionable data and reporting tools that allow participants to review performance on required measures, examine utilization and cost data for Medicare and Medicaid beneficiaries, and identify opportunities for improvement.
4. A care delivery and quality improvement reporting platform to capture information on care delivery approaches, preventive-care strategies, and model outcomes, allowing for peer-to-peer comparisons and shared learning.

B. State-Level Supports

Within each participating state, CMS will work with state Medicaid agencies and partners to deliver TA and education that align with the IBH Model's operational requirements and goals.

Table 11. State-Level Supports

Support	Description
Practice Transformation and Coaching	• Implement integrated care workflows within behavioral settings; • Strengthen interprofessional care-team coordination; • Adopt and optimize certified electronic health record (EHR) systems and interoperability tools; and • Improve performance on quality and reporting requirements.

Support	Description
Data and Health IT Technical Support	• Strengthen health information exchange (HIE) participation; • Implement secure data-sharing processes; • Leverage the Transformed Medicaid Statistical Information System (T-MSIS) and other data sources; and • Develop and execute Health IT Implementation Plans that build interoperability and analytics capacity.
Convening Structure and Stakeholder Collaboration	• Each IBH Model state will maintain a Convening Structure that brings together state partners, Practice Participants, managed-care entities, and community-based organizations to support coordination, troubleshoot operational issues, and promote learning across participants.

C. Continuous Learning and Improvement

CMS and its partners will implement a structured technical assistance and educational program to enable ongoing improvement across all IBH Model participants. Activities may include:

- Quarterly feedback reports summarizing quality, utilization, and cost trends;
- Learning collaboratives focused on integrated care delivery and preventive care;
- Annual assessments of TA effectiveness to refine future support offerings; and
- Dissemination of model updates, lessons learned, and performance benchmarks.

D. Implementation Approach and Delivery Mechanisms

The IBH Model's TA and education functions will be coordinated across multiple delivery mechanisms:

- Implementation and Monitoring Contractor provides peer learning opportunities, individualized TA, develops tools and materials, and tracks Recipient and Practice Participant progress.
- CMS Innovation Center Learning and Diffusion Group fosters peer knowledge sharing across CMS Innovation Center models in virtual meetings and online learning collaboration platforms, captures care delivery and operational changes participants make throughout model, and disseminates successful care delivery interventions and innovations.
- 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.

VII. Data Reporting and Sharing

CMS will require the use of information technology (IT) services to share, collect, and analyze information to support model operations, and will use existing CMS systems alongside new systems and processes to efficiently implement the IBH Model. In accordance with applicable law, CMS will offer Practice Participants an opportunity to request pertinent data and reports from CMS.

This opportunity to receive certain data and reports would allow Practice Participants access to information about their quality, utilization, and payment metrics relevant to model performance.

Data Sharing Systems: CMS may exchange data with Practice Participants via the following data systems.

- CMS's Data Feedback Tool (DFT) gives Practice Participants information about their quality, utilization and payment metrics relevant to model performance.
- CMS's Centralized Data Exchange (CDX) enables Practice Participants to send and receive data using Application Programming Interfaces (APIs).
- CMS's Health Data Reporting (HDR) platform enables Practice Participants to share beneficiary-level data as well as other health related screening data for analysis via Excel spreadsheets.
- The state-based learning infrastructure provides Practice Participants with support for data collection and sharing efforts.

The DFT's interactive dashboard will help Practice Participants identify the care needs and trends of their patients including supporting rapid identification of referral and follow-up needs. The qualitative and quantitative data analysis will help CMS and Practice Participants track model performance in real-time. The privacy and security of the data will be a fundamental tenet of all aspects of the data management. The IBH Model will integrate both Medicare and Medicaid data into the DFT to support the multi-payer approach of this model.

Practice Participant Data Collection: The IBH Model may use CMS's Data Feedback Tool (DFT) and Centralized Data Exchange (CDX) to collect Practice Participant reported data and share operational reports with Practice Participants. If Practice Participants lack experience with receiving and processing claims, training will be built into the IBH Model via the learning system or implementation contractor.

The IBH Model will require Practice Participants to collect certain beneficiary-level demographic data, prevention data, and population health information. This data will be reported to the CMS via a centrally managed solution (HDR platform) that uses an API to simplify and reduce the reporting burden for specialty behavioral health practices.

The IBH Model's Pre-Implementation funding is designed to assist Practice Participants in updating their EHRs and health IT systems to be compatible with data reporting at a large scale. CMS may also provide supplemental technical assistance either through the implementation contractor or additional resources from the state cooperative agreement to Practice Participants who are participating in the IBH Model, to help ensure that they are able to prepare for and execute on quality performance and operational requirements. The state-based learning platform will facilitate communication among Practice Participants and with CMS to ensure troubleshooting and technical assistance are available.

Practice Participant reporting and data sharing requirements will be outlined in the Participation Agreement. Failure to meet reporting requirements may result in corrective action, termination, or both.

VIII. Participant Monitoring, Auditing, and Termination

A. Monitoring

The IBH Model will include robust monitoring activities to ensure state awardees, their partners, and Practice Participants are implementing the IBH Model in compliance with CMS policy, and that throughout implementation the IBH Model is on track to achieve its quality and savings goals among Medicare and Medicaid populations. Before model implementation, the CMS will vet selected state awardees to ensure their Medicaid programs are in good standing with CMS. Similarly, the CMS will vet Practice Participants to ensure they are in good standing with the Center for Medicare and not the subject of investigation by the Office of the Inspector General (OIG) or other regulatory agencies. Once implementation of the payment model has begun, CMS will monitor the use of infrastructure payments, level of the ISP and other model requirements to ensure participant compliance. If necessary to meet CMMI statutory requirements to achieve savings or budget neutrality, CMS will take action to modify the IBH Model if projections show low potential for savings.

B. Auditing

CMS will conduct comprehensive audits to ensure compliance with Participation Agreements and cooperative agreements. Such audits will focus on areas where there are high risk to program integrity, including but not limited to: duplication of payment, overpayment, IBH Model attribution, provision of IBH Model services when not reasonable and necessary, potential harm to beneficiaries, and other program integrity concerns. Results of such audits could result in the recoupment of funding from Practice Participants, and potentially termination of model participation. In addition, CMS may refer a state awardee and/or their Practice Participants to the appropriate federal or state department or agency due to audit results. Practice Participants must cooperate with CMS model audits.

C. Termination

CMS reserves the right to terminate a Practice Participant's Participation Agreement at any point during the IBH Model for reasons associated with poor performance, program integrity issues, non-compliance with the terms and conditions of the applicable Participation Agreement, or as otherwise specified in the Participation Agreement or required by Section 1115A(b)(3)(B) of the Social Security Act. An IBH Practice Participant may voluntarily terminate their Participation Agreement with CMS, subject to terms that will be outlined in the IBH Participation Agreement.

CMS will conduct a Program Integrity (PI) screening of all applicants. CMS may deny selection to an otherwise qualified applicant based on information found during PI screening of the applicant or any other relevant individuals or entities associated with the applicant. For Medicare enrolled practices, the PI screening may include the following, without limitation, with respect to the applicant:

- Confirmation of current Medicare enrollment status as relevant and history of adverse enrollment actions;
- Identification of Medicare and Medicaid debt;
- Review of performance in, and compliance with the terms of, other CMS models, demonstration programs, and initiatives;

- Review of compliance with Medicare and Medicaid program requirements;
- Review of billing history and any administrative audits, investigations, or other activities conducted regarding suspicious billing or other potential program fraud and abuse; and
- Review of any administrative, civil, or criminal actions related to program integrity or other factors relevant to participation in an initiative involving federal funds.

CMS will conduct program integrity screenings throughout the application period, after selecting Practice Participants, and during the performance period, and may deny or terminate participation in the IBH Model based on the results of a PI screening or other information obtained regarding an individual's or entity's history of program integrity issues at any point during or after the application and selection processes.

IX. Evaluation

Practice Participants will be required to cooperate with CMS efforts to conduct an independent, federally funded evaluation of the IBH Model. In addition to required quality measure and patient demographic data collection efforts, this may include completion of surveys and participation in interviews, site visits, and other activities that CMS determines necessary to conduct a comprehensive mixed-methods evaluation. The evaluation will address both Pre-Implementation and Implementation Periods to assess both model impact and implementation experiences, examining outcomes such as levels of integration, quality of care, patient experience of care, utilization, and costs.

X. Program Authority and Legal Framework

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

Section 1115A(b)(2) provides a non-exhaustive list of examples of models that the Secretary may select to test, which includes models under which CMS contracts directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment (see section 1115A(b)(2)(B)(ii) of the Act); and models under which the CMS promotes care coordination between providers of services that transition health providers away from FFS based payment and toward salary-based payment (see section 1115A(b)(2)(B)(iv) of the Act).

Information Sharing and Data Privacy: CMS, IBH Model state Recipients, and local partners must comply with all applicable laws and regulations concerning information sharing and privacy. The IBH Model incorporates both horizontal information sharing (across partners on the local level) and vertical information sharing (between the Recipient's state managed care organization, and CMS). These activities may implicate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules (45 C.F.R. part 160 and subparts A, C, and E of part 164) and the Confidentiality of Substance Use Disorder Patient Records regulations (42 C.F.R. Part 2), among other federal and state laws.

XI. Merit-based Incentive Payment System (MIPS) Alternative Payment Model (APM) and Advanced APM Status

An CMS Innovation Center model may be considered a MIPS APM if it meets two criteria: 1) Participants in the IBH Model ("APM Entities") participate under an agreement with CMS or through a law or regulation; and 2) the APM bases payment on quality measures and cost/utilization. CMS requires IBH Participants to sign a participation agreement with CMS and bases payment on utilization and quality measures through performance-based payments. Therefore, the IBH Model will satisfy both MIPS APM criteria and is expected to qualify as a MIPS APM.

A model (or track within a model) must meet three specific criteria to be considered an Advanced APM: 1) require use of Certified Electronic Health Record Technology (CEHRT), 2) provide for payment based on performance on MIPS-comparable quality measures, and 3) require Participants to bear a more than nominal amount of financial risk. CMS does not expect IBH to qualify as an Advanced APM.

XII. Program Overlaps and Synergies

CMS reserves the right to prohibit simultaneous participation in IBH and other CMS initiatives, potentially include additional requirements and revise initial guidance based on several factors, including CMS' capacity to avoid counting savings twice in overlapping initiatives and to conduct a robust evaluation of each initiative. CMS may also encourage collaboration among Participants across models with the goal of enhancing the impact of models on reducing expenditures and improving quality.

CMS will allow organizations to participate in both the IBH Model and all other current CMS Innovation Center models for which they meet the eligibility criteria, as well as the Medicare Shared Savings Program. Current and future CMS Innovation Center models may establish their own model overlaps policies with the IBH Model as well. The following sections discuss overlap policies for three types of models and programs: Shared Savings Program and CMS Innovation Center ACO models; episode-based models; and CMS Innovation Center models that have care management payments.

Shared Saving Program and CMS ACO Models

- *Participant overlap:* CMS will allow Participant overlap at the TIN and NPI level with the ACO Primary Care (PC) Flex Model and the Shared Savings Program.
- *Beneficiary overlap:* Eligible beneficiaries may simultaneously be attributed to the IBH Model and attributed to Participants in ACO PC Flex or the Shared Savings Program. For beneficiaries who are aligned to both an IBH Participant and a Participant ACO PC Flex or the Shared Savings Program, the IBH Model will share beneficiary-level data on IBH Model payments with each of these programs, allowing them the flexibility to account for these payments in their benchmarking or spending calculations.

The ISP made to an IBH Model Participant for an attributed beneficiary will be included in ACOs' expenditures and benchmarks. The ISP made to an IBH Model Participant for an attributed beneficiary will count towards the shared savings or losses in the Medicare Shared Savings Program.

Episode-Based Models

- *Participant overlap:* The IBH Model will allow organizations and their practitioners that participate in episode-based payment models, such as the Enhancing Oncology Model (EOM), to participate simultaneously in IBH.
- *Beneficiary overlap:* Eligible beneficiaries may simultaneously be aligned to an IBH Participant and a Participant in the EOM model.

Models with care management payments

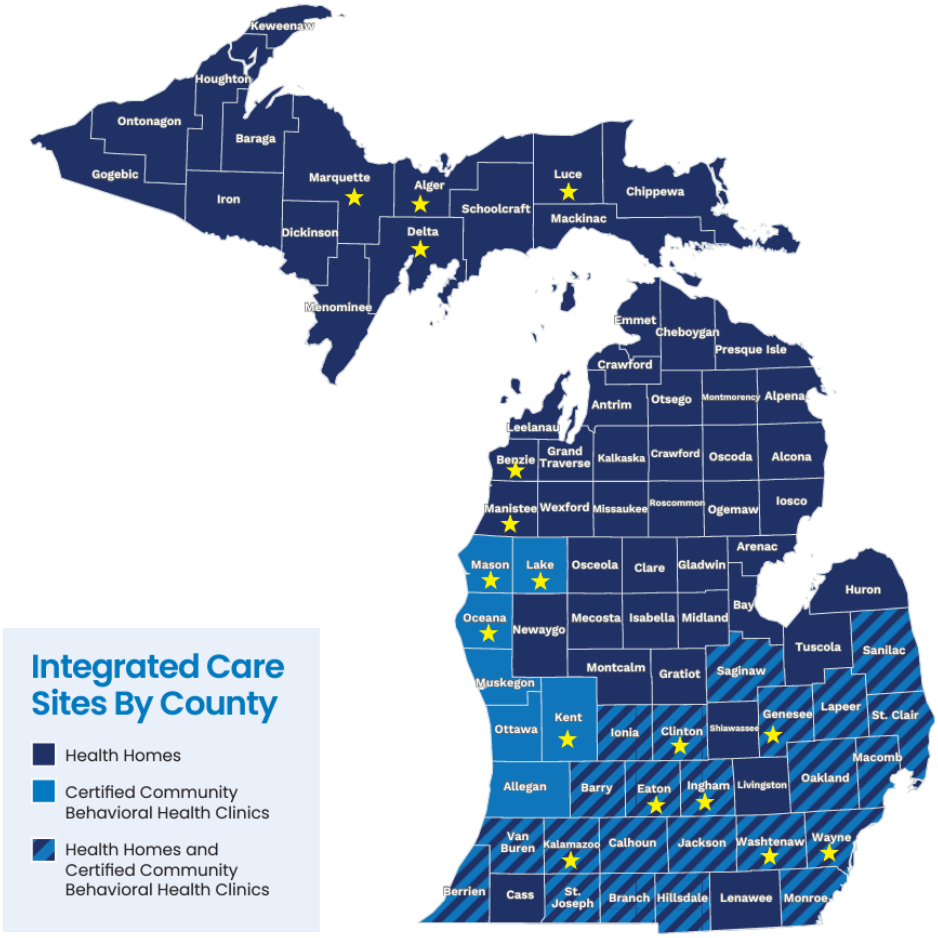
- *Participant overlap:* The ISP covers care coordination services similar to other Innovation Center models such as EOM and the Guiding an Improved Dementia Experience Model (GUIDE). IBH will permit Participant overlap at the TIN and NPI level with EOM and GUIDE.
- *Beneficiary overlap:* Eligible beneficiaries may simultaneously be aligned to an IBH Participant in the IBH Model and attributed or aligned to Participants in active CMMI models. The same provider or supplier can receive payment for care coordination under the IBH Model and another model for treating the same beneficiary who may be aligned or attributed to both models. If such an overlap occurs, the IBH Model will reconcile the overlap amount for that provider retrospectively. If only the beneficiary, and not the provider, or only the provider and not the beneficiary, overlaps with two models that have care management payments, then no payment will be recouped.

Appendix A: List of sub-state geographic service areas for Michigan, New York, and South Carolina

Michigan will implement the proposed IBH Model throughout the state, including the Upper Peninsula, and in the following counties (graphic below):

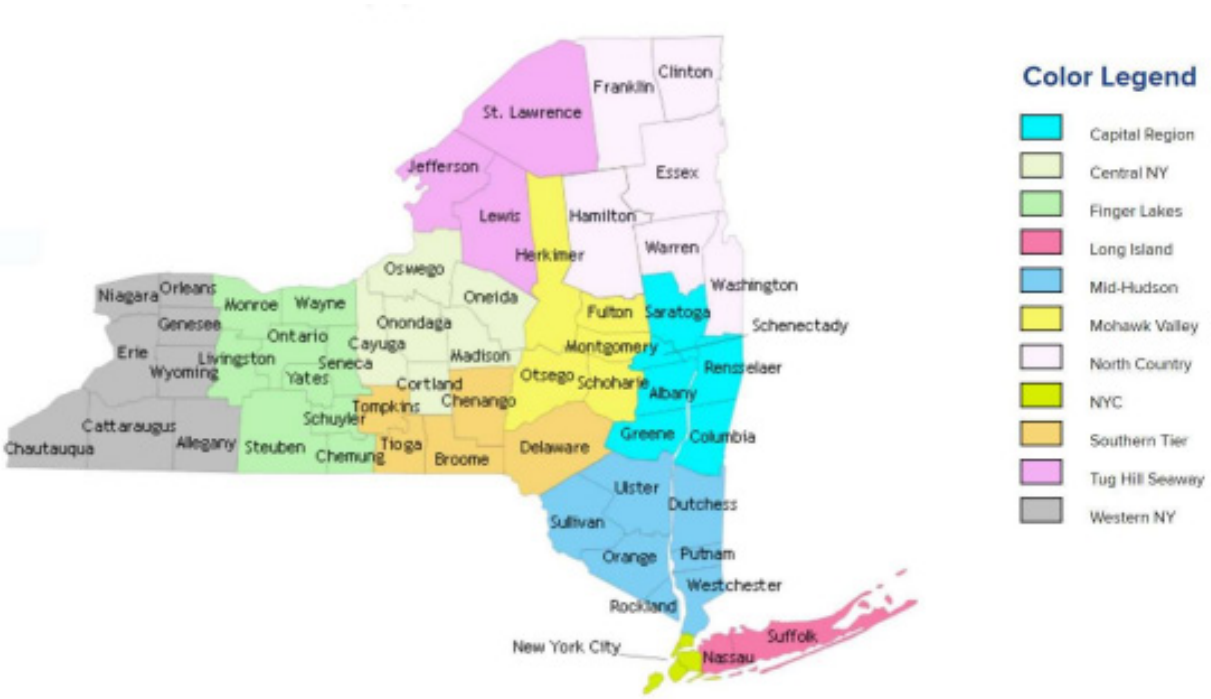
- Alger, Benzie, Clinton, Delta, Eaton, Genesee, Ingham, Kalamazoo, Kent, Lake, Luce, Manistee, Marquette, Mason, Oceana, Washtenaw, Wayne – Downriver Region*
    - *A collection of 21 suburban municipalities located south of Detroit

The 17 counties in the proposed IBH Model service area for Michigan are indicated by yellow stars:



New York will implement the proposed IBH Model in its Western Region, which includes the following counties (graphic below):

- Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming counties. The region includes a large urban center (Buffalo in Erie County), many suburban and rural communities, and tribal lands.
- The region includes a large urban center (Buffalo in Erie County), many suburban and rural communities, and tribal lands.



South Carolina will implement the proposed IBH Model in all regions of the state, and in all counties.

Appendix B: Certified Health IT Requirements

Health information exchange allows specialty behavioral health practices to securely and efficiently transmit and exchange patient health information at the point of care, often in real time. This enables better care through electronic transmission of data.

Health IT and interoperability between behavioral health and physical health practices are critical for care integration, Practice payment, and the success of the Care Delivery Framework. Patient care may be improved when specialty behavioral health practices can leverage the capabilities and efficiencies that health IT can offer both within behavioral health settings and in integrating with non-behavioral health settings, such as primary or acute care.

By the beginning of model implementation (MY4, 2028), all Practice Participants will be required to connect with a HIE. Additionally, all Practice Participants are required to adopt and use Certified Electronic Health Record Technology (CEHRT), or other health IT as detailed in Table 12, as certified under the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program by implementation. CMS may consider exceptions to these policies on a case-by-case basis.

Because health IT and data exchange capacity can vary greatly among specialty behavioral health practices, the IBH Model has worked with the Assistant Secretary for Technology Policy / Office of the National Coordinator for Health Information Technology (ASTP/ONC) to develop a set of questions Practice Participants, state Recipients, or both should ask health IT vendors to ensure they are meeting any technology requirements of the IBH Model. Completing this “Health IT and Practice Transformation Needs Assessment” will facilitate Practice Participants’ use of evidence-based tools to improve access and adherence to care and consider how they will interact with the patient’s longitudinal records.

The adoption of health IT capabilities that support patient engagement (e.g., a portal integrated into the Practice Participant’s EHR, or a smartphone app connected to an EHR via an application programming interface) is important in engaging patients and their families and caregivers to take ownership for their health and improve the patient experience. Furthermore, digital health tools, including those facilitating clinical measurement (e.g., PHQ) and interventions (e.g., SBIRT), can augment Practice capabilities, including FDA-approved digital therapeutics for use by patients. These tools may be incorporated within an EHR, interface with the EHR directly, or be entirely separate.

During the application process, applicants may use the elements detailed in the IBH Model Notice of Funding Opportunity (NOFO) to gain an understanding of what type of HIT and Practice Transformation will be expected of them if selected to participate. These elements are represented in a “Health Information Technology and Practice Transformation Needs Assessment,” which each Practice Participant will need to complete. The information requested is broadly represented in the NOFO HIT Requirements Table (represented here in Table 12. Certified Health IT Capabilities). This will, in part, determine the amount and cadence of subsequent infrastructure funding.

This assessment will glean information regarding the following:

- The Practice Participant's current health IT capabilities, including the use of electronic health records (EHRs), modular health IT tools (e.g., e-prescribing, clinical decision support, these use of "apps" to facilitate data exchange with community-based organizations).
- The Practice Participant's current use of technology that facilitates telehealth encounters.
- The Practice Participant's current capabilities for population health data capture and reporting and associated capabilities (e.g., use of data dashboards).
- The Practice Participant's current level of connectivity to Health Information Exchanges (HIEs) or other Health Information Networks (HINs). This is further described in section 5A, *Infrastructure Funding.*

Table 12. Certified Health IT Capabilities describes the health IT requirements detailed above for IBH Model Practice Participants. The minimum requirements below provide the minimum necessary health IT capabilities for participation in the IBH Model.

Table 12. Certified Health IT Capabilities

Requirement	Notes
Certified Health IT Capabilities	
"Capture demographic information	See certification criterion for "Patient demographics and observations."[28]
At a minimum, support care coordination by sending and receiving summary of care records.	See certification criterion (i) under "Transitions of care."[29]
Provide people receiving services with timely electronic access to view, download, or transmit their health information or to access their health information via an API using a health app of their choice.	See certification criteria for "View, download, and transmit to 3rd party"[30] and "Standardized API for patient and population services." [31]
Utilize decision support tools.	See certification criterion for "Decision support interventions."[32]
Conduct electronic prescribing, if applicable.	See certification criterion for "Electronic prescribing."[33]

[28] 45 CFR 170.315(a)(5), see https://www.healthit.gov/test-method/demographics

[29] 45 CFR 170.315(b)(1), see https://www.healthit.gov/test-method/transitions-care

[30] See 170.315(e)(1) at https://www.healthit.gov/test-method/view-download-and-transmit-3rd-party

[31] 45 CFR 170.315(g)(10), see https://www.healthit.gov/test-method/standardized-api-patient-and-population-services

[32] 45 CFR 170.315(b)(11), see https://www.healthit.gov/test-method/decision-support-interventions

[33] 45 CFR 170.315(b)(3), see https://www.healthit.gov/test-method/electronic-prescribing

Requirement	Notes
Exchange information in accordance with an unexpired version of the United States Core Data for Interoperability (USCDI) adopted for use in the ONC Health IT Certification Program[34]	Incorporated as part of health information exchange criteria.
Information Blocking	
Practice Participants in the IBH Model must comply with applicable law, including but not limited to, the information blocking provisions of the 21st Century Cures Act.	A health care provider or developer of certified health IT, HIN or HIE, must know that a practice is unreasonable and is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information to meet the definition of information blocking.[35] For more information about information blocking, see: https://www.healthit.gov/topic/information-blocking
Health Information Exchange	
Participate in health data exchange (e.g., by connecting to an HIE or health information network) to facilitate exchange of electronic health information for care coordination, including participating in arrangements to receive electronic notifications for patient transitions of care.	The term "HIE" broadly refers to arrangements that facilitate the exchange of health information and may include arrangements commonly denoted as exchange "frameworks," "networks," or using other terms. HIEs shall be capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs and shall not engage in exclusionary behavior when determining exchange partners.
Preventive Care and Population Health	
Track upstream drivers of health screening information and link to community-based organizations for referral and follow up.	Practice Participants may, but are not required to, use IBH Model upfront funding to update existing EHRs to be able to track other needs that impact health screening information and link to community-based organizations for referral and follow up.
Model Reporting	
Maintain Health IT Details Tab in the Practice Portal	Practice Participants must maintain up-to-date health IT information in the Practice Portal as required by CMS.

[34] Currently adopted versions of the USCDI are specified at 45 CFR 170.213. For more information about USCDI, see https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi

[35] See Public Health Services Act section 3022(a)(1)(B)(ii) and section 3022(a)(1)(B)(i)

Exceptions: CMS may exempt potential Practice Participants from these certified health IT requirements on a case-by-case basis if the CMS determines that certified health IT is not applicable to the behavioral health services provided by the Participant.

For these Practice Participants, CMS shall define alternative requirements for these Practice Participants to ensure they are effectively coordinating care with other specialty behavioral health practices and be subject to a monitoring plan. CMS will provide technical assistance, guidance, and best practices on how to address the health IT needs of these Practice Participants. Note that Practice Participants may only use Infrastructure Funding for adopting health IT that meets the requirements in Table 12.

Appendix C: Prohibited and Permitted Billing Codes

The IBH Model incorporates specific care management and behavioral health integration services into the PBPM payment. As a result, Medicare FFS payments will not be made separately for these services when furnished to beneficiaries who consent to receive IBH Model services.

Table 13: IBH Model Prohibited Billing Codes identifies the Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes that correspond to services covered under the PBPM payment and, therefore, during months of active enrollment, may not be billed separately under FFS for beneficiaries who consent to receive IBH Model services.

Table 14, *IBH Permitted Billing Codes* with Potential Payment Duplication Concerns lists codes that are allowable under Medicare but could overlap with IBH Model-funded activities. These codes are not prohibited; however, practices should use caution and maintain documentation to ensure that billing these services does not duplicate payment for work already supported under the PBPM.

All CPT® and HCPCS codes listed in these tables and throughout this document are current as of the Calendar Year 2026 Medicare Physician Fee Schedule Final Rule and are subject to change through future rulemaking or CMS guidance. CMS will notify IBH Model Participants of any updates to prohibited or conditionally permitted billing codes.

Table 13. IBH Model Prohibited Billing Codes

Category	CPT® and HCPCS Codes	Description
Chronic Care Management (CCM)	99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: • multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; • chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; • comprehensive care plan established, implemented, revised, or monitored
CCM	99439	Add-on code for 99490; additional 20 minutes per month

Category	CPT® and HCPCS Codes	Description
CCM	99491	Chronic care management services, provided personally by a physician or other qualified healthcare professional, at least 30 minutes of physician or other qualified healthcare professional time, per calendar month, with the following required elements: • multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; • chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; • comprehensive care plan established, implemented, revised, or monitored.
CCM	99437	Add-on code for 99491, additional 30 minutes per month
Complex CCM	99487	Complex chronic care management services, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or function decline, • Establishment of substantial revision of a comprehensive care plan, • Moderate or high complexity medical decision making; • 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
Complex CCM	99489	• Add-on code for 99487, additional 30 minutes per month
Complex CCM	G0506	• CCM code G0506 requires that the physician or qualified healthcare (QHP) professional must personally perform and document face-to-face assessments beyond what is reflected in the initiating visit and monthly CMC service codes. The Physician or QHP is responsible for personally performing the care planning, all required elements of the care plan must be documented and the work must bear signature of the physician or other QHP.

Category	CPT® and HCPCS Codes	Description
Principal Care Management (PCM)	99424	PCM services performed by a physician or QHP, initial 30 minutes per month, with the following required elements: • One complex chronic condition expected to last at least 3 months • Chronic condition places the patient at significant risk of death, hospitalization, acute exacerbation/decompensation, or function decline • Chronic conditions require frequent adjustments in the medication regimen and/or management that's unusually complex due to comorbidities • Ongoing communication and care coordination between relevant practitioners furnishing care, which can be carried out via telehealth or virtual/remote devices • Creation of a disease-specific care plan
PCM	99425	• Add-on code for 99424, additional 30 minutes per month
PCM	99426	• Same as 99424 above, performed by clinical staff under the direction and guidance of a physician or QHP
PCM	99427	• Add-on code for 99426, additional 30 minutes per month
Advanced Primary Care Management (HCPCS)	G0556	• A physician or other qualified healthcare provider (Non-physician practitioner, physician assistant or clinical nurse specialist) directs advanced primary care (CMS program) service: Services include: • Conducting initiating visit – can be a wellness visit by the provider responsible for the APCM care • Provide 24/7 access and continuity of care • Develop, implement, revise, and maintain an electronic patient-centered comprehensive care plan • Coordinate care transitions • Coordinate practitioner, home, and community-based care • Provide enhanced communication opportunities to patients to communicate with their provider • Conduct patient population-level management that includes gaps in care, and needed services • Measure and report performance

Category	CPT® and HCPCS Codes	Description
Advanced Primary Care Management (HCPCS)	G0557	• This code is used in place of G0556 if the patient has two or more chronic conditions. These conditions must: ○ Be expected to last at least 12 months or until the death of the patient ○ Place the patient at risk of death, acute exacerbation/decompensation, or functional decline • The services include all of the requirements for code G0556
Advanced Primary Care Management (HCPCS)	G0558	• This code is used in place of G0557 if the patient is a Qualified Medicare Beneficiary (a CMS program that helps low-income individuals pay for Medicare premiums and cost-sharing) with 2 or more chronic conditions. These conditions must: ○ Be expected to last at least 12 months or until the death of the patient ○ Place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline • The services include all of the requirements for code G0556
Psychiatric collaborative care management services	99492	• A Practice performs psychiatric collaborative care management (CoCM) for a patient receiving behavioral health treatment and regular psychiatric inter-specialty consultation in collaboration and in conjunction with a patient's treating (or billing) primary care Practice. Report 99492 for the initial 70 minutes of CoCM in the first calendar month.
	99493	• A Practice performs psychiatric collaborative care management (CoCM) for a patient receiving behavioral health treatment and regular psychiatric inter-specialty consultation in collaboration and in conjunction with a patient's treating (or billing) primary care Practice. Report 99493 for the first 60 minutes of CoCM in a subsequent month after the first month of care.
	99494	• A Practice performs psychiatric collaborative care management (CoCM) for a patient receiving behavioral health treatment and regular psychiatric inter-specialty consultation whose conditions are not improving in collaboration and in conjunction with a patient's treating (or billing) primary care Practice. Report this code in addition to 99492 or 99493 for each additional 30 minutes of initial or subsequent psychiatric care management in a calendar month, in addition to the primary codes.

Category	CPT® and HCPCS Codes	Description
Psychiatric collaborative care management services *(continued)*	G2214	• Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified healthcare professional. Must contain the elements of 99492, 99493, or 99494.
Behavioral health Integration/ Care management services for behavioral health conditions	99484	• Care management services for behavioral health by clinical staff members spend at least 20 minutes per calendar month coordinating and managing a patient's behavioral health services under the direction of a physician or other qualified health care professional.
	G0323	• Describes general BHI that a clinical psychologist (CP) or clinical social worker (CSW) performs to account for monthly care integration • A CP or CSW, serving as the focal point of care integration furnishes the mental health services • At least 20 minutes of CP or CSW time per calendar month
	G0511	• HCPCS code G0511 for Rural health clinic for FQHC or RHC only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or an FQHC practitioner (Physician, NP, PA, CNM), per calendar month as maintained by CMS.
Community Health Integration Services	G0019	• Community health integration services performed by certified or trained auxiliary Practice Participant, including a community health worker, under the direction of a physician or other practitioner, 60 minutes per calendar month, in the flowing activities to address social determinants of health that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit
	G0022	

Table 14. IBH Model Permitted Billing Codes

Category	HCPCS Code	Description
Administration of a standardized, evidence-based assessment of physical activity and nutrition	G0136	• Administration of a standardized, evidence-based assessment of physical activity and nutrition, 5-15 minutes, not more often than every 6 months.
Principal illness navigation services	G0023	• Principal Illness Navigation services by certified or trained auxiliary Practice Participant under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month
	G0024	• Principal Illness Navigation services, additional 30 minutes per calendar month
	G0140	• Peer Support by certified or trained auxiliary Practice Participant under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month
	G0146	• Principal Illness Navigation – Peer Support, additional 30 minutes per calendar month
Complexity add-on	G2211	• Is for evaluation and management (E/M) visits that are part of an ongoing, longitudinal care relationship. It is an add-on code that can be listed separately in addition to office/outpatient E/M visits for new or established patients (i.e., codes 99202-99215).

Appendix D: Application Process

This document is **not** the application to be filled out by the specialty behavioral health practice applicant. **This is a draft list of the questions that may be found in the online application portal**. This list is for your reference as you assemble your application. CMS reserves the right to seek additional information from applicants to the IBH Model after the application period closes. The Request for Application outlines all programmatic requirements and the latest IBH Model policy. Any specialty behavioral health practice applicant interested in applying to the IBH Model should also review the June 17, 2024, NOFO for more information on the policies outlined in this Request for Application. The NOFO is found here.

Applicants that are interested in the IBH Model as a Medicare Practice Participant but are not ready to apply can also reach out to CMS at IBHModel@cms.hhs.gov to express their interest in the IBH Model. CMS reserves the right to share expressions of interest with the relevant Recipients, as applicable (i.e., the state in which the applicant practices).

The application must be certified as true, accurate, and completed by an individual authorized to represent the specialty behavioral health practice (i.e., the legal entity submitting the application). The application will be found online at: link - https://app.innovation.cms.gov/IBH/IDMLogin.

Questions about the application for IBH should be directed to IBHModel@cms.hhs.gov.

CMS may publicly share questions or responses or compile them into a Frequently Asked Questions list to ensure that all interested specialty behavioral health practices have access to information regarding the IBH Model.

General Instructions

All applications will be assessed to determine the specialty behavioral health practice applicant's eligibility to participate in the IBH Model. Specialty behavioral health practices that apply and are identified to be eligible will then be scored based on application scoring criteria and responses to questions in the application. Specialty behavioral health practices that apply and are accepted to the IBH Model will be called Practice Participants. The first Pre-Implementation Year for Practice Participants for Cohort I is 2026.

Specialty behavioral health practices applying to the IBH Model must answer all application questions. CMS reserves the right to seek additional information from specialty behavioral health practice applicants after the application period closes.

This application is not a legally binding contract. If selected, CMS will require selected specialty behavioral health practice applicants to sign a Participation Agreement with CMS before beginning participation in the IBH Model. The Participation Agreement will contain greater detail regarding model requirements, and some aspects of the IBH Model may be modified as CMS continues to consider stakeholder feedback and operational issues.

CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5 U.S.C. § 552a) and other applicable laws and agency policies. For more information, please see the CMS Privacy Policy at https://www.cms.gov/privacy.

Application Check-Off List

Eligibility Requirements

The questions in this section are required to move forward with the application to the IBH Model. The answers to these questions impact your organization's eligibility for the IBH Model and may disqualify you from completing the remainder of the application. Please note, practice eligibility for the IBH Model is dependent on your participation in the state Medicaid agency's (Recipient's) Medicaid Payment Approach.

1. I certify that I am applying with a taxpayer identification number (TIN) that is enrolled in Medicare Part B and eligible to bill under the Medicare Physician Fee Schedule (PFS), or that prior to signing the participant agreement, will be enrolled in Medicare Part B and eligible to bill under the PFS. Please select one:

   ☐ YES, I certify that I am applying with a TIN that is enrolled in Medicare Part B and eligible to bill under the PFS.

   ☐ YES, I certify that prior to signing the participant agreement, I will enroll in Medicare Part B and be eligible to bill under the PFS.

   ☐ NO

2. The specialty behavioral health practice applicant is an entity listed in the eligibility section of this RFA (list only one entity that will serve as the Practice Participant). If you select Other fill in the entity that will serve as a Practice Participant:

   ☐ Community Mental Health Centers (CMHCs)

   ☐ Rural Health Clinics (RHCs) that provide specialty behavioral healthcare services

   ☐ Federally Qualified Health Centers (FQHCs) and Look- a-Likes that are dually certified as a behavioral health provider

   ☐ Critical Access Hospital (CAH) outpatient behavioral health clinics

   ☐ Independent health care providers with and without clinic affiliations

   ☐ Certified Community Behavioral Health Clinics (CCBHCs)

   ☐ Opioid Treatment Programs (OTP)

   ☐ Private specialty behavioral health clinics with and without medical center affiliations

   ☐ Specialty substance use disorder provider organizations

   ☐ Tribal health organizations and clinics

☐ Local health departments or similar governmental entity with authority to oversee behavioral health services at the local level (specify below)

☐ Other (specify below) (maximum of 255 characters)

3. Is the specialty behavioral health practice applicant identified by a single TIN for billing purposes?

   ☐ YES (Please provide)

   ☐ NO (Please provide the identifier that will be used to bill Medicare when participating in the program)

4. Is the applicant capable of repaying demonstration payments to CMS, if applicable? See *Section IV. Payment Design and Methodology* of the RFA for more information.

   ☐ YES

   ☐ No (if no, the applicant is ineligible)

5. Is applicant able to establish reporting mechanisms, including but not limited to mechanisms for reporting on quality measures?

   ☐ YES

   ☐ NO (if no, the applicant is ineligible)

6. Specialty behavioral health practices must comply with all model requirements and show readiness to implement the IBH Model. Can the applicant show readiness for the following? (Check those that apply).

   ☐ Accept Medicare Payment Approach described in Section IV, *Payment Design and Methodology*

   ☐ Report on performance of the measures described in Section V, *Performance Assessment*

   ☐ Meet health IT requirements listed in Appendix B, *Certified Health IT Requirements*

   ☐ Serve Medicare beneficiaries with Part A and Part B coverage

- ☐ Adopt a Care Delivery Framework that meets the requirements detailed in Section III, *IBH Care Delivery Requirements*
- ☐ Facilitate and maintain provider enrollment and participation in the Medicare Program through PECOS
- ☐ Comply with any state-specific IBH Model requirements

7. The applicant's care team is able and available to provide diagnosis and management of behavioral health services.
   - ☐ YES
   - ☐ NO (if no, the applicant is ineligible)
8. Does the applicant use telehealth (including audio only) for assessment and treatment where telehealth appointments are otherwise allowed?
   - ☐ YES
   - ☐ NO

Applicant Governance Structure and Compliance

This section requests information regarding the applicant's governance structure. Governance structure questions are intended to illustrate how the applicant's organizational layout or governance can readily accommodate implementation and responsibilities of the IBH Model. If you have a question about organizational structure that is not addressed in the Request for Applications (RFA) or in the Application Instructions, please contact CMS at IBHModel@cms.hhs.gov.

9. Contact Information (individual filling out the application)
   a. First and Middle Name:
   b. Last Name:
   c. Title/Position:
   d. Relationship with the Applicant Organization:
   e. Mailing Address (Street Address, City, State, Nine-Digit ZIP Code):
   f. Telephone Number:
   g. E-mail Address:
10. Behavioral Health Practice Applicant Information
    a. Legal Business Name of applicant, as reported to the Internal Revenue Service:
    b. Additional Name(s) (i.e., "Doing Business As"/DBA Name) (enter N/A if not applicable):
    c. Legal and/or financial affiliations to other entities (enter N/A if not applicable):

d. Mailing Address (Street Address, City, State, and Nine-Digit ZIP Code):

e. Please provide a single TIN and single National Provider Identification (NPI) number to be used for IBH Model billing purposes:

   TIN:

   NPI:

f. Applicant's Provider Transaction Access Number (PTAN) for applicants enrolled in Part B (enter N/A if not applicable):

g. Applicants' CMS Certification Number (CCN), for applicants enrolled in Part A (enter N/A if not applicable):

h. Does the applicant confirm that all information in the PECOS is accurate and up to date as of the submission of its responses to this RFA?

   ☐ YES (if yes, applicant may proceed with application)

   ☐ NO (applicant checks if they must update PECOS information or are pursuing Medicare provider PECOS enrollment - the application will be considered and may be approved by CMS)

   If no, please explain your status regarding your answer to question 1(h) above including a date by which applicant intends to become enrolled in Medicare. Note: no practice will receive any funding from CMS until they are approved to bill Medicare in PECOS. (maximum of 1800 characters)

i. Does the applicant or any of its affiliates (subsidiaries) have any outstanding overpayments or other debts to CMS?

   ☐ YES (if yes, please identify amount owed and date of the determination of the amount owed)

   Amount:

   Date of Determination:

   ☐ NO

j. In a short paragraph (maximum of 1800 characters), please specify applicant's governing body and decision-making process, including the organizational structure for IBH Model functions and the designated individual/s making IBH Model implementation decisions.

k. To the best of your knowledge, has the applicant or anyone employed by the applicant had a final adverse legal action (as defined in Section 3 of the Medicare Enrollment Application for Physicians and Non-Physician Practitioners, CMS-855i)? Failure to disclose could be grounds for application denial or immediate termination from the initiative.

☐ YES (if yes, please list each adverse legal action and specify when each occurred and the entity that imposed the action) (maximum of 1800 characters)

☐ NO

l. To the best of your knowledge, has the applicant or anyone employed by the applicant been the subject of an investigation by, prosecution by, or settlement with the Health and Human Services Office of the Inspector General, U.S. Department of Justice, or any other federal or state enforcement agency in the last five years relating to allegations of failure to comply with applicable Medicare or Medicaid billing rules, the Anti-Kickback Statute, the physician self-referral prohibition, or any other applicable fraud and abuse laws? Failure to disclose could be grounds for application denial or immediate termination from the initiative.

☐ YES (if yes, please list and describe each investigation, prosecution, or settlement) (maximum of 1800 characters)

☐ NO

Proposed Model Region(s)

Practice Participants must be in a state that was accepted as a Recipient and is receiving funding for the IBH Model (MI, NY, SC).

11. Please identify the state/s and county/counties in which the applicant proposes to furnish treatment services to applicable beneficiaries under the IBH Model.

    State(s): Format is two-digit state abbreviation; separate with comma <“,”> if more than one listed.

    County/counties: Format is state county SSA code; separate with comma <“,”> if more than one listed.

Care Delivery Framework

The Care Delivery Framework is a foundational component of the IBH Model, aligning with its quality and payment strategies to drive improvements in patient outcomes. It is directly tied to the IBH Medicare Payment Approach and is designed to support Practice Participants in delivering high-quality, integrated care.

As described in *Section III, IBH Care Delivery Requirements* of the RFA, 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:

(1) Core Element 1: Care Integration: Practice Participants will screen, assess, and treat and/or refer patients as needed for both behavioral health and physical health conditions, within the Practice Participant’s scope of practice. Screening must 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 person-centered care plans;

(2) Core Element 2: Care Management: Practice Participants will assemble an interprofessional care team who 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 coordinating and following up on referrals related to behavioral health, physical health and upstream drivers of health; and

(3) Core Element 3: 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. States may add additional health conditions based on their Population Health Needs Assessment. Practice Participants should promote prevention and health education strategies and leverage existing state and practice-level population health data to inform these activities.

Please refer to Attachment 1 on the application portal and complete the requested information, including the Provider Roster, in accordance with the embedded guidance. If applicable, please also list any associated physical health consultants. This attachment is part of the application package and failure to submit it may result in the application being determined to be incomplete and/or nonresponsive.

Proposed Care Delivery Framework Services

IBH Model Practice Participants will have the flexibility to use the Medicare Integration Support Payment (ISP) to implement the Care Delivery Framework services to best meet an eligible beneficiary's needs. This section serves as the applicant's proposed implementation plan and requires the applicant to identify current challenges engaging eligible beneficiaries, how the applicant intends to implement the IBH Model Care Delivery Framework, and explain how the ISP will be used to support service delivery. (1800 maximum character limit for each response)

12. Please describe the applicant's anticipated beneficiary population, how you plan to engage and retain eligible beneficiaries in care, and how you will address challenges encountered in engaging and retaining eligible beneficiaries in care.

13. Describe the applicant's plans to meet the requirements of Core Element 1: Care Integration.

14. Describe the applicant's plans to meet the requirements of Core Element 2: Care Management.

15. Describe the applicant's plans to meet the requirements of Core Element 3: Preventive Care and Population Health.

16. Describe the applicant's plan to address Upstream Drivers of Health (screening, closed loop referrals, and developing partnerships to facilitate access to food, housing, transportation, and other supports (must comply with applicable laws).

17. Quality Reporting: Developing infrastructure and workflows to report quality measures required under the IBH Model, including preparation for the collection and reporting of the Patient-Reported Outcome Measure (PROM).

18. Indicate which of the following statements are true by selecting all that apply.

- ☐ A strategy for ensuring patient safety and quality is or will be established. Includes clinical and procedural protocols for proposed services, corrective action for violations, and tracking quality measures.
- ☐ A strategy for obtaining beneficiary's signed informed consent to receive Model services is or will be established. Includes written notice to beneficiaries explaining their rights (including the right to opt out of data sharing).
- ☐ A strategy for ensuring family and caregiver engagement is or will be established. This includes involving family members or caregivers in beneficiary education, consent processes, and treatment planning, as appropriate.
- ☐ A strategy for partnering with physical health consultant(s) is or will be established. This includes coordination with primary care providers and specialists to support individualized care and clinical integration.

- ☐ A strategy for partnering with community-based organizations is or will be established. Includes building referral pathways and follow-up coordination to address upstream drivers of health needs (e.g., nutrition, housing instability, transportation).
- ☐ A strategy for coordinating with emergency departments, inpatient facilities, and intensive outpatient program or partial hospitalization programs is or will be established. Includes coordinating upon referral and coordinating transitions of care.
- ☐ A strategy for accepting prospective payments, billing Medicare, and participating in annual reconciliation is or will be established. Includes ensuring the provision of services or activities outside ISP funding parameters is not included.

Infrastructure Funding

CMS published a Health Information Technology and Practice Transformation Needs Assessment (Health IT Needs Assessment) prior to this RFA being released. All applicants are required to complete this Assessment prior to signing a participant agreement. If the Health IT Needs Assessment is not complete by the time of the RFA application deadline, CMS reserves the right to find the applicant ineligible for Infrastructure funding.

19. Has the practice applicant submitted a Health IT Needs Assessment on the IBH Model Salesforce Project Officer Support Tool (POST) Portal (https://app.innovation.cms.gov/IBH/IDMLogin)? If NO, CMS may follow up to collect additional information.

    - ☐ YES
    - ☐ NO

20. Is the applicant currently participating in a Health Information Exchange (HIE), or will be participating in a HIE during the IBH Model performance period?

    - ☐ YES
    - ☐ NO (if no, please describe how patient data will be shared and communicated among the Care Team and other formal partners. 1500 maximum character limit.)

Program Duplication Assessment

The purpose of the Program Duplication Assessment is for applicants to identify other models, programs, or demonstrations that target similar populations and/or services relevant to the applicant's participation in IBH Model. Applicants will also identify how they will monitor potential programs and funding duplication. Failure to complete the Program Duplication Assessment may disqualify the applicant. CMS, in its sole discretion, will determine whether the information provided by the applicant, Participant or both constitutes duplication. Participation in other

models, programs, or demonstrations will not preclude applicant from participation in IBH Model. This section will not be scored.

21. Is the applicant participating in any of the Medicare initiatives below as of January 1, 2026? Please check all that apply. (1500 maximum character limit for each response)

☐ Shared savings initiatives

Please specify:

☐ Total cost of care initiatives

Please specify:

☐ Medical home initiatives

Please specify:

☐ CMS initiatives

Please specify:

☐ Other

Please specify:

22. Will the applicant be participating in other federally funded programs targeting individuals including State/Tribal Opioid Response (SOR/TOR), State Targeted Response (STR), Medicaid Demonstration Project to Increase Substance Use Provider Capacity as of January 1, 2028 insert date.

    ☐ YES (1500 maximum character limit)

    Please specify:

    ☐ NO

Request for Application (RFA) Checklist

Below is a checklist detailing the documents that your organization is required to submit for consideration in IBH model. It is the responsibility of the applicant to ensure that all documents required are included in the application. Failure to comply may result in applications determined to be ineligible, incomplete, and/or non-responsive based on initial screening and may be eliminated from further review.

All documents must be signed, scanned, and attached to the application email. Please retain the original, signed documents. If you have any questions about what your organization is required to submit, please contact CMS at ibhmodel@cms.hhs.gov.

Checklist:

- ☐ Completed Application
- ☐ Completed *Attachment 1* (Care Team Roster)

I understand that CMS provides no opinion on the legality of any contractual or financial arrangement that has been proposed or documented in this application. The receipt by CMS of any such documents in the course of the application process or otherwise shall not be construed as a waiver or modification of any applicable laws, rules, or regulations, and will not preclude CMS, HHS (including its Office of Inspector General), any law enforcement agency, or any other federal or state agency from enforcing any and all applicable laws, rules, and regulations.

I have read the contents of this application, and I certify that I am legally authorized to submit the application. Upon submission of this application, I certify to the best of my knowledge that all of the submitted information is true, accurate, and complete. If I become aware that any submitted information is not true, accurate, and complete, I will correct such information promptly. I understand that the knowing omission, misrepresentation, or falsification of any submitted information may be punished by criminal, civil, or administrative penalties, including fines, civil damages, and/or imprisonment.

Signature of authorized individual:

_____

Date: _____

Appendix E: Glossary of Terms

Term	Definition
“Behavioral Health Specialty Practice Applicant”	Specialty behavioral health practice, recruited by the state who is applying to participate in the IBH Model on the Medicare side pursuant to the terms of this RFA who has not yet received acceptance to the program.
“Beneficiary Population”	The IBH Model serves both Medicare, Medicaid, and beneficiaries dually eligible for Medicare and Medicaid. The population(s) served are adult Medicaid and Medicare beneficiaries with moderate to severe mental health condition(s) or SUD(s), or both.
“Care Delivery Framework”	An Integration framework for adult Medicaid and Medicare beneficiaries with MSBH implemented for Practice Participants statewide or within a sub-state region.
“Data Sharing”	The IBH Model will require the use of information technology (IT) to share, collect, and analyze information to support model operations, and will use existing CMS systems alongside new systems and processes to efficiently implement the IBH Model.
“Directional Alignment”	Refers to the minimum expectations for each IBH Model design element that Recipients and payers participating in the IBH Model should seek to achieve. Ultimately, directional alignment pushes payers towards a shared framework and promotes multi-payer alignment.
“Evaluation”	The IBH Model evaluation will assess both model impact and implementation experiences. CMS will assess outcomes such as levels of integration, quality of care, patient experience of care, utilization, and costs.
“Health Care Provider”	A health care provider, practice, facility, or other community-based organization delivering behavioral health treatment services outside of an inpatient, emergent, or urgent care level of care where behavioral health services are available to beneficiaries and are the predominate health care service type delivered, or where longitudinal behavioral health services are available and delivered by a specialty behavioral health provider.
“Health IT”	Health Information Technology
“Health IT and Transformation Needs Assessment”	A standardized needs assessment process to assess the current Health IT infrastructure and capacity of Practice Participants. The Health IT and Transformation Needs Assessment will determine the amount of infrastructure funding that Practice Participants receive.
“Implementation Period”	2028 – 2032

Term	Definition
“Infrastructure Funding”	Payments made directly by CMS or the Recipient to Practice Participants to support and fund investments in certified Health IT products and infrastructure improvements for (1) improving data infrastructure, (2) establishing quality goals, (3) supporting data collection efforts to advance accountable care and (4) support Practice transformation activities.
“Integration”	The coordination (and as appropriate, provision) of physical health care[36] by the behavioral health care team and in the behavioral health setting, along with attention to needs that impact health and appropriately matched behavioral health setting interventions. Integration in the IBH Model is a person-centered approach to identify and address (as appropriate within the Practice’s scope of Practice) physical health in the behavioral health setting in which the Practice Participant with moderate to severe behavioral health setting conditions may be already engaged, or more frequently engaged to supporting preventive care and health promotion. Integration may involve co-location, virtual integration, or care coordination through informal or formal agreements, or closed-loop referrals with physical health and specialty behavioral health practice. This approach allows for flexibility in addressing physical health needs in a manner that aligns with the care setting and legal or regulatory requirements.
“Interim Performance Indicators”	Specific metrics are used to monitor interim model success. These will potentially include measures such as Total Cost of Care (TCOC), Acute Hospital Utilization, and Emergency Department Utilization.
“Medicaid Payment Approach”	A payment approach developed by the Recipient in partnership with CMS that incentivizes Practice Participants for providing the IBH Care Delivery Framework to eligible Medicaid and dual-eligible beneficiaries.
“Medicare Integration Support Payment” or “ISP”	A prospective per-beneficiary-per-month payment provided to practices for their Medicare patients for implementing the IBH Model Care Delivery Framework.
“Medicare Payment Approach”	The Medicare Payment Approach flows directly from CMS to Medicare Practice Participants. The Medicare Payment Approach includes the Medicare Integration Support Payment (ISP), a quarterly prospective per beneficiary per month (PBPM) payment, and a performance-based payment (PBP). The risk adjusted ISP covers the Care Delivery Framework’s integrated services for the IBH Model’s attributed population.

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

Term	Definition
“Moderate to Severe Mental Health Conditions and/or Substance Use Disorders (SUD)”	Specific behavioral health diagnoses defined by CMS, in consultation with clinical subject matter experts from SAMHSA, as “moderate to severe,” which are suggested for practice identification. However, they are not definitive, and not everyone with these diagnoses by default has moderate to severe behavioral health conditions. These diagnoses shall not be used as doctrine, nor shall they use it for different purposes.
“NOFO”	Notice of Funding Opportunity and means the NOFO identified by the funding opportunity number CMS-2Q2-25-001.
“Participation Agreement”	The written agreement between CMS and the Practice Participant that governs the Practice Participant’s participation in the Medicare component of the IBH Model.
“Patient-Reported Outcome Measure (PROM)”	Standardized instruments for capturing patients’ perspectives on their health status and quality of life following medical treatments, which can in turn be used to develop patient-reported outcome-based performance measures.
“Performance Assessment”	The IBH Model uses quality measures to assess key quality goals that Practice Participants are required to meet during the IBH Model performance period.
“Physical Health Consultant”	A physical health practice who specializes in the diagnosis, evaluation, and therapeutic management of physical health conditions and is licensed and qualified to prescribe medication (e.g., physician, nurse practitioner, etc.).
“Physical Health Providers”	Physicians and non-physician practitioners whose primary area of practice involves the diagnosis, evaluation, and therapeutic management of non-behavioral health conditions.
“Population Needs Assessment”	A systematic and comprehensive evaluation conducted by state, tribal, local, or territorial entities to identify and prioritize the health needs of the community served by Practice Participants. This assessment involves gathering and analyzing data on a wide range of health determinants, including health disparities, access to care, preventive health needs, and the impact of social, behavioral, and environmental factors. The process incorporates input from a diverse range of community stakeholders to ensure the identified needs reflect the community’s broad interests.
“POST”	IBH Model Salesforce Project Officer Support Tool

Term	Definition
“Practice Participants”	Recipients will recruit a select group of Medicaid specialty behavioral health practices to participate in the IBH Model. Any Practice Participant that intends to participate in the Medicare portion of the IBH Model must be in good standing and meet the IBH Model Practice Participant criteria by the start of model year 2029. Those practices must apply to CMS using this RFA to participate in the Medicare Payment Approach of the IBH Model. Once accepted by CMS, successful specialty behavioral health practice applicants must sign a Participation Agreement with CMS. A specialty behavioral health practice that only serves Medicare beneficiaries is not eligible to participate in the IBH Model.
“Pre-Implementation Period”	The first thirty-six (36)-month period of the cooperative agreement period of performance (i.e., BP 1-3 or 2025 – 2027). The Pre-Implementation Period begins on January 1, 2025, and ends on December 31, 2027.
“Primary Care”	Primary care is the provision of preventive and integrated health care by interprofessional teams that are accountable for addressing the majority of an individual’s health and wellness needs across settings and through sustained relationships with patients, families, and communities.
“Protected Health Information”	Protected Health Information has the meaning given to that term at 45 CFR 160.103.
“Recipient”	The state Medicaid agency (SMA) that submitted the application for CMS’ consideration and received the NoA from CMS. The term “Recipient” does not include Subrecipients. The Recipient retains the primary responsibility and role for planning, directing, and executing the required activities under the program Terms and Conditions for the cooperative agreement award.
“Specialty Behavioral Health Practices”	A health care Practice or other community-based organization delivering behavioral health treatment services outside of an inpatient, emergent, or urgent care level of care where behavioral health services are available to beneficiaries and are the predominate health care service type delivered, or where longitudinal behavioral health services are available and delivered by a specialty behavioral health practice. This includes local health departments, or another entity that is part of a local government behavioral health authority where a locality, county, region, or state maintains authority to oversee behavioral health services at the local level and uses the entity to provide those services. This longitudinal accountable behavioral health care arrangement involves a Practice Participant who agrees to be accountable for quality, utilization, patient experience, and care integration over a sustained period.

Term	Definition
“Specialty behavioral health (“behavioral health”) Providers”	Specialty behavioral health providers refer to physicians, non-physician practitioners, and other eligible professionals whose primary area of practice involves diagnosis, evaluation, and therapeutic management of mental health and SUD conditions, as permitted under federal and state law. Specialty behavioral health practices must be eligible to bill for services (i.e., be billing practitioners) and may include physicians (medical doctors or doctors of osteopathy), clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners, physician assistants, independently practicing psychologists, marriage and family therapists, and mental health counselors as specified in the CY 2024 Physician Fee Schedule final rule.
“State Medicaid Agency (SMA)”	Medicaid Agency in a particular state who is a Recipient in the IBH Model.
“State Quality Improvement Program (SQIP)”	A component of the IBH Model that places a portion of cooperative agreement funding at risk dependent on state-based quality measure performance.
“Subrecipient”	The IBH Model evaluation will assess both model impact and implementation experiences. CMS will assess outcomes such as levels of integration, quality of care, patient experience of care, utilization, and costs.
“Terms and Conditions”	Contract between CMS and state Recipients.
“Upstream Drivers of Health”	Clinically relevant non-medical factors that influence health included but not limited to nutrition, transportation, housing status and access to utility services.

Appendix F: Glossary of IBH Model Acronyms

Acronym	Full form
APMs	Alternative Payment Models
ASTP/ONC	Assistant Secretary for Technology Policy / Office of the National Coordinator for Health Information Technology
CEHRT	Certified Health Information Technology
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CoCM	Collaborative Care Model
EHR	Electronic Health Record
FFS	Fee-For-Service
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
IBH	Innovation in Behavioral Health Model
ID	Identification Number
IT	Information Technology
MCO	Managed Care Organization
MIPS	Merit-based Incentive Payment System
MSBH	Moderate to Severe BH
NOFO	Notice of Funding Opportunity
OTP	Opioid Treatment Program
PBP	Performance-based Payments
PBPM	Per Beneficiary per Month
PO	Project Officer
PPS	Prospective Payment System
SMA	State Medicaid Agency
(SOR/TOR)	State/Tribal Opioid Response
STR	State Targeted Response

Acronym	Full form
SUD	Substance Use Disorder
T-MSIS	Transformed Medicaid Statistical Information System
TCOC	Total Cost of Care
TIN	Tax Identification Number
VBP	Value-based Payment