

Innovation in Behavioral Health (IBH) Model

Care Delivery Framework Flexibilities

June 24, 2026

2:00 pm ET

CMS Innovation Center



Welcome!



Please place your name and the IBH Model state you represent in the chat.

Webinar Functionality

- This session is being recorded.
- All lines are currently muted.
- You may enter questions or comments in the **chat box** at any time during the presentation.
- Links to the slides, transcript, and recording will be made available to you in the coming weeks.

Agenda

- IBH Model Care Delivery Framework
 - Overview of Core Elements and Services
 - Required Elements and Example Flexibilities
 - Requirements and Flexibilities of the Interprofessional Care Team
 - Illustrative Example of Beneficiary Experience in the IBH Model
- Available Resources
- Questions & Answers
- Next Steps
- Closing

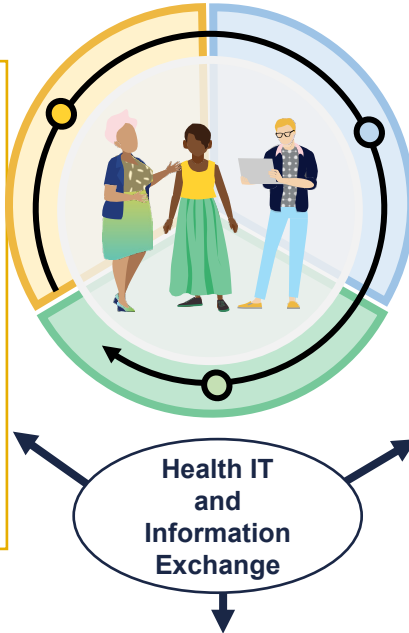
IBH Model Care Delivery Framework: Core Elements, Services, Care Team, and Flexibilities

Required Elements of the Care Delivery Framework

The IBH Model's Care Delivery Framework aims to improve quality and outcomes by testing a framework for integration of physical health needs and upstream drivers of health needs in behavioral health settings.

CARE INTEGRATION

- **Screen, treat, and/or refer** for behavioral and physical health needs and upstream drivers of health (UDOH) needs
- **Conduct person-centered care planning and treatment** of behavioral and physical health conditions and/or closed-loop referral to physical health care
- **Monitor behavioral health conditions** and a subset of priority health conditions, make care plan adjustments if outcomes are not improving



CARE MANAGEMENT

- **Interprofessional team-based care**
 - Develop care teams that reflect the needs of the service population, and include the patient, licensed mental health professionals, physical health consultants, and care management staff
- **Ongoing care management**
 - Monitor person-centered planning goals, treatment and outcomes and coordinate beneficiary needs related to behavioral and physical health conditions and other needs

PREVENTIVE CARE AND HEALTH PROMOTION

- **Track and manage** IBH Model priority health conditions (tobacco use, diabetes, hypertension) and state-identified conditions
- **Provide and Promote** prevention and health education services

Care Delivery Framework Flexibilities



States must ensure that Practice Participants implement the functions of the core elements but have the **flexibility to determine how to operationalize them.**

Example flexibilities include:

- Service delivery
- Staffing
- Workflows
- Payment design
- Additional services based on existing programs, state priorities, or needs identified through your Population Health Needs Assessment

Core Element One: Care Integration - Required Services

Welcome Visit Components:

- Patient consent for services and data sharing
- Orientation to IBH Model services
- Screening, assessment, and referrals for behavioral health, physical health*, and upstream drivers of health;
- Screening for primary care access and engagement
- Person-centered care plan with beneficiary and input from the physical health consultant

Reassessment Visits:

- Reassess for physical, behavioral, and UDOH needs
- Review primary care access and engagement
- Adjust and update care plan with beneficiary and care team members
- Determine appropriate referrals and/or in-house services

*Physical health includes the IBH Model priority health conditions (i.e., diabetes, hypertension, and tobacco use) and other health conditions identified by the state's Population Health Needs Assessment.

Core Element One: Care Integration – Flexibilities

Example Flexibilities

- *Number and length of visits, workflows*
- *Choice of evidence-based UDOH screening tools and screening for additional needs*
- *Methods for receiving input from physical health consultant*

Core Element Two: Care Management - Required Services

Care Coordination and Closed-Loop Referrals¹:

- Facilitate referrals for behavioral, physical, and UDOH needs (or outside screenings, if needed)
- Support referral completion, including addressing barriers
- Follow up on referrals with providers and the beneficiary

Care Plan Maintenance:

- Monitor, review, and update the care plan with the beneficiary as clinically appropriate
- Ongoing monitoring and longitudinal care management
- Document changes in goals, referral outcomes, or care needs; priority and other physical and behavioral health conditions; primary care engagement, and preventive care

1. A process that includes initiating a referral, confirming receipt by the receiving provider or entity, tracking the status of the referral, and documenting the outcome or follow-up action in the beneficiary medical record.

Core Element Two: Care Management – Flexibilities

Example Flexibilities

As clinically appropriate:

- *Timeframes for referrals, tracking, and follow up*
- *Processes for making referrals; additional outreach and referral support for specific populations*
- *Intervals for care plan updates*

Core Element Three: Preventive Care and Health Promotion – Required Services

Track Priority Health Conditions:

In consultation with the beneficiary:

- Periodically review screening and assessment results
- Conduct ongoing monitoring of IBH Model and state-identified priority health conditions
- Determine appropriate supports or services for prevention, based on beneficiary needs and preferences

Preventive Care and Health Promotion Services:

- Provide preventive care guidance related to priority health conditions and health risks; support understanding of healthy lifestyle practices and self-management
- Support access to preventive services, programs, and resources
- Review progress toward goals; adjust guidance, goals, or referrals as needed

Core Element Three: Preventive Care and Health Promotion – Flexibilities

Example Flexibilities

- *Use existing (or develop new) policies and procedures to track priority health conditions*
- *Frequency, modality, and length of visit(s)*
- *Provide in-house or external referrals for preventive or health promotion services*

Interprofessional Care Team Requirements

At a minimum, each Practice Participant must ensure care teams include:



Behavioral Health Billing Practitioner

Licensed provider eligible to independently deliver mental health and/or SUD treatment services at the outpatient level of care; Serves as the clinical lead for integrated behavioral health services.



Physical Health Consultant

Clinician qualified to diagnose, evaluate, and manage physical health conditions and prescribe medication; reviews physical health status, advises the care team on physical health condition management, informs care plan adjustments, and advises on treatment interactions.

Care Team – Example Flexibilities



Behavioral Health Billing Practitioner

- May be employed, leased, or contracted with Practice Participant
- May or may not provide services directly
- May be more than one practitioner per Practice Participant



Physical Health Consultant

- May be employed or contracted with Practice Participant
- May or may not be the beneficiary's primary care provider
- May be a physician, nurse practitioner, physician assistant, or dual certified physical-behavioral health practitioner
- Frequency, mode, and degree of input determined by Practice Participant, but must support integrated care

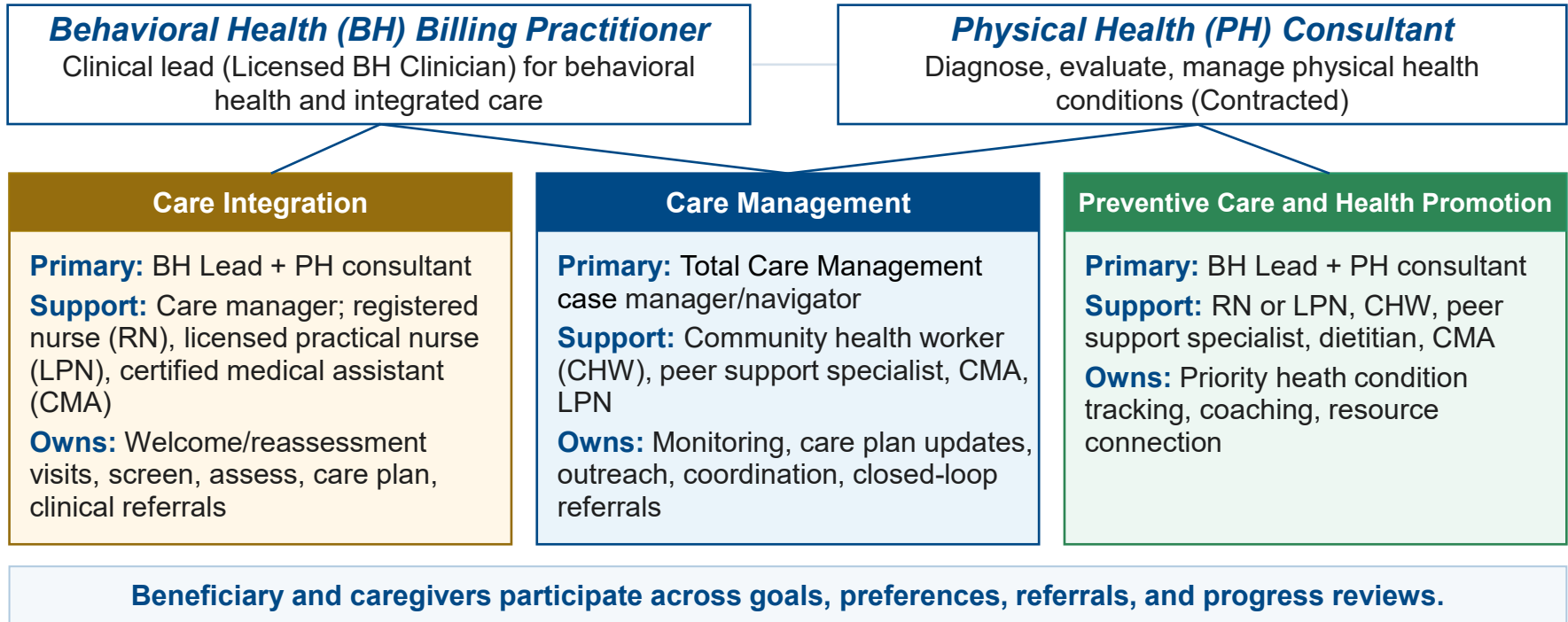


Additional Care Team Member(s)

- May be licensed or unlicensed staff, for example: certified mental health professionals, peer support specialists, community health workers, nurses, or other qualified staff
- May or may not be professionals who meet all the requirements to independently deliver Medicaid services

Example Care Team Structure

Practice Participants can organize an integrated care team centered on the beneficiary, with clear accountability for each core element.



Illustrative Sample Beneficiary Experience in the IBH Model



Background

Name: Robert

Age: 65

Health Conditions:

- Bipolar disorder (BPD)
- Alcohol use disorder (AUD)
- Hypertension (HTN)

Emergency Department

Visits: 4 times in the past 6 months

Situation

- Recently lost his job
- Under a lot of stress to afford groceries, car repairs, and health care
- Primary care staff are not well informed about how to treat his BPD and AUD
- His BH clinic is the provider that he visits most often, but the clinic is not equipped to assist him in managing his PH needs

Robert's Experience in the IBH Model



Initial Contact

- Visits an IBH-participating BH clinic
- Care team recognizes he could benefit from IBH
- Consents to participate
- Screened for **BH** and **PH** conditions and UDOH



Care Integration

- IBH care team contacts Robert's primary care provider (PCP) to discuss the results of his screening
- They discuss how Robert's AUD and BPD make it difficult to manage his HTN



Care Planning

- Robert, his IBH provider, and PCP create a care plan to address his BH and PH conditions and UDOH
- His care team plans to connect him to AUD and BPD support groups



Integration with Upstream Needs

- A CHW connects Robert to community organizations that deliver nutritious food and provide transportation to appointments
- Robert begins meeting with his AUD and BPD support groups and a peer support specialist



Care Management

- Robert's IBH care team follows up with him before and after his BH appointments to send reminders and check on his experience



Ongoing Monitoring

- As appropriate, Robert is screened again for BH, PH, and UDOH needs by his IBH care team
- His outcomes are improving
- Receives IBH services until no longer medically necessary

Robert's Outcomes



Supported by his care team and follows his care plan



Lower stress, improved medication management, reduced hypertension, and improved food security



Confident enough to start applying for a job

Available Resources

Available Resources



- [Medicare Practice Participant Guide: Care Delivery Framework & Integration Support Payment Requirements](#): a high-level view of the Care Delivery Framework that can serve as a policy development resource and reference.
- [Operational Guidance for Medicare Practice Participants: Care Delivery Framework and Integration Support Payment](#): detailed Medicare operational guidance for implementing the IBH Model Care Delivery Framework and receiving the IBH Model Medicare ISP.



- Medicaid Care Delivery Framework Template and Checklist – ***Available July 2026***

Questions & Answers

Questions & Answers



1. Is there a template for the Care Delivery Framework? What elements must be included in it?
2. How can the Convening Structure support the flexibilities in the Care Delivery Framework?
3. How can our state adapt existing care frameworks while maintaining fidelity to the IBH Model's foundational elements?

Next Steps



Designing a Medicaid Payment Approach to Support the Care Delivery Framework

- Identify Care Delivery Framework services currently covered (or not covered) by Medicaid
- Payment mechanisms to cover services
- Confirm providers' readiness for any changes in billing procedures

Closing

Polling Question



What kinds of innovations are you considering as part of your state's Care Delivery Framework and Medicaid Payment Approach?

➤ *Please share your answer in the chat.*

Thank you!

