

Webinar: Care Delivery Framework Flexibilities

June 24, 2026, 2:00–3:00 PM ET

Andrea Amodeo (IBH Implementation and Monitoring Contractor [IMC]): Hello, and welcome to today's IBH Model webinar, Care Delivery Framework Flexibilities. My name is Andrea Amodeo. I work with the team at the American Institutes for Research, which is supporting the implementation of the IBH Model, and I'll serve as one of your presenters today.

To share who is in the virtual room with us, we'd appreciate it if you would please enter your name and the IBH Model state you represent in the chat box. While you do that, I'll review some information about today's session.

We are recording today's session. Your lines are muted, but you may post questions and comments in the chat box throughout the session as you think of them. Links to the slides, recording, and transcript from today's webinar will be made available to you on IBH Connect in the coming weeks.

Today we'll provide an overview of the requirements and flexibilities states have in designing their Medicaid Care Delivery Framework in the IBH Model. We'll start by walking through the three core elements of the Care Delivery Framework and the requirements within each. Then, we'll describe examples of areas in which states have flexibility to determine how to meet those requirements or introduce innovations. Then, we'll discuss the interprofessional care team requirements and example flexibilities, and we'll provide an example of the beneficiary experience in the IBH Model. We'll also remind you of available resources to support the design of your Care Delivery Framework and use questions you submitted in advance of the webinar to review some questions and answers. We will also note next steps as they relate to designing your Medicaid Payment Approach.

As a reminder and to help orient everyone to today's discussion, this slide presents an overview of the Care Delivery Framework for the IBH Model. At a high level, the Care Delivery Framework comprises three core elements: Core Element One, which is Care Integration; Core Element Two, which is Care Management; and Core Element Three, which is Preventive Care and Health Promotion. These core elements represent the minimum required elements to which states must align when developing your Medicaid Care Delivery Framework. States may implement these requirements differently, but all required functions must be operationally available.

We'd also like to highlight that states must establish or support the health IT interoperability capabilities necessary to support integrated care delivery, care coordination, and monitoring. Health IT is a critical component of the IBH Model for supporting effective information sharing and coordination across providers and the interprofessional care team.

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Before we delve into each core element, we want to again emphasize that, while states must ensure that Practice Participants implement the functions of each core element, you have flexibility in how you operationalize them. At a high level, flexibilities may include, but are not limited to, service delivery, staffing, workflows, and payment design. In addition, states may add other services based on existing programs, state priorities, or needs you identified through your Population Health Needs Assessment.

With this broad list of flexibilities in mind, I'll now turn to my colleague Melissa Hafner, a Principal Researcher at the American Institutes for Research. Melissa will walk through each of the core elements in more detail and highlight examples of flexibilities.

Melissa Hafner (IBH IMC): Thank you, Andrea. Let's start with Core Element One and the required services. These are services that must be provided to the beneficiary to functionally align with the IBH Model. This core element includes the main integration functions within the model, which include screening for physical health conditions, assessing for primary care access and engagement, and incorporating input from a physical health consultant into care planning. As we'll talk about on the next slide, there is flexibility in how Practice Participants accomplish the requirements.

First is a welcome visit, which establishes a beneficiary's entry point into the model, either after they've been attributed through claims or have otherwise been identified for the IBH Model. This welcome visit includes four service components. First, obtaining consent and orienting the beneficiary to the model services. Second, screening, assessing and referring for behavioral health, physical health, and upstream drivers of health needs. We want to note that for the IBH Model, screening, assessment, and referrals associated with physical health include the IBH Model priority health conditions, which are diabetes, hypertension, and tobacco use, as well as other health conditions identified by your state's Population Health Needs Assessment, if any were identified. Third, developing a care plan in partnership with the beneficiary and with input from the physical health consultant. And fourth, determining referrals or facilitating engagement with services, including primary care, and/or services available within the practice.

Reassessments, which need to occur at intervals that are clinically appropriate and meet the beneficiary's needs, include many of the same components of the welcome visit, but also offer an opportunity to adjust or update the care plan as needed based on the beneficiary's progress and any new or emerging needs. As we'll touch on later, the screenings and assessments in this core element form the basis for tracking priority health conditions and providing preventive care and health promotion services in Core Element Three.

Now that we've reviewed the required services for Care Integration, we'll discuss some of the areas where states can design their Care Delivery Framework in ways that align with the needs of their Practice Participants and beneficiary population. As we discuss flexibilities today, please keep in mind that what we show are examples and not exhaustive lists. There may be other areas where, based on the types of Practice Participants in your state or existing programs that you are

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building on, you may need to accomplish the required services differently. We encourage you to think about the potential flexibilities you may need and to share any questions with your Project Officer.

For Core Element One, one flexibility is the number of interactions that may be needed to complete the welcome visit and reassessment activities. For example, you may use one encounter or multiple encounters to conduct screening and assessments; develop a care plan; or connect patients to primary care. In addition, the length of the visits may vary based on how your Medicaid Payment Approach covers these components. The screening tools used for upstream drivers of health are flexible, as long as providers are using a standardized, evidence-based tool. A physical health consultant must provide input on the beneficiary's care plan, but how practices obtain that input is flexible. For example, the physical health consultant is not required to be co-located, and the consultation does not need to be on the same day that the welcome visit takes place. In addition, the physical health consultant's input may be obtained through various modes such as phone or through EHR access.

Core Element Two, Care Management, is designed to support ongoing, longitudinal care management. The required services in this core element, which are care coordination and closed-loop referrals and care plan maintenance, are continuous functions that the care team must provide. Providing care coordination and closed-loop referrals requires Practice Participants to facilitate referrals internal or external to the practice, support beneficiaries in completing those referrals, addressing any barriers, and following up on the outcome of the referrals. Care plan maintenance requires Practice Participants to keep the care plan up to date while monitoring the beneficiary's care. This means documenting any changes in their behavioral or physical health conditions, their goals, primary or preventive care, or the outcomes of the closed-loop referrals.

Now, we'll review example flexibilities in how your state might operationalize care coordination and closed-loop referrals. For example, states can design timeframes for referrals, tracking and follow-up that are consistent with Practice Participants' capacity and current processes, as long as they are clinically appropriate, reasonable, and timely, and meet beneficiaries' needs. As states design these timeframes, you should consider the balance between the expectations you set to support care continuity and operational feasibility for your participating practices. For Medicare, the IBH Model's Care Delivery Framework requires updates to the care plan every 180 days. An example flexibility here is how states operationalize the interval for care plan updates within Medicaid to serve the needs of Medicaid beneficiaries and align with Practice Participants' standard procedures.

In Core Element Three, Practice Participants are required to track priority health conditions. This includes the three priority health conditions of the IBH Model, which are diabetes, hypertension, and tobacco use, as well as any conditions that states add based on their Population Health Needs Assessment. Tracking priority health conditions means consulting with the beneficiary to review the screening and assessment results from Core Element One, monitoring the priority health conditions over time, and determining any additional supports the beneficiary may need.

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Preventive care and health promotion includes offering preventive care guidance to the beneficiary on the priority health conditions and helping to connect them with healthy lifestyle and self-management resources, such as tobacco cessation, nutrition education, or physical activity and exercise programs. It also relates back to maintaining the care plan, because preventive care and health promotion is an opportunity to review the beneficiary's progress toward health goals and adjust them as needed or make new referrals.

Opportunities for flexibilities in how you operationalize the functions of Core Element Three recognize that Practice Participants may have existing policies around preventive care and health promotion that can be leveraged to track these priority health conditions. Alternatively, states may want to work with Practice Participants to develop new policies and procedures, innovations, or build on existing programs to accomplish the aims of this core element. Similar to other core elements, the modalities for preventive care and health promotion services can be flexible. These services can be delivered in a variety of ways and can include a mix of in-house services, such as wellness programs, self-care tools, or could include external services.

Now that we've covered the flexibilities in the core elements, we want to briefly talk about the flexibilities that states and Practice Participants have in creating interprofessional care teams that provide services to IBH Model beneficiaries. First, as we've described in the recent Care Delivery Framework resources, each beneficiary who receives IBH Model Care Delivery Framework services must be assigned to a care team that includes, at a minimum, a behavioral health billing practitioner and a physical health consultant. Care teams are required to deliver all components of the IBH Model Care Delivery Framework services. The information provided on the slide reflects the minimum required roles and functions, rather than a standardized staffing model for the care team.

The behavioral health billing practitioner must be able to serve as the clinical lead for the team that is providing integrated care and oversee the beneficiary's care and treatment plan. The behavioral health practitioner must be licensed to deliver behavioral health services in the state at the outpatient level of care. The physical health consultant advises the care team led by the behavioral health billing practitioner specifically on physical health conditions. The physical health consultant must be qualified, and state licensed to diagnose, evaluate, and manage physical health conditions and prescribe medications.

Like the behavioral health billing practitioner, the physical health consultant is not required to provide direct clinical services to the beneficiary as part of the IBH Model Care Delivery Framework. The care team may also be supported by additional care team members who are licensed or unlicensed, and we'll talk about them on the next slide.

There are a number of flexibilities in the composition of the interprofessional care team. Because beneficiaries will have varied needs and conditions—and practices will have different staffing resources and available providers—a Practice Participant may have multiple care teams and configurations led by different behavioral health billing practitioners.

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As we touched on earlier, each beneficiary must be assigned to a care team that includes a behavioral health billing practitioner and a physical health consultant. States and practices have flexibility in how these roles are operationalized and can leverage existing staffing models they already have in place, as long as they are able to support integrated care. For example, the physical health consultant may or may not be the beneficiary's primary care provider and may be part of an external primary care practice that has an agreement with the Practice Participant, or, if a behavioral health billing practitioner is dually certified and licensed, they can fulfill both roles. States can also determine how frequently the physical health consultant advises on the beneficiary's care plan and the modes they use to collaborate, as long as these specifications support integrated care. Additional care team members include various licensed or unlicensed staff who are already included in many practices to support integrated care delivery. In the IBH Model, states can consider how to leverage additional care team members in innovative ways to deliver the Care Delivery Framework services, for example, helping to address barriers that beneficiaries face in completing a referral, conducting screenings or outreach to keep beneficiaries connected to care.

This slide shows one possible structure for an interprofessional care team. In this example, the behavioral health billing practitioner serves as the clinical lead as required, and physical health consultant is contracted with the practice. Both the behavioral health practitioner and physical health consultant take the lead on care integration by conducting the welcome visit and reassessments with support from a care manager, nursing, and medical assistant staff. Care management is led by a case manager with support from a community health worker, peer support specialist, and nursing and CMA staff to keep the care plan updated, coordinate care and ensure closed-loop referrals. The behavioral health practitioner and physical health consultant also lead preventive care and health promotion services with support from both licensed and unlicensed staff who track priority health conditions and offer coaching and connections to resources as needed.

I'll turn the call back to Andrea to review the beneficiary experience.

Andrea Amodeo (IBH IMC): Thanks, Melissa. This slide shows an illustrative example of a beneficiary's experience under the IBH Model. This example aims to show the model's intended impact on the beneficiary care experience and outcomes. In this example, Robert is 65 years old and has bipolar disorder, alcohol use disorder, and hypertension. He has visited the emergency department four times in the last six months. Robert recently lost his job, which has caused stress and financial challenges. He can no longer afford groceries, car repairs, or health care costs. Robert's primary care staff are not well informed about how to treat his bipolar disorder or alcohol use disorder. His behavioral health clinic is the provider that he visits most and prefers, but the clinic is not equipped to assist him in managing his physical health needs. Robert's care is disjointed, with different members of his care team not always aware of the whole picture of Robert's behavioral health, physical health, and other health related needs. Robert has difficulty navigating the health care system, and this contributes to higher stress and poor health.

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Now, I'll walk us through Robert's experience in the IBH Model and how IBH can improve Robert's outcomes and experience of care. First, when Robert visits an IBH-participating behavioral health clinic, the care team recognizes he can benefit from IBH, and he consents to participate. Next, he is screened for behavioral health and physical health conditions along with upstream drivers of health needs. The care team flags his bipolar disorder, alcohol use disorder, and hypertension. The care team also identifies that he experiences food, transportation, and financial barriers. Not only does the care team simply identify his needs; they engage in active follow up and closed-loop referral. The care team then calls Robert's primary care office to discuss the results of his screening. They discuss how Robert's bipolar and alcohol use disorders make it difficult to manage his hypertension. Next, Robert, his IBH provider, and primary care provider collaborate to create a comprehensive care plan for Robert's behavioral, physical, and other health related needs. During this stage, Robert's care team connects him to support groups for alcohol use disorder and bipolar disorder. After the care planning step, a community health worker helps address Robert's upstream drivers of health needs by connecting him to community organizations that deliver nutritious food to his home and provide transportation to and from appointments. Robert also begins to meet with his alcohol use disorder and bipolar disorder support groups and a peer support specialist.

The IBH care team follows up with Robert before and after care appointments to send reminders and check on his experience. As appropriate, Robert's care team screens him for his physical health, behavioral health, and upstream drivers of health needs. Also, they adjust his care plan based on the outcomes, which start to improve. Robert continues to receive IBH services until his care team determines they are no longer medically necessary. By participating in the IBH Model, Robert feels supported by his care team, and the different providers engaged in his care actively share information and collaborate to develop and implement his care plan. His input to the care plan gives him confidence to follow it. Robert experiences lower stress, improved medication management, reduced hypertension, and improved food security. He is confident enough to start applying for a job. This is just one illustrative example of how a beneficiary may experience the IBH Model. The model is suited to address a range of beneficiary behavioral health and physical health conditions and other health related needs.

Next, we'd like to remind you that there are a few resources on IBH Connect that explain the Care Delivery Framework and Integration Support Payment, or ISP. These include the *Medicare Practice Participant Guide* and the more detailed *Operational Guidance for Medicare Practice Participants*. These are Medicare-focused guidance documents to support your state's design and implementation of the Medicaid Care Delivery Framework.

In July, we'll also be providing a template for your use in developing your Care Delivery Framework for Medicaid Practice Participants, as well as a checklist tool that will help ensure that all required aspects of the Care Delivery Framework are included when you submit it at the end of the year.

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We asked you to submit questions before the webinar so that we could share back some early answers on things that all states may be thinking about. For any questions you submitted in advance of the webinar or in the chat that are not answered today, we'll develop written responses that will be provided as soon as possible in the coming weeks.

Our first submitted question is, "Is there a template for the Care Delivery Framework? What elements must be included in it?" CMS will distribute a template to help states complete your draft Medicaid Care Delivery Framework in late July. The template provides a structured format to support the design of the Medicaid Care Delivery Framework in an effort to facilitate state readiness to implement the IBH Model and to submit both the draft and final versions of the Care Delivery Framework. States must use the template for their draft submission due December 31, 2026. States should use the draft submission to describe how they plan to operationalize the required Care Delivery Framework functions and demonstrate progress toward implementation readiness during the pre-implementation period. CMS will also distribute a checklist to accompany the template. The checklist can be used to ensure your draft Care Delivery Framework includes sufficient detail before submitting it to CMS.

Our second question is, "How can the Convening Structure support the flexibilities in the Care Delivery Framework?" The Convening Structure is an ideal place to discuss how your state will use the flexibilities in the Care Delivery Framework. Convening Structure members, such as provider groups, community-based organizations, and patient advocates, can help advise you on how care delivery can vary while meeting the requirements of the model. For example, you might hold breakout discussions with members of the Convening Structure on topics like: timeframes for referrals to community partners and methods of communication; eliciting patient preferences while developing the care plan; different ways to structure the care team; or innovations that other providers or organizations have introduced to make care integration more effective.

Our third question for today is, "How can our state adapt existing care frameworks while maintaining fidelity to the IBH Model's foundational elements?" States may build on existing integrated care models, care management programs, Health Homes, CCBHC workflows, or other behavioral health transformation efforts, as long as the resulting Medicaid Care Delivery Framework includes all IBH Model requirements. Fidelity to the IBH Model means that Practice Participants operationalize and deliver the required services and activities associated with the three Core Elements: Care Integration, Care Management, and Preventive Care and Health Promotion. States are encouraged to leverage existing infrastructure and have flexibility in staffing, workflows, partnerships, service delivery, and Medicaid payment design. However, states must ensure that all the required IBH Model Care Delivery Framework services and activities are implemented, supported through the Medicaid Payment Approach, and monitored to ensure ongoing fidelity and performance.

Now, I'll turn the call back to Melissa.

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Melissa Hafner (IBH IMC): As a next step, we want to touch on the Medicaid Payment Approach and its connection to the Care Delivery Framework. The Medicaid Payment Approach has a number of important components, and we know that you are all working on different aspects of the payment approach. As you think about the flexibilities offered in the Care Delivery Framework, consider how your Medicaid Payment Approach will align with them, given that they are interdependent.

This slide shows a few key considerations for aligning your Medicaid Payment Approach with your state's Care Delivery Framework. First, your state should determine the Care Delivery Framework services that are currently covered—or not covered—by Medicaid. This may be particularly important if you are building on an existing care model or adding new services to your framework. Depending on your specific state circumstances, you may also need to determine what Medicaid authority, or authorities, can be leveraged to provide these services. Next, consider the payment mechanisms available to cover any services that are not currently covered. Finally, ensure that Practice Participants understand any changes in billing that may be needed to support the Care Delivery Framework. Similar to the Care Delivery Framework, states will receive a template and guidance to support development and submission of your Medicaid Payment Approach.

Before we wrap up, we'd like to ask everyone to answer one polling question to help us think about your plans and provide more targeted technical assistance. The question is: "What kinds of innovations are you considering as part of your state's Care Delivery Framework and Medicaid Payment Approach?" Please take a moment to share your response in the chat.

[Pause]

I think we can leave the chat running if folks would like to consider adding their responses.

Thank you all for joining this webinar today, we greatly appreciate your time. We look forward to sharing materials from today's webinar with you in the coming weeks. Enjoy the rest of your day!