

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation

Innovation in Behavioral Health (IBH)

Notice of Funding Opportunity Type: New

Funding Opportunity Award Type: Cooperative Agreement

Notice of Funding Opportunity Number: CMS-2Q2-26-001

Federal Assistance Listings Number (CFDA): 93.610

Notice of Funding Opportunity Posting Date: October 16, 2025

Applicable Dates:

(Optional) Letter of Intent to Apply Due Date: April 1, 2026

Electronic Application Due Date: June 3, 2026

Anticipated Issuance Notice(s) of Award: September 15, 2026

Anticipated Period of Performance: January 1, 2027 - December 31, 2033

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Executive Summary

The Innovation in Behavioral Health (IBH) Model (the “Model”) for Cohort II Recipients¹ is a seven-year, voluntary service delivery and payment model promoting integrated care in behavioral health (BH) settings. The IBH Model will test the impact of a value-based payment (VBP) model aligned across Medicaid and Medicare that supports an integrated care delivery framework in specialty BH organizations and settings for adult Medicaid, Medicare, and dually eligible beneficiaries with moderate to severe mental health conditions and/or substance use disorders (SUDs).

The Centers for Medicare & Medicaid Services (CMS), through its Center for Medicare & Medicaid Innovation (Innovation Center), will select up to **five** state Medicaid agencies (SMAs) to participate in the Model. The Model will have a seven-year performance period, which will be comprised of a two-year Pre-Implementation Period (beginning January 2027 and ending December 2028) along with a five-year Implementation Period (beginning January 2029 and ending December 2033). Up to \$7.5 million dollars in cooperative agreement award funding will be available to each selected Recipient over the course of the seven years.

Item	Description
HHS Awarding Agency	Centers for Medicare & Medicaid Services (CMS)
CMS Awarding Center	Center for Medicare and Medicaid Innovation (The Innovation Center)
Notice of Funding Opportunity Title	Innovation in Behavioral Health
Authorization	Section 1115A of the Social Security Act (the Act)
Federal Assistance Listings Number (CFDA)	93.610
Funding Opportunity Type	New
Funding Opportunity Number	CMS-2Q2-26-001
Type of Award	Cooperative Agreement
Type of Competition	Competitive

¹ CMS previously released an earlier version of this NOFO for Cohort 1 Recipients and issued those awards in 2024.

Item	Description
Letter of Intent	CMS recommends a letter of intent to apply for this funding opportunity. These are optional. See Section C.3 Letter of Intent for more information.
Application Due Date and Time	June 3, 2026, by 11:59 pm EST
Anticipated Issuance Notice(s) of Award	September 15, 2026
Period of Performance Start Date	January 1, 2027
Period of Performance End Date	December 31, 2033
Anticipated Total Available Funding	\$37.5 million (subject to availability of funds)
Estimated Maximum Award Amount	\$7.5 million per Recipient
Estimated Maximum Number of Recipients	5

A. Program Description

A1. Purpose

This Notice of Funding Opportunity (NOFO) provides details and instructions on how to apply to the Innovation in Behavioral Health (IBH) Model.

The IBH Model will test the impact of a value-based payment (VBP) model aligned across Medicaid and Medicare that supports an integrated care delivery framework in specialty BH organizations for adult Medicaid, Medicare, and dually eligible beneficiaries with moderate to severe mental health conditions and/or substance use disorders (SUDs). The IBH Model framework for integrated care in BH settings will:

- Build and strengthen connections to physical health (PH) care for beneficiaries;
- Promote screening and referral for needs that impact health;
- Identify beneficiary issues that interfere with diagnosis, management, and treatment of health conditions, such as food, housing, and transportation needs;
- Leverage care management and care coordination to increase access to and engagement

- with primary care and community services; and
- Encourage investments in certified health information technology (health IT) products and infrastructure improvement for their practice and patient population.

CMS will evaluate the Model's ability to:

- Improve quality of care;
- Increase access to care;
- Achieve greater balance in outcomes;
- Reduce avoidable emergency department and inpatient utilization, and thereby reduce federal program spending under Medicare and Medicaid; and
- Strengthen health IT systems capacity.

CMS will award up to five Cohort II cooperative agreement awards to state Medicaid agencies (SMAs). The Model for Cohort II Recipients will consist of a two-year Pre-Implementation Period along with a five-year Implementation Period as follows:

- **Pre-Implementation Period:** Two-year Pre-Implementation Period begins January 1, 2027, and ends on December 31, 2028.
- **Implementation Period:** Five-year Implementation Period begins on January 1, 2029, and ends on December 31, 2033.

This NOFO provides detailed information regarding the level of funding, flexibilities, and requirements for Recipients.

A2. Authority

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.

The Medicaid elements of the IBH Model shall operate according to existing Medicaid law, regulation, and sub-regulatory guidance, including, but not limited to, all requirements of any Medicaid demonstration projects under Section 1115 of the Act.

A3. Background

The United States is currently facing an unprecedented BH crisis, which was further exacerbated by the COVID-19 public health emergency that began in 2020.⁽¹⁾ A quarter of Medicaid beneficiaries have BH diagnoses, yet they account for nearly half of total Medicaid expenditures.⁽²⁾ An increasing number of Americans have mental health conditions and substance use disorders (collectively referred to in this document as "behavioral health" or "BH"). As of 2022, 23.1 percent of adults age 18 or older (or 59.3 million people) had a mental illness in the past year.⁽³⁾ Among people age 12 and older, 17.3 percent (or 48.7 million people) had a SUD in the past year. Additionally, during the COVID-19 public health emergency, racial and ethnic minority communities experienced disproportionately higher rates of psychosocial stressors. The BH system has long been uncoordinated and under-resourced, resulting in the following long-standing challenges:

1. Poor Clinical Outcomes & Premature Mortality: People with BH conditions more frequently report co-occurring health conditions, such as diabetes, cardiovascular disease, and metabolic conditions, and higher rates of tobacco use.⁽⁴⁾ Moreover, people with BH conditions are more likely to live with untreated or unmanaged HIV/AIDS and hepatitis C.^(5, 6) Without adequate attention to PH needs, adults with mental health conditions and/or SUDs often have more emergency department (ED) visits and potentially preventable medical hospitalizations resulting from uncontrolled chronic conditions.⁽⁷⁾ Adverse issues related to food, housing, or transportation, further contribute to the medical comorbidity of people with BH conditions. Research has found that, “persons with mental illness have increased rates of poverty...lack of access to healthy food choices, unsafe living conditions, exposure to early trauma, chronic psychological stress, and poor social networks.”⁽⁸⁾

Due in part to these factors, people with BH conditions experience worse health outcomes and significantly increased risk of premature mortality.⁽⁹⁻¹¹⁾ Premature mortality among people with mental illness is further magnified by substance use.⁽¹²⁾ Preventable PH conditions contribute to premature mortality among people with severe mental illness and SUDs, reducing their lifespan by an average of 10 - 20 years.^(13, 14) Compared to the general population, people living with serious mental illness (SMI) and/or moderate to severe SUDs have worse health outcomes and premature mortality due to: access to care obstacles, stigma related to receiving care, and untreated health conditions.^(15, 16) A substance use disorder increases risk for overdose, accidental injury, attempted suicide, associated medical conditions, infectious diseases, and mental health conditions.

2. Increased Expenditures: Mismanaged (or unmanaged) BH conditions can lead to difficulty managing people’s other chronic conditions as well as overutilization of certain types of costly care across the continuum, particularly in emergency department settings that are expensive and not aimed at prevention.⁽¹⁷⁾ Total spending on BH increased approximately 62 percent between 2006 and 2015.⁽¹⁸⁾ CMS spends substantially more on beneficiaries with BH conditions compared to spending for beneficiaries without.⁽¹⁹⁾ People with co-occurring BH and PH conditions have higher overall health care needs and expenditures, and there is an opportunity for an intervention targeted at these people that aims to improve outcomes and reduce unnecessary spending. These higher costs are not just attributable to the costs of needed BH treatment, but to the mismanagement of BH conditions and lack of coordinated, accessible care for both BH and PH conditions. Because people with co-occurring BH and PH conditions have higher overall health care needs and expenditures, there is an opportunity for an intervention that aims to increase access to appropriate levels of prevention and treatment, coordinate care, improve outcomes, and reduce unnecessary spending.

3. Uncoordinated System with Significant Disparities in Care and Outcomes: Negative outcomes and disparities of care for patients with BH conditions are driven by systemic issues, including historical underinvestment in BH care, siloing of BH and PH services, and the stigma of BH treatment.⁽²⁰⁾ Individuals with mental health disorders often have poor access to and continuity of quality medical care, and exhibit patterns of underusing primary care and overusing emergency and medical inpatient care.⁽⁸⁾ Individuals with SUDs often experience difficulties navigating the complex SUD treatment system due in part to structural barriers within the system itself like limited access to providers and treatment, insufficient team training, and policy and legal constraints.⁽²¹⁾ The BH care delivery system is often fragmented from PH care and lacks the

integrated structures of care that promote long-term recovery.² While care in acute clinical settings remains important, there is also a need for clinically appropriate, community-based integrated services to meet people in the settings in which they are already actively engaged.

4. Health Information Technology (health IT) Barriers: BH system challenges are further exacerbated by slow adoption of certified health IT products and infrastructure improvements for their practice and patient population, including certified electronic health record (EHR) technology, and lower participation in health information exchanges (HIEs) among specialty BH providers compared to PH providers, as current reimbursement rates and increasing costs leave specialty BH providers unable to invest in the necessary hardware, software, staff, and training to support integrated care.⁽²²⁾ Many specialty BH providers were not eligible for financial incentives for 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), of 9, further exacerbating low uptake rates.⁽²³⁾ Interoperability across different providers and settings of care is critical to facilitate the collaboration and communication necessary for integrated, preventative care and health promotion.

The HHS Substance Abuse and Mental Health Services Administration (SAMHSA) and the HHS Office for Civil Rights has made modifications under the authority of 42 U.S Code § 290dd–2 regarding the confidentiality of substance use disorder patient records, which are codified at [42 C.F.R. Part 2](#) and generally prohibits certain types of treatment programs from disclosing a patient’s SUD information treatment records without patient consent except under specific circumstances such as reporting alleged child abuse, valid court orders, medical emergencies, and health care operations. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules also include protections for protected health information. Additionally, SAMHSA supports the Center of Excellence for Protected Health Information to help educate health professionals, family members, patients and others on HIPAA, Part 2, and other BH privacy requirements.⁽²⁴⁾ SAMHSA and the Office of the National Coordinator for Health Information Technology (ONC) also are working on efforts to promote use of EHRs by specialty BH providers.⁽²⁵⁾

5. Lack of Payment Innovation in the BH Space: Payment innovation has not focused on BH services, which are historically underfunded and rely on a patchwork of state, federal, and grant sources. Specialty BH providers often lack a clearly defined role in VBP models designed for PH providers, leaving specialty BH providers with limited opportunities to meaningfully participate in alternative payment models (APMs). There is a lack of BH process measures that evidence has shown are appropriate for use in clinical quality improvement programs. This absence of BH process measures has made it difficult for specialty BH providers to meaningfully engage in accountable care.⁽²⁷⁾ VBP arrangements have the potential to transform the way providers deliver care, by encouraging more time spent on collaboration and services that may not be traditionally covered under Medicare and Medicaid fee-for-service (FFS).

² SAMHSA defines recovery as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” <https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf>

A3.1 How the IBH Model Addresses These Challenges Through Integrated Care and VBP

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

Value-based care, where providers are paid based on patient outcomes, has the potential to reduce health care spending and improve overall health. However, specialty BH providers have had limited opportunities to participate in VBP models. The IBH Model will address these challenges by providing a VBP model for specialty BH organizations and settings to deliver preventive care.

Integrated care improves access to general health care by fostering better communication, alignment, and collaboration among providers caring for individuals with complex BH and co-occurring priority health conditions. Members of a care team collaborate to establish a comprehensive treatment plan addressing the person's biological, psychological, and other needs that impact health. For many individuals with moderate to severe BH (MSBH) needs and co-occurring PH conditions, the BH setting may be the setting in which they are most actively engaged to receive needed care.

Significant progress has been made in developing various frameworks to build upon and advance integrated care⁽³⁰⁻³³⁾, but the barriers described in Section [A3 Background](#) persist. The IBH Model will help minimize the barriers to high quality integrated care as exhibited in *Table A.1*.

Table A.1: IBH Model care delivery solutions for barriers to integrated care

Barriers to Care	IBH Care Delivery Solutions
1. Poor Clinical Outcomes: People often face barriers to having their PH needs identified in BH settings. This is due in part to a lack of: provider knowledge, support, and training related to PH screening needs; patient knowledge regarding PH screening needs; clarity regarding provider responsibility and accountability for screening for PH conditions; as well as insufficient resources and time during visits to facilitate screening and associated referrals. ^(34, 35)	The care delivery framework will prioritize specialty BH practices as the entry points for integrated, value-based care. Interprofessional care teams will provide screening, assessment, treatment, and referral for PH and BH needs with ongoing care management and individual-level interventions to address beneficiary issues that interfere with diagnosis, management, and treatment of health conditions, such as food, housing, and transportation needs.
2. Increased Expenditures: BH and PH services and providers are often siloed, and people are not connected with the range of health services they need. This fragmentation can be especially difficult for people with BH diagnoses and results in underutilization of primary care, lack of access to specialty PH care, and the overuse of emergency department and inpatient medical care.	Interprofessional care teams will collaborate to establish a comprehensive treatment plan addressing the person's biological, psychological, and other needs that impact health, improving access to PH care by fostering better communication, alignment, and collaboration among providers caring for individuals with complex BH and co-occurring chronic conditions. The Model will also support the development of care pathways and protocols to ensure that people are connected with needed PH care when a need is identified.

Barriers to Care	IBH Care Delivery Solutions
3. System Challenges: <i>Broader health system lacks capacity to address needs that impact health.</i> Individuals with BH conditions have increased rates of poverty, limited access to healthy food choices, and unsafe living conditions, which have been shown to exacerbate PH comorbidities.⁽⁸⁾	The IBH Model will require needs that impact health are screened and referred using a validated screening tool, such as the Accountable Health Communities (AHC) screening tool and ensure that providers consider other needs that impact health within their treatment plans.
4. Health IT Barriers: <i>Limited investment opportunities for specialty BH providers.</i> Many specialty BH providers were not eligible for the EHR adoption financial incentives that were provided to other categories of providers as part of the Health Information Technology for Economic and Clinical Health Act (HITECH) Act enacted in 2009, further exacerbating low uptake rates.⁽²³⁾	The IBH Model will provide specialty BH practices and SMAs infrastructure and cooperative agreement funding and technical assistance necessary for them to effectively adopt and implement health IT tools and to participate in local, regional, or state information sharing systems.
5. Lack of Payment Innovation: <i>Payment innovation has not focused on specialty BH practices.</i> Specialty BH practices often lack a clearly defined role in VBP models, leaving them with limited opportunities to meaningfully participate in APMs.	The IBH Model will provide an on-ramp to value-based payment by providing support for necessary infrastructure and health IT funding, preparing these providers to participate in VBP models. The IBH VBP model will align Medicare and Medicaid to enhance multi-payer alignment.
6. Preventive Care and Health Promotion in BH: <i>Differences in access to and quality of care, use of care, and comprehensiveness of insurance coverage are persistent in BH care.</i> Limited access can be rooted in historical exclusion from social and economic opportunities that result in barriers to care and unequal treatment over time.	Practice Participants will engage in activities that improve health for all beneficiaries, including conducting a population health needs assessment and identifying beneficiary issues that interfere with diagnosis, management, and treatment of health conditions, such as food, housing, and transportation needs. Practice Participants will develop plans to address needs identified in the population health needs assessment through enhanced care coordination or closed-loop referrals to community-based organizations.

A3.2 Alignment with Federal Priorities and State Medicaid Program Trends and Themes

The IBH Model is aligned with the BH priorities set by CMS and the Department of Health and Human Services (HHS) in the September 2022 HHS Roadmap for Behavioral Health Integration. The IBH Model will support these priorities by:

- Reducing silos across programs and settings; and
- Ensuring that “the full spectrum of BH care will be integrated into health care, social service, and early childhood systems to ensure all people have equitable access to evidence-based culturally appropriate, person-centered care.”⁽³⁶⁾

In addition, the IBH Model is designed to harness state interest and capacity-building in BH and build directly on this architecture, where appropriate. Specific examples that may support the IBH Model include:

- States have been the early innovators in designing and operationalizing VBP efforts among specialty BH practices through various Medicaid innovation initiatives including but not limited to waivers, demonstration programs, and grants.⁽³⁷⁾
- Approximately eight states are utilizing flexibilities under Section 1115 of the Social Security Act to cover services for needs that impact health that would otherwise not be available for federal match, including services such as housing and housing supports, transportation assistance, and nutritional services.
- Over twenty states noted initiatives in their American Rescue Plan Act of 2021 Section 9817 State Spending Plans related to mental health, substance use disorder treatment, and initiatives focused on needs that impact health.
- States have also undertaken the Certified Community Behavioral Health Clinic (CCBHC) demonstration, the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) program, and the Medicaid State Plan option to provide coordinated care through the establishment of Health Homes³ for individuals with chronic conditions (see Section 1945 of the Social Security Act) to improve access to BH care, improve statewide BH crisis systems and develop comprehensive approaches to PH and other needs that impact health.⁽³⁸⁻⁴⁰⁾ As of December 2023, 20 states support 35 health home models to support care coordination for patients with complex needs, including those with BH conditions.

A4. Program Requirements

Below are the core functions Recipients are required to complete in the Pre-Implementation and Implementation Periods of the IBH Model, with associated examples of cooperative agreement funding use.⁴ Recipients may fulfill these requirements themselves and may also work with managed care entities or other state entities like agencies with regulatory authority over mental health and/or substance use disorder providers to ensure these tasks are completed. Of note, the funding provided pursuant to the Cooperative Agreement may not be claimed for Federal financial participation (FFP) purposes.

Recipients also have reporting and evaluation requirements throughout the period of performance as detailed in Section [F6. Reporting](#).

Recipients must detail their potential plans to operationalize the core functions as part of their application as further described in Section [D2.4.1 Project Narrative](#).

A4.1 Model Structure Overview

The IBH Model will focus on state-based innovation, led by the state Medicaid agency (SMA) as the Recipient, to test a care delivery framework where the BH setting is the facilitator of integrated care. Specialty BH practices and settings (see Section [A4.1.1 Definitions](#)) within the selected states

³ <https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html>

⁴ This is not an exhaustive list of requirements or cooperative agreement funding use.

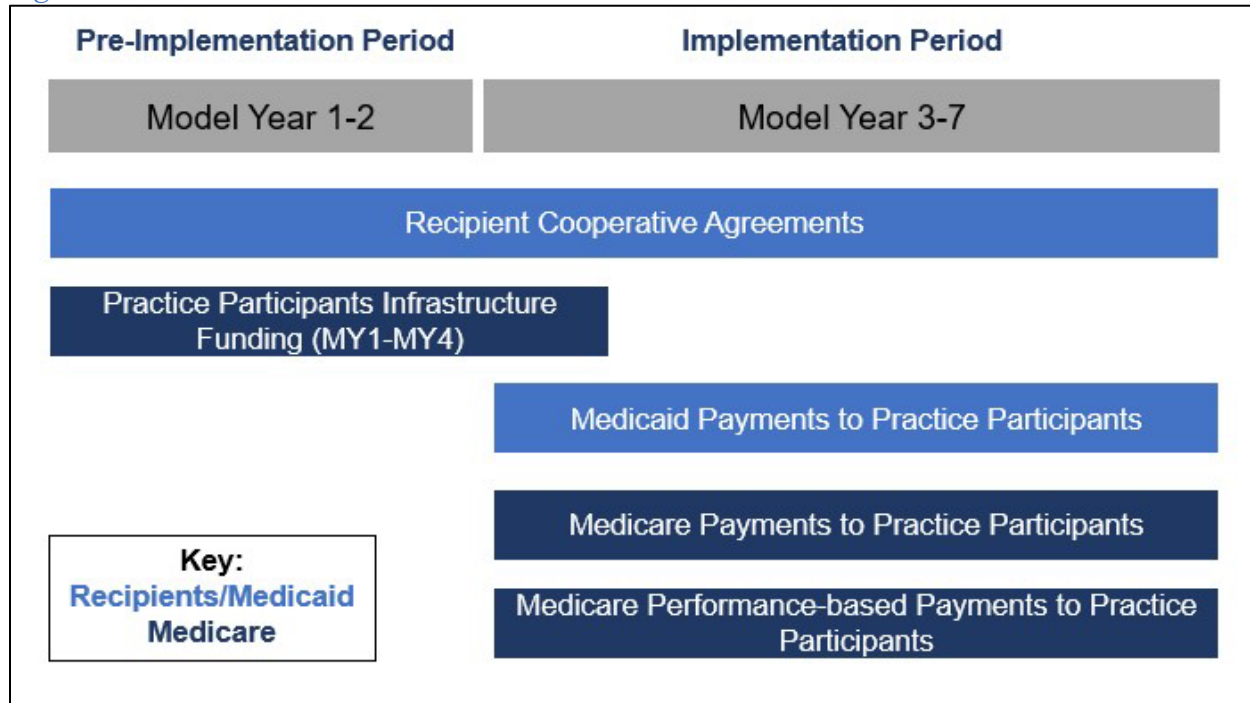
will be the Practice Participants and entry points for adult Medicaid, Medicare, and dually eligible beneficiaries to receive integrated care.

Recipients of this award will develop a Medicaid Payment Approach that includes a Medicaid performance-based payment (PBP). The Medicaid Payment Approach shall align with the Integration Support Payment (ISP) and Medicare PBP developed by CMS (further details available in [Appendix VI Medicare Payment Approach Details](#)). The Medicaid Payment Approach will be implemented in parallel to the Medicare Payment Approach for eligible Practice Participants within the selected states. Recipients can operate the IBH Model across their state or in a specified sub-state area.

CMS will award, through a competitive process, cooperative agreements to up to five successful Cohort II Recipients. During the two-year Pre-Implementation Period, Recipients will be required to undertake several readiness and technical assistance activities to support Practice Participants and develop their Medicaid Payment Approach in partnership with CMS. The Pre-Implementation Period is designed to help Recipients:

- identify and recruit Practice Participants alongside relevant partners (Such as MCOs or state mental health authorities and/or single state agencies for SUDs;
- support their Practice Participants in developing the needed infrastructure and technical expertise to implement the care delivery framework;
- meet data reporting requirements; and
- establish a Medicaid Payment Approach, in partnership with CMS, to support the care delivery framework.

Figure 4.1.3: IBH Model Structure



A4.1.1 Model Definitions and Components

IBH Model Definitions	
Infrastructure Funding	Payments made by Recipients to Practice Participants to support and fund investments in certified health IT products and infrastructure improvements for their practice and patient population, including (1) improving data infrastructure; (2) establishing quality goals; (3) supporting data collection efforts to advance toward accountable care and the development of a plan to address needs specified in the population health needs assessment; and (4) support practice transformation activities.
Integration	The coordination (and as appropriate, provision) of PH care ⁵ by the BH care team and in the BH setting, along with attention to needs that impact health and appropriately matched BH interventions. Integration in the IBH Model is a person-centered approach to identify and address (as appropriate within scope of practice) PH in the BH setting in which the person with moderate to severe BH conditions may be already or more frequently engaged to supporting preventive care and health promotion. This care may be co-located or virtual.
Moderate to Severe Mental Health Conditions and/or Substance Use Disorders (SUD)	The specific BH diagnoses defined by CMS, in consultation with clinical subject matter experts from SAMHSA, as “moderate to severe” are listed in Appendix IX .
Physical Health (PH) Consultant	A PH provider who specializes in the diagnosis, evaluation, and therapeutic management of PH conditions and is qualified to prescribe medication (physician, nurse practitioner, etc.). The PH Consultant participates in regular review of the clinical status of beneficiaries receiving IBH services and advises the billing practitioner and care management team about screening and follow-up for positive screens, PH diagnosis, treatment initiation, care options, monitoring for complications of PH conditions, and options for resolving issues with beneficiary adherence and tolerance of PH treatment with a culturally informed and person-centered approach. The PH Consultant also advises on managing any negative interactions between beneficiaries’ PH and BH treatments and other needs that impact health and offers a referral for direct provision of primary care when clinically indicated and suggests specialty care options as needed. The PH Consultant could be an in-house provider working at a specialty BH practice or could be an outside provider who contracts with a specialty BH practice.

⁵ Physical health care includes care and services for non-behavioral health conditions (i.e., mental health and SUDs) and is inclusive of oral health.

IBH Model Definitions	
Physical Health (PH) Providers	Physicians and non-physician practitioners whose primary area of practice involves the diagnosis, evaluation, and therapeutic management of non-BH conditions.
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.
Specialty BH Organizations and Settings	A health care provider, practice, facility, or other community-based organization delivering BH treatment services outside of an inpatient, emergent, or urgent care level of care where BH services are available to beneficiaries and are the predominate health care service type delivered, or where longitudinal BH services are available and delivered by a specialty BH provider. 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 BH care arrangement involves a Practice Participant who agrees to be accountable for quality, utilization, patient experience, and care integration over a sustained period.
Specialty Behavioral Health ("BH") Providers	Specialty BH providers refers to physicians, non-physician practitioners, and other eligible professionals whose primary area of practice involves the diagnosis, evaluation, and therapeutic management of mental health and SUD conditions, as permitted under federal and state law. Specialty BH providers 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 CY2024 Physician Fee Schedule final rule.
IBH Model Components	
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.
Commercial payer participation	Recipients are encouraged to use existing relationships with commercial payers to further strengthen payer alignment efforts in their states.

IBH Model Components	
Medicaid participation	Practice Participants that currently serve (or will serve) Medicaid beneficiaries and/or are currently billing Medicaid in participating states by the start of model year MY1 (BP1). Practice Participants must at minimum participate in their state's Medicaid Payment Approach to participate in the IBH Model. Practices that participate in the Medicaid Payment Approach may be eligible to participate in the Medicare Payment Approach. State agreements with Practice Participants will follow existing state protocols for Medicaid participation. Recipients will lead the design of the Medicaid Payment Approach and care delivery framework and provide technical assistance and programmatic support to Practice Participants.
Medicare participation	Practice Participants that participate in their state's Medicaid Payment Approach <i>and</i> are accepted to participate in the Medicare Payment Approach. Practice Participants will enter into separate participation agreements with CMS that govern the Medicare Payment Approach. Providers that do not participate in the Medicaid Payment Approach cannot participate in the Medicare Payment Approach.
Multi-Payer Approach	The IBH Model is focused on multi-payer alignment. Multi-payer alignment is critical to achieving model success because it streamlines care delivery efforts and payment for IBH Practice Participants across their patients and lines of business. The IBH multi-payer approach consists of the following principles: • Directional alignment: CMS will work with Recipients to closely align on areas of the Model that directly reduce provider burden and are important to model aims and evaluation of outcomes, such as quality measurement, the type and format of data provided, and learning priorities. CMS will not require Recipients to build identical payment arrangements to other Recipients and/or to what is proposed in the Medicare ISP and PBP. Directional alignment is detailed further in Section A4.4.4: Multi-Payer Alignment. • Medicaid Flexibility: Recipients may customize certain model elements, such as Medicaid payment systems and care delivery, while remaining directionally aligned with IBH's Medicare Payment Approach. Specifically, CMS will require Recipients to move Practice Participants away from traditional Medicaid FFS payment, but Recipients will have flexibility to choose what type of non-FFS Medicaid payment to implement. (See Sections A4.4 IBH Payment Strategy and A4.3 IBH Care Delivery Framework for specific areas of flexibility.)

IBH Model Components	
Practice Participation	Eligible specialty BH organizations and settings (“Practice Participants”) may elect to participate by delivering the IBH care delivery framework (A.4.3 IBH Care Delivery Framework) and, in exchange, receive payment for their eligible beneficiaries (defined further in Section A4.2.1 Eligible Practice Participants). Practice Participants may also be eligible to receive specific funding to procure necessary health IT upgrades such as adopting EHRs.
SMA Participation	Recipients (SMAs) receive cooperative agreement funding in both the Pre-Implementation and Implementation Periods to support the development of key model activities, including, but not limited to, the Medicaid Payment Approach, care delivery framework, and key data sharing and infrastructure activities.

This section displays the Recipient cooperative agreement requirements for the pre-implementation and implementation periods. Table A.4.1.2 exhibits a summary of each requirement and where further details can be found.

Table A.4.1.2: Cooperative agreement requirements – at a glance:

Requirement	Description	Relevant Section
Recruit IBH Practice Participants	The Recipient will be required to work with relevant parties to recruit eligible BH Practice Participants to the IBH Model	A4.2 Recruit Practice Participants
Design and implement the IBH care delivery framework	The Recipient will collaborate with CMS, Practice Participants, and relevant parties to design and implement the IBH care delivery framework	A4.3 IBH Care Delivery Framework
Design and implement the IBH Medicaid payment arrangement	The Recipient will design, establish, and implement the IBH Medicaid Payment Approach in partnership with CMS	A4.4 IBH Payment Strategy
Distribute cooperative agreement funding, including Infrastructure Funding	The Recipient will distribute cooperative agreement funding (including Infrastructure Funding) to help achieve model goals	A4.5 Infrastructure Development and Funding Distribution
Participate in the convening structure	The Recipient will aid in identifying and implementing a convening of relevant IBH parties	A4.6 Convening Structure

Requirement	Description	Relevant Section
Participate in model data, quality, and evaluation efforts	The Recipient will enable the continuous flow of IBH Model data, including through quarterly measure submission and technical assistance to Practice Participants	A4.7 Data, Quality, and Evaluation

A4.2 Recruitment of Practice Participants

A4.2 Recruitment Requirements:

Pre-implementation period requirements	Implementation period requirements
<i>During the pre-implementation period, Recipients must:</i> • Implement the BH practice recruitment strategy. ◦ Identify, recruit, and enroll eligible BH Practice Participants. • Secure a letter of intent from at least one managed care organization (MCO), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs) (where applicable) to participate in the IBH Model. • Secure a letter of intent from the State Mental Health authorities and/or Single state agencies for SUDs.	<i>During the implementation period, Recipients must:</i> • Enroll and retain BH Practice Participants. • Continue to recruit Practice Participants through the end of MY3 (BP3).

Recipients are required to solicit interest and recruit Practice Participants into the IBH Model who meet the eligibility criteria detailed below in Section [A4.2.1 Eligible Practice Participants](#) and must submit a practice recruitment strategy with their application. CMS encourages Recipients to include State Mental Health Authorities and/or Single State Agencies for SUDs, and managed care organizations, risk-based prepaid inpatient health plans (PIHPs), risk-based prepaid ambulatory health plans (PAHPs)⁶, or other intermediaries in developing the practice recruitment strategy given their knowledge of existing practice networks. The practice recruitment strategy shall include:

- A plan for recruiting Practice Participants into the IBH Model, including key partners and how they may support recruitment activities.
- Plans to include outreach with rural, safety-net specialty BH providers, under-resourced providers, tribal providers, and providers serving vulnerable populations in the recruitment strategy.
- An estimated number of Practice Participants enrolled in the IBH Model by the end of MY3 (BP3).
- An estimated number of total Medicaid enrollees with MSBH conditions to be attributed to the IBH Model for the entire duration of the Implementation Period.

⁶ All references to PIHPs and PAHPs refer to risk based PIHPs and PAHPs

Recipients may begin enrolling practices starting in MY1 (BP1). Recipients (or their fiscal intermediaries) are required to have Practice Participants recruited into the IBH Model by the start of MY2 (BP2) and may continue recruiting Practice Participants through the end of MY3 (BP3).

In addition to recruiting Practice Participants, the Recipient must secure a letter of intent (LOI) from at least one MCO, PIHP, or PAHP, if the Recipient's BH network is managed through an MCO, PIHP, or PAHP, at the time of submitting this application. The Recipient must also secure a letter of intent from their State Mental Health Authorities and/or Single State Agency for SUDs.

CMS will work with participating state Medicaid agencies to determine the pathway for implementing the Medicaid payment arrangement, including any state plan amendments, waivers (including but not limited to Medicaid section 1115(a) authority, 1915 authority), or Medicaid managed care contract modifications that may need to be approved.

A4.2.1 Eligible Practice Participants

Within the Recipient's proposed geographical service area, specialty BH organizations and settings will be eligible Practice Participants who, at the time of application, meet all the following criteria:

- Have at least one BH provider that is an employee, leased employee, or independent contractor of the practice and:
 - 1) Is licensed by the state to deliver BH treatment services; and
 - 2) Meet any state-specific Medicaid provider enrollment requirements and is eligible for Medicaid reimbursement.
- Meet all state-specific requirements to deliver BH services, if applicable;
- Serve adult Medicaid beneficiaries (age 18 or older) with moderate to severe BH conditions; and
- Provide MH and/or SUD treatment services at the outpatient (OP) level of care. This does not include the intensive outpatient (IOP) level of care.

Practices that provide only case management⁷ or only recovery services or do not provide direct delivery of diagnostic or treatment of BH services are **not** eligible 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 and value-based purchasing programs.

Examples of eligible Practice Participants may include but are not limited to:

- Community Mental Health Centers (CMHCs);
- Rural Health Clinics (RHCs) that provide specialty BH care services;⁸
- Federally Qualified Health Centers (FQHCs) that are dually-certified as a BH provider
- Critical Access Hospital (CAH) outpatient BH clinics;
- Independent health care providers with and without clinic affiliations;

⁷ 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.

⁸ Additional information regarding RHC eligibility requirements will be released in future guidance materials.

- Certified Community Behavioral Health Clinics (CCBHCs);
- Opioid Treatment Programs (OTP);
- Private specialty clinics with and without medical center affiliations.
- Specialty substance use disorder provider organizations;
- Tribal health organizations and clinics; and
- Local and territorial health departments and governments or other entity that is part of a local government BH authority where a locality, county, region, or state maintains authority to oversee BH services at the local level and uses the entity to provide those services.

Practice Participants will be identified using a combination of their tax identification number (TIN) and national provider identifier (NPI), cross-referenced through the required provision of Medicaid provider identification numbers.

To be eligible to participate in the model, when the state recruits a practice to participate, that practice must serve, at the outpatient level of care, at least 25 Medicaid MSBH beneficiaries on average per month. As outlined in Section [A4.2.2 Eligible Beneficiaries](#) all adults served by the eligible Practice Participant are eligible to receive model services where medically necessary and appropriate regardless of diagnostic status. CMS anticipates each state will include approximately 10,000 Medicaid beneficiaries with MSBH conditions throughout the course of the Model. To reduce practice burden and ensure an equitable continuity of services, states are encouraged to require Practice Participants to treat all Medicaid beneficiaries with BH needs through the IBH care delivery framework, where the services are deemed reasonable and medically necessary.

The specific BH diagnoses defined by CMS, in consultation with clinical subject matter experts from SAMHSA, as “moderate to severe” are listed in [Appendix IX](#).⁹ CMS reserves the right to consider changes should diagnoses need to be added or removed from the list of MSBH diagnoses. CMS will communicate any changes to Recipients with advance notice. Recipients will work with their Practice Participants, State Mental Health authorities and Single state agencies for SUDs and partnering MCO (or other fiscal intermediary) to develop a process to verify that practices serve the minimum number of Medicaid MSBH beneficiaries, no less than annually. Additionally, Recipients will make their Practice Participant Lists available to CMS as part of their model reporting requirements detailed in Section [F6.3 Performance Milestones](#).

The Practice Participant eligibility criteria will be the basic framework that Recipients will be required to use to identify eligible Medicaid Practice Participants. Recipients and their applicable subrecipients (such as MCOs, PIHPs, or PAHPs) may not apply further limiting eligibility criteria in addition to the criteria laid out by CMS, except for limiting eligibility by sub-state region as allowable and identified in its application.

Medicaid Practice Participants will also be eligible to participate in the Medicare Payment approach of the Model, assuming they are enrolled as fee-for-service Medicare providers and are in good standing,¹⁰ and meet the IBH Practice Participant criteria. Practice Participants will not be allowed to participate in the Model as Medicare-only providers, but Practice Participants may choose to participate only in the Medicaid payment arrangement. Ideally, all IBH Model Practice

⁹ The IBH Model’s “moderate to severe” behavioral health conditions are not to be confused with SUD mild, moderate, or severe classifications that are based on the number of diagnostic criteria that are fulfilled. Thus, in this NOFO, “moderate to severe” does not refer to those specific SUD classifications.

¹⁰ Good standing means able to bill Medicare, Medicare Provider Enrollment, Chain, and Ownership System (PECOS) is up to date, and provider does not have any outstanding fraud and abuse litigation.

Participants will participate in both Medicaid and Medicare to bolster multi-payer alignment. Any IBH Medicaid Practice participant unable to have payments withheld will be required to also participate in the Medicare Payment Approach, where applicable. CMS will review this on a case-by-case basis. Please see [Appendix VI](#) for more details on this requirement.

A4.2.2 Eligible Beneficiaries

All adult Medicare and/or Medicaid beneficiaries receiving care from eligible Practice Participants will be eligible for the Model, regardless of their specific BH diagnoses, if the services are deemed reasonable and medically necessary. If services are not reasonable and medically necessary (i.e., the level of care required by the IBH care delivery framework is not needed), the beneficiary will not be enrolled in the IBH Model. Recipients shall encourage Practice Participants to educate beneficiaries regarding IBH services and develop standardized practices to assess a beneficiary's need for the IBH care delivery framework services.

A4.3 IBH Care Delivery Framework

A4.3 Section Requirements:

Pre-implementation period requirements	Implementation period requirements
<i>During the pre-implementation period, Recipients must:</i> - Design and prepare implementation of the IBH Medicaid care delivery framework as described in this section. - Provide updates on the design of the care delivery framework in quarterly progress reports.	<i>During the implementation period, Recipients must:</i> - Implement the IBH Medicaid care delivery framework as described in this section. - Provide implementation updates, successes, challenges, and lessons learned in quarterly progress reports.

The Recipient must design and prepare for implementation of the IBH care delivery framework that enables Practice Participants and their partners to deliver care integration, care management, preventive care and health promotion services as detailed below in Section [A4.3.1 Care Delivery Framework Overview](#).

The Recipient must provide updates on the development of the care delivery framework in Quarterly Progress Reports during the pre-implementation period. The IBH care delivery framework must be ready for implementation by Practice Participants at the start of MY3 (BP3). Recipients must adhere to all applicable Federal, state, and local laws and ordinances, and shall work with their Convening Structure to determine what patient authorizations and reauthorizations may be required to implement the IBH Model as designed, for example, to engage in data sharing activities.

The Recipient must implement the IBH care delivery framework including maintaining the infrastructure, processes, and programs established during the model Pre-Implementation Period throughout the duration of the Model. As detailed below and throughout this NOFO, these include, but are not limited to, maintaining and supporting required staff to implement the Model, and ensuring all required services are being furnished by Practice Participants and their partners. Additionally, Recipients must maintain relationships with Practice Participants and MCOs, PIHPs, PAHPs, or other fiscal intermediaries.

Examples of funded activities:

- Practice transformation activities for Practice Participants to carry out the IBH care delivery framework.
- Clinical subject matter support to implement the IBH care delivery framework.
- Benefit design activities to support the implementation of the IBH care delivery framework.

A4.3.1 Care Delivery Framework Overview

The Recipient is responsible for developing the IBH Medicaid care delivery framework in partnership with CMS according to the requirements set forth in this document. Recipients will leverage convenings with commercial payers, potential Practice Participants, and other stakeholders to design and operationalize the IBH Model's Medicaid component of the care delivery framework. The Recipient will use a shared vision for population health, preventive care, and health promotion outcomes, considering state-specific nuances and context, to build the Medicaid care delivery framework, capitalizing on existing infrastructure and capacity within the state. CMS will publish further care delivery framework guidance in model pre-implementation.

Required Elements: The IBH Model's care delivery framework includes three required core elements necessary to test a standard of integrated, person-centered care in specialty BH organizations and settings. Recipients will aid Practice Participants in delivering the following services:

- 1) **Care integration:** Practice Participants will screen, assess, treat, and refer patients as needed for both BH and PH conditions, within the scope of practice of the Practice Participants' providers.
- 2) **Care management:** an interprofessional care team will address the needs of the beneficiary and provide ongoing care management across the beneficiary's BH and PH needs.
- 3) **Preventive Care and Health Promotion:** Practice Participants will engage in activities that improve health for all beneficiaries, including conducting a population health needs assessment and identifying beneficiary issues that interfere with diagnosis, management, and treatment of health conditions, such as food, housing, and transportation needs. Practice Participants will develop plans to address needs identified in the population health needs assessment.

Optional and Complementary Components: As previously noted, the IBH Model encourages Recipients to build on existing initiatives, and as such, Recipients may include additional care delivery services, particularly those that are relevant to their state or sub-state context. The care delivery framework requirements listed in Section [A4.3.3 Care Delivery Framework Requirements](#) are necessary to reach model directional alignment for integration and shall not deter additional innovation at the state level.

- The IBH Model encourages Recipients to provide additional services, as relevant to their populations and context.
- Recipients are encouraged to build on existing policy infrastructure and integrate the IBH Model into existing Medicaid BH models focused on the priority population (beneficiaries with moderate to severe BH conditions) including but not limited to CCBHCs, Medicaid Health Homes, OTPs, and the PIPBHC program.

A4.3.2 Priority Health Condition Requirements: Diabetes, Hypertension, Tobacco Use

The IBH Model will use diabetes, hypertension, and tobacco use as measures of care integration. Therefore, Practice Participants must screen eligible beneficiaries for diabetes, hypertension, and tobacco use. These priority health conditions were based on:

- evidence on their prevalence in the BH beneficiary population;
- the level of spending on each condition by CMS;
- clinical expertise on the ability to treat these conditions in the BH setting; and
- the increased risk of morbidity, disability, and mortality for beneficiaries associated with these conditions.

Assessment and treatment of these conditions in BH settings can be carried out by an in-person PH consultant. Alternatively, a telehealth appointment may also be used for assessment and treatment where the use of telehealth appointments is otherwise allowed.

Mandatory Components: Recipients will develop a Medicaid Payment Approach that enables their Practice Participants to screen and assess the beneficiary's PH needs, followed with appropriate treatment and/or referral. Screening must be evidence-based and must include, at a minimum, diabetes, hypertension, and tobacco use. Screening may include, but is not limited to:

- Reviewing the beneficiary's medical history and medications to assess for a current diagnosis;
- Assessing risk factors or symptoms; and
- Performing screening labs or tests in accordance with evidence-based guidelines.

Optional Components: Recipients may require additional priority health conditions to be included in each beneficiary's screening. Recipients are encouraged to include:

- conditions that are a priority within the Recipient's state or regional context;
- conditions where health disparities are prevalent; and
- conditions that can enhance the case for post-model sustainability. For example, high-cost conditions that have savings potential within the proposed geographic region.

For example, a Recipient may choose to include hepatitis C as a priority health condition.

If a Recipient chooses to add additional priority health conditions, the Recipient shall propose an accompanying quality measure to assess outcomes.

A4.3.3 Care Delivery Framework Requirements

The requirements for the IBH Model care delivery framework are listed in the table below. The first two columns of the table include requirements for Recipients and Practice Participants. The third column lists examples of enhanced innovation opportunities for Recipients and Practice Participants to drive further innovation. The fourth column shows existing initiatives and policies as examples of activities or requirements that are occurring in states. The latter two columns are not exhaustive and are intended for illustrative purposes only.

Core Element	Recipient Requirements	Practice Participant Requirements	Enhanced Innovation Opportunities	Existing Initiatives and Policies
Care Integration	• Provide evidence-based guidelines for BH and PH screenings to Practice Participants as needed. • Evaluate and map Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes to ensure all IBH requirements can be delivered. • Work with intermediaries to evaluate primary care provider networks and access standards to ensure IBH beneficiaries can access PH care in a timely manner. • Work with the convening structure and or intermediaries to facilitate learnings and TA around care integration.	• Use evidence-based guidelines to screen and assess BH and PH conditions, and other needs that impact health as part of the IBH Welcome Visit.¹¹ • Use evidence-based guidelines to screen and assess BH and PH conditions and other needs that impact health as part of ongoing patient care. • Screen to determine if a beneficiary is engaged with a provider to receive primary care services. • Build a comprehensive care plan with input from a PH consultant¹². • Consult with a PH provider on PH treatment initiation, care options and monitoring for complications of PH conditions, and negative interactions of PH with BH treatment and other needs that impact health.	• Recipients may establish guidelines around the provision of PH treatment in the BH setting, including but not limited to: ○ Telehealth consultation by a PH provider, ○ Co-location of a PH provider, ○ Treatment by a dual-trained or certified BH/ PH provider, and/or ○ Protocol-guided treatment initiation with PH provider referral and follow-up	• CCBHC demonstrations and grants • Medicaid Health Homes • PIPBHC program

¹¹ The IBH Welcome Visit also involves the receipt of informed consent from the beneficiary for IBH Model services and participation in the model.

¹² Practice Participants who cannot provide identified E&M services within their scope of practice will be encouraged to develop an annual care agreement or other relationship with PH providers outlining roles and shared accountability and will be required to submit a roster of their partnering PH providers; the roster would make the listed PH providers eligible to use a new or modified consult and/or care management code. If no roster is in place, the PH provider will use existing professional consult codes for payment. Referral to a specific PH care provider shall align with the beneficiary's preferences; if the beneficiary's physical health provider is not included on the roster under this model with the Practice Participant, the physical health provider shall use existing professional consult codes for payment.

Core Element	Recipient Requirements	Practice Participant Requirements	Enhanced Innovation Opportunities	Existing Initiatives and Policies
Care Integration (continued)	• Work with CMS to ensure compliance with Medicaid rules and secure any necessary modifications to existing program structures.	• Re-evaluate the care plan based on patient outcomes, with input from a PH consultant if needed. • Treat identified BH and PH conditions based on the specialty BH provider's scope of practice or refer to a PH provider as needed. • Refer beneficiaries to social services to address identified needs that impact health, with support from a community health worker, peer support specialist, or other navigator as needed. • 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		

Core Element	Recipient Requirements	Practice Participant Requirements	Enhanced Innovation Opportunities	Existing Initiatives and Policies
Care Management	Recipients will provide state-specific guidance to Practice Participants on utilization of any state-based data warehouse or care management tools for health care and social service navigation	- Provide care management that includes person-centered planning, care coordination, utilization management, transitional care services, and health care navigation for each beneficiary's BH and PH conditions and other needs that impact health. - Provide beneficiary self-management support, and outreach and engage beneficiaries in BH and PH care, with support of 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. - Establish procedures for and manage instances of hospitalization, emergency department use, and other care transitions (admission, discharge, and transfer) - Track and monitor beneficiaries' BH and PH conditions, other needs that impact health, and treatment needs to coordinate across disciplines	Recipients may add additional care management requirements for Practice Participants, with associated quality metrics as appropriate	MCO may support providers with data analytics, care management workflows, provide encounter information and claim line feed, provide data on member preferences, educate providers on existing programs or opportunities for members to connect them appropriately, enrollment support, connect with social support agencies and organizations etc.

Core Element	Recipient Requirements	Practice Participant Requirements	Enhanced Innovation Opportunities	Existing Initiatives and Policies
Preventive Care and Health Promotion	- Facilitate relationships between social service agencies and Practice Participants through introductions, shared meetings, and appropriate connections to facilitate warm hand-offs (e.g., through the Model's convening structure). - Provide Practice Participants with a population needs assessment detailing the health disparities experienced by the Practice Participant's service population. This population needs assessment:	- Screen each beneficiary for other needs that impact health on a minimum of an annual basis and use this information to inform the beneficiary's care plan. - Participants will (1) choose a state-required other needs that impact health screening instrument or (2) select questions for each required domain from the Gravity Project's list of validated, health IT-encoded screening instruments, located in the National Library of Medicine Value Set Authority Center, or (3) from a list of screening instruments provided by CMS.	- Recipients may develop and implement statewide protocols for screening, referral, and follow up of food, housing, transportation, and other needs. - Recipients may be able to use new or existing waiver authorities or demonstrations to fund the provision of social services for identified needs that impact health.	- Existing population health/needs assessments - State-led whole person health coalitions - State departments of social and/or human services

Core Element	Recipient Requirements	Practice Participant Requirements	Enhanced Innovation Opportunities	Existing Initiatives and Policies
Preventive Care and Health Promotion (continued)	• Will include cultural, linguistic, geographic, and technological needs, the impacts of large-scale public health emergencies (e.g., COVID-19), and BH and PH treatment needs as well as other needs that impact health. • Identify existing disparities in outcomes stratified by certain characteristics. • Will include a statewide plan that identifies the strengths and challenges in how the Recipient is addressing these disparities at the state level. • Provide suggested opportunities for how Practice Participants can address disparities within their practice and align their efforts with state activities. • Be no less than 5 years old and be updated at least every 5 years during this model.	• Develop and implement protocols for screening, referrals, and follow-up of needs that impact health. • Build a plan that details steps Practice Participants will take to address the needs identified in the population needs assessment, including how the Practice Participant will build care teams that reflect the needs of the population based on the population needs assessment. The plan shall stipulate how the Practice Participant will address needs that disproportionately impact their service populations.	• Recipients may add additional state requirements for health-related needs data collection in addition to the CMS-approved screening tools. • Recipients may facilitate closed-loop referrals with social service agencies by providing appropriate data warehousing and management. • Recipients are encouraged to use an existing population needs assessment that is completed for another state or federal program	• Section 1115 demonstration • Other needs that impact health opportunities • Managed care contracts • SAMHSA block grants

A4.4 IBH Payment Strategy

A4.4 Section Requirements:

Pre-implementation period requirements	Implementation period requirements
<i>During the pre-implementation period, Recipients must:</i> • Develop the IBH Medicaid Payment Approach by the end of MY2 (BP2) for implementation at the start of MY3 (BP3). ○ Provide updates on the design of the Medicaid Payment Approach in quarterly progress reports. ○ The Medicaid Payment Approach shall include an attribution approach.	<i>During the implementation period, Recipients must:</i> • Implement the IBH Medicaid Payment Approach. ○ Provide Medicaid Payment Approach updates, successes, challenges, and lessons learned in quarterly progress reports. ○ Provide CMS with a list of Medicaid attributed beneficiaries on a quarterly basis.

The Recipient must develop an IBH Medicaid Payment Approach that includes all of the required services detailed in Sections [A4.3 IBH Care Delivery Framework](#), [A4.4.1 Medicaid Payment Approach Overview](#), and [D2.4.1 Project Narrative](#). The IBH Medicaid Payment Approach must have a performance-based payment component which includes all practice-based measures detailed in Section [A4.7.2.1 State-based and Practice-based Measures](#). Recipients are encouraged to engage members of their Convening Structure (further described below) in the design of their Medicaid payment arrangement. The Medicaid Payment Approach must be established by the end of MY2 (BP2) for Practice Participants to utilize at the start of MY3 (BP3). The Recipient must communicate successes and difficulties in developing their Medicaid Payment Approach with their federal Project Officer so they can help in providing technical assistance. Examples of relevant updates in the design phase of the Medicaid Payment Approach include but are not limited to:

- Identifying the applicable federal or state authorities to establish the IBH Model Medicaid Payment Approach;
- Developing the IBH Model payment rates; and
- Designing and implementing any necessary billing procedures.

The Recipient must implement the approved Medicaid Payment Approach starting at the beginning of MY3 (BP3). The Recipient shall clearly report progress and impediments in implementing the Medicaid Payment Approach in quarterly progress reports. Such updates shall include information about the performance-based payments that the Practice Participants are receiving, including but not limited to:

- Collection of cost data to support monitoring and overall evaluation of the IBH payment approach;
- Performance of practice participants in the Medicaid Payment Approach and PBP;
- Successes and challenges of implementing the Medicaid Payment Approach.

Please note that payments for the Medicaid Payment Approach are required to come from existing state Medicaid funds. The federal funds provided as part of this NOFO cannot be used to cover any clinical services or administrative expenses for which the state is claiming FFP for Medicaid administrative services.

A4.4.1 Medicaid Payment Approach Overview

The Medicaid Payment Approach shall support practice participants in achieving person-centered care and include value-based incentives that reach the care teams who deliver care and incentivize practice participants to invest in and adopt new approaches to care delivery and integration of care, while striking a balance of financial and clinical risk that is appropriate and manageable. The Medicaid Payment Approach includes the Medicaid Payment Approach and the PBP.

The Medicaid Payment Approach and PBP shall move Recipients away from traditional Medicaid FFS payments to value-based payments. More specifically, Recipients must at a minimum initially meet the LAN Category 2A payment model with ties to infrastructure (such as those provided for health IT investments). No later than MY3 (BP3), the payment shall progress to at least a LAN Category 2B and transition to a Category 2C or above for select measures in MY4 (BP4), where payments are based on FFS architecture with ties to reporting and performance on specific quality measures. By MY6 (BP6), each Recipient will be required to include both a withhold and an upside bonus payment in the Medicaid payment approach, where appropriate. The Medicaid Payment Approach is designed to be flexible to meet the unique needs of individual states and comply with existing state Medicaid program rules and regulations. CMS recognizes that many states have undergone comprehensive innovation in BH benefit design and payment. In addition, many states have implemented, or are considering implementing, existing Medicaid state-based initiatives, such as Behavioral Health Homes and CCBHCs. CMS will work with states to implement IBH in a way compatible with those programs' requirements.

The IBH Model's approach to Medicaid payments aims to:

- Leverage the strengths and innovation of Recipients;
- Harness the policy momentum in states;
- Bring Medicare to the table; and
- Develop aligned Medicare and Medicaid alternative payment models that provide stability and support providers during their transition to value-based care. Recipients have flexibility in designing their approach to the Medicaid IBH payment model to allow the state to align IBH with their state's current BH delivery systems design and priorities.

As described in Section [A4.1 Model Structure Overview](#), the IBH Model will include aligned Medicaid and Medicare Payment Approaches. Each payment approach includes the same core elements, described below. Recipients who are currently participating in the federal CCBHC Demonstration and want to include their CCBHC Demonstration providers in the IBH Model shall reference [Appendix V: Medicaid Payment Scenarios for Health Homes and CCBHCs](#) for information about Infrastructure Funding, payment, and performance-based payments.

The IBH Model's approach to multi-payer alignment is designed to provide flexibility across three core features in a way that enables payer alignment and offers Practice Participants a glidepath to VBP. The Model's multi-payer alignment approach is built with key elements that are required across payers, but with considerable room for customization. If desired, Recipients are permitted to use the Medicare Payment Approach ([Appendix VI Medicare Payment Approach Details](#)) to build their Medicaid Payment Approach, increasing alignment between payers while also promoting state innovation.

A4.4.2 Medicaid Payment Approach Requirements

The IBH Model allows states to build their own Medicaid Payment Approach in partnership with, and subject to approval by, CMS, use existing state or federal authorities (i.e., State Plan Amendments, 1915 waivers, Section 1115(a), managed care contracts) or use the Medicare Payment Approach as a basis for their payment design. Recipients may also be able to adapt an existing Medicaid payment authority to meet IBH Model requirements. The Cooperative Agreement funding can be used in part for developing the Recipient's Medicaid Payment Approach, and CMS will also offer technical assistance to Recipients in this development process. The Medicaid Payment Approach must be established by the end of MY2 (BP2) for Practice Participants to utilize at the start of MY3 (BP3) and must shift that payment away from traditional Medicaid FFS. The payment principles and guidelines outlined further in Section [D2.4.1 Project Narrative](#) are flexibly designed to align with a variety of state Medicaid BH programs or payment arrangements (e.g., BH MCOs, PIHPs, PAHPs, and Medicaid FFS).

The IBH Model recognizes that many Medicaid programs have invested significant time and resources into developing BH programs and payment authorities. Therefore, the Model will not ask Recipients to revert to less sophisticated payment strategies if they have already developed (or are on track to implement) their Medicaid Payment Approach that can be leveraged for the purposes of the IBH Model.

Recipients have flexibility, subject to CMS approval, in reaching directional alignment in the design of the following components of their Medicaid Payment Approach:

- **Payment type:** Whether the payment uses a per-beneficiary per-month (PBPM), prospective payment system (PPS), or fee-for-service¹⁴.
- **Financial risk level:** The payment must have a combination of both upside and downside risk.
- **Performance-based payment strategy:** How the Recipient plans to reward improvements in quality and potential reductions in cost at the Practice Participant level. Please note that the Recipients' performance-based payment strategy must at least align with the Medicare Payment Approach's performance-based payment strategy.
- **Attribution strategy:** Recipients are required to attribute Medicaid beneficiaries using an attribution methodology outlined as part of their Medicaid Payment Approach. Recipients are not required to replicate the Medicare attribution methodology outlined in [Appendix VII: CMS Attribution Methodology for Medicare and Dually Eligible Beneficiaries](#). However, the Recipient must align their approach with the Medicare attribution methodology and send CMS a list of Medicaid attributed beneficiaries on at least a quarterly basis.

Core Required Elements of the Medicaid Payment Approach

- **Payments for implementing the care delivery framework:** Recipients will make payments to Medicaid Practice Participants to support the package of services and activities under the care delivery framework, as described in Section [A4.3 IBH Care Delivery Framework](#), beginning at the start of MY3 (BP3). Recipients may rely on existing Medicaid programs to implement this care delivery framework, where existing programs can provide

¹⁴ The Medicaid payment Approach must have a performance-based payment that aligns with the Medicare payment arrangement, at a minimum.

the required level of alignment as described in Section [A4.3 IBH Care Delivery Framework](#). Under the aligned Medicare model, Practice Participants that participate in Medicare will also receive an Integration Support Payment (ISP), as described in [Appendix VI: Medicare Payment Approach Details](#), that will be paid to Practice Participants beginning at the start of MY3 (BP3). Medicaid Payment Approach payments must come from existing state Medicaid funds, and the federal funds provided pursuant to this NOFO may not be used to cover any clinical services or administrative expenses for which the state is claiming FFP for Medicaid administrative services.

- **Performance based payments (PBP) to Practice Participants that participate in Medicaid:** Recipients must also make Performance Based Payments to Practice Participants, in addition to payments for clinical services during MYs 3 – 7 (BPs 3-7). The PBP must have a combination of upside and a withhold that shall be designed to encourage and reward behaviors such as data reporting, the advancement of care quality and accountability across multiple dimensions including care integration, care coordination, care efficiency, and patient-centered outcomes as demonstrated through performance on certain model quality measures. If Recipients are unable to include a withhold in the PBP of certain provider types, CMS will work with Recipients on a case-by-case basis to determine other performance-based accountability features. These practices will also be required to participate as a Medicare Practice Participant. The PBP to Medicaid providers will be paid for out of existing state Medicaid funds. The Medicare Payment Approach will also include an aligned PBP, as described in [Appendix VI: Medicare Payment Approach Details](#).

A4.4.3 Practice Participant Infrastructure Funding:

The IBH Model includes Infrastructure Funding during MY2–5 (BP2-5) for Practice Participants to develop infrastructure and capacity that will be necessary to address challenges to implement the care delivery framework for their patient population. Infrastructure Funding is available to Practice Participants through two mechanisms:

- **Infrastructure Funding to Practice Participants who participate in both the Medicaid and Medicare Payment Approaches:**
 - Practice Participants who participate in the IBH Medicare Payment Approach may receive Infrastructure Funding directly from CMS.
- **Infrastructure Funding to Practice Participants who participate in the Medicaid Payment Approach but not the Medicare Payment Approach:**
 - Recipients must implement a standardized practice needs assessment process to determine the final amount of Infrastructure Funding to pass through to each Medicaid-only practice.
 - Funding allocated towards infrastructure costs on behalf of the Practice Participant(s) will remain restricted until the Recipient submits a detailed budget for these costs and subsequently receives CMS approval.
 - More details on this requirement are available in Section [A4.5 Infrastructure Development and Funding](#).

Please note that federal funding provided to Recipients pursuant to their Cooperative Agreement for infrastructure-related activities may not also be claimed for Medicaid FFP purposes. Regardless of whether Infrastructure Funding is facilitated by CMS or Recipients, Practice Participants can use the Infrastructure Funding for the uses identified below in Table A4.4.3. Recipients can also

propose additional categories of permitted uses that are not currently listed, subject to review and approval by CMS.

Practice Participants with existing EHRs may be allowed to use Infrastructure Funding to further the goals of the Model, such as updating their EHR to allow for referral for needs that impact health. Recipients may also use their Cooperative Agreement funding to support similar, aligned activities, and will be encouraged to offer centralized resources and TA to their Practice Participants. Examples of activities that Infrastructure Funding may be used for are listed in *Table A4.4.3*.

Table A4.4.3: Examples of ways Practice Participants are allowed to use Infrastructure Funding from Recipients.

Category of activity	Example activities
Health IT and data sharing capacity building	• Adoption and upgrading of EHRs • 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 BH¹⁵. 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 necessary capabilities to connect the patient to a primary care or specialty provider, including use of audio-only telehealth as appropriate • Training and technical assistance to enhance knowledge around telehealth rules, regulations, and best practices.
Practice transformation activities	• Developing new clinical and payment infrastructure, policies, procedures, and workflows for systematic screening and tracking of PH conditions and other needs that impact health, referrals, and/or social service agency referrals as well as ongoing clinical coordination. • Implementing organization change management activities to facilitate provider behavior change, mastery, and self-efficacy in providing integrated care. • Hiring and training of 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 PH consultants to establish care protocols. • Establishing formal or informal agreements with primary care providers 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.

¹⁵ 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

A4.4.4: Multi-Payer Alignment

Due to the likelihood that many Recipients may already have BH innovations underway, the IBH Model is intentionally designed to ensure Recipients can continue to build on these efforts. Some Recipients may have developed well-established relationships with MCOs and commercial payers, and CMS expects Recipients to use these relationships to advance multi-payer alignment in their state. In addition, Recipients will build their care delivery framework and Medicaid Payment Approach in alignment with the requirements outlined in this NOFO.

Below, *Table A4.4.4* shows key areas of directional alignment among Recipients, Medicare, (and, where applicable, commercial payers) to the core model design elements. This approach provides a way for Recipients, MCOs, PIHPs, PAHPs, intermediaries, and other commercial payers taking part in, or aiming to align with, the IBH Model to move forward with a shared model framework while limiting provider burden in the process.

Table A4.4.4: IBH Medicare, Medicaid, and Multi-Payer Alignment Principles

Design Element	Design Feature	Directional Alignment Required Elements for Recipients
IBH Payment Strategy	Payment alignment	- Recipients must develop a Medicaid Payment Approach that is new, adapted from, or complements existing payment approaches in their state. - At a minimum, the Recipient's Medicaid Payment Approach must begin with pay for reporting by MY3 (BP3), (LAN Category 2B) and shift into pay for performance on certain measures by MY4 (BP4) (LAN Category 2C). The Payment Approach should also include a performance-based payment withhold by MY6. - Recipients will ensure alignment and eliminate payment duplication of any state waiver or demonstration that provides payment for services listed in this NOFO.
	Risk adjustment	Recipients are encouraged to implement a Medicaid Payment Approach that uses a risk adjustment methodology for both clinical and social risk factors¹⁶
	Attribution	- Beneficiary attribution is a method to associate beneficiaries with Practice Participants for the purposes of payment. Recipients will attribute Medicaid beneficiaries to the IBH Model using the Recipient's own attribution methodology (or using an existing attribution model, such as health homes) that generally aligns with the Model's Medicare alignment parameters. For example, Recipients will send each Medicaid Practice Participant a list of its attributed Medicaid beneficiaries on a quarterly basis during the Model Implementation Period. - Recipients will provide CMS, on a quarterly basis, a list of all dually eligible and Medicaid-attributed beneficiaries.

¹⁶ Though the Medicare risk adjustment methodology is currently under development, initial plans include leveraging non-clinical (social) and clinical risk factors. See Appendix VI: Medicare Payment Approach Details for additional detail.

Design Element	Design Feature	Directional Alignment Required Elements for Recipients
Data, Quality, and Evaluation	Quality measures	- Recipients and MCOs, PIHPs, or PAHPs must agree to report on the state-based quality measures listed in Table A4.7.1. - Recipients, MCOs, PIHPs, or PAHPs, will help Practice Participants to submit practice-based measures.
	Quality incentives	Recipients must develop a performance-based Medicaid Payment Approach using the quality measures listed in Table A4.7.2 under practice-based measures. Recipients shall add measures for any additional PH conditions they plan to add into the care delivery framework.
Convening Structure	Frequency	- Alongside CMS, identify a third-party convener to host the IBH Model-related efforts six months after the start of the pre-implementation period. - By the start June MY1 (BP1), it is strongly recommended that the convening structure meet no less than quarterly.

*Recipients shall refer to Section [A4.3.3 Care Delivery Framework Requirements](#) to reach directional alignment for the care delivery framework.

A4.5 Infrastructure Development and Funding

A4.5 Section Requirements:

Pre-implementation period requirements	Implementation period requirements
<i>During the pre-implementation period, Recipients must:</i> - Develop yearly funding requests for Cooperative Agreement Funding - Distribute funding to eligible parties, where applicable - Develop and implement the Health IT implementation plan - Provide cooperative agreement funding to Medicaid only Practice Participants between MYs 1-4 (BPs 1-4) using a standardized practice needs assessment process	<i>During the implementation period, Recipients must:</i> - Develop yearly funding requests for Cooperative Agreement Funding - Distribute funding to eligible parties, where applicable

Recipients are required to develop detailed annual plans for Cooperative Agreement funding use, in a form and manner specified by CMS, as part of their non-competing continuation (NCC) application. The annual plans must address the following factors:

- Practice participants that participate in the IBH Medicare Payment Approach will receive Infrastructure Funding directly from CMS. Medicaid-only Practice Participants cannot receive Infrastructure Funding from CMS and, instead, must receive Infrastructure Funding from the Recipient as available under this cooperative agreement.
- Recipients will be required to allocate a portion of cooperative agreement funding for each Medicaid-only Practice Participant between MYs 1-4 (BPs 1-4) using a standardized practice needs assessment process. This funding must be passed through for practice-level

Infrastructure Funding.

- Recipients shall plan to set aside approximately \$100,000 in cooperative agreement funding per Medicaid-only Practice Participant for budgeting purposes.
- Recipients must implement a standardized practice needs assessment process to determine the final amount of Infrastructure Funding to pass through to each Medicaid-only Practice Participant.¹⁷
 - If this needs assessment discovers a Medicaid-only practice has part of the necessary infrastructure needed for implementing the IBH Model, the Recipient is permitted to distribute only partial Infrastructure Funding to support practice transformation.
- Each Medicaid-only practice shall receive at least a portion of infrastructure funding for practice transformation activities.
 - Recipients can distribute Infrastructure Funding to Medicaid-only Practice Participants during MYs 1-4 (BPs 1-4), as a one-time payment, or in more frequent installments.
 - The practice needs assessment process for Medicaid-only practices is required to align to the process set forth by CMS for practices participating in the Medicare Payment Approach ([Appendix VI](#)). The needs assessment must assess for relevant infrastructure such as adoption of certified health IT, HIE integration, other population health management tools, as well as the need for practice transformation activities.
 - Recipients may cap Infrastructure Funding for Medicaid-only Practice Participants at 30 percent of the Recipients' total cooperative agreement funds. If the Recipient chooses to cap infrastructure funding for Medicaid-only Practice Participants at 30 percent of the Recipient's total cooperative agreement funds, the Recipient must work with CMS on a plan for how to appropriately target the funding. Recipients can provide more than 30 percent of their total cooperative agreement funds if they choose.
 - Funding allocated towards infrastructure costs on behalf of the Practice Participant(s) will remain restricted until the Recipient submits a detailed budget for these costs and subsequently receives CMS approval.
- Recipients and Practice Participants may seek other sources of funding to supplement Infrastructure Funding activities. Recipients shall communicate other sources of funding used to CMS via programmatic reporting, including assurances that such other sources do not duplicate or supplant cooperative agreement funding.
- The requirements listed in [Appendix II: Health IT Capabilities and Support for Practice Participants](#) apply regardless of the funding source for the Infrastructure Funding.

Recipients will be required to develop a Health IT Implementation Plan. The Health IT Implementation Plan shall be submitted as part of the NOFO application. The Health IT Implementation Plan shall detail how Cooperative Agreement funding, specifically Infrastructure Funding to Practice Participants, would aid in achieving the anticipated future state of health IT and data infrastructure and capacity. Furthermore, the Health IT Implementation Plan shall detail:

- Existing goals for health IT and how the IBH Model can help the applicant reach these goals;
- Existing data infrastructure;
- Approaches to ensuring privacy and confidentiality consistent with applicable laws, including HIPAA, 42 CFR Part 2 and state requirements;

¹⁷ CMS will provide further information on the Medicare needs assessment in the pre-implementation period.

- Existing and projected (if awarded) staff capacity;
- Existing and projected (if awarded) data analytic capabilities;
- Experience supporting value-based payment and quality reporting;
- Anticipated technical assistance needs in meeting model requirements related to data and health IT;
- Facilitate data sharing agreements between Practice Participants and payers;
- Provide data and health IT technical assistance to Practice Participants;
- Enable Practice Participants to use quarterly data in support of continuous quality improvement.
- Submit relevant claims and encounter data;
- Facilitate data alignment between payers, MCOs, PIHPs, PAHPs, intermediaries and Practice Participants; and
- Support health information exchange to identify admissions, discharges, transfers, and other events important to care coordination.

Example of health IT uses for infrastructure funds:

- Health IT and practice transformation funding for Practice Participants.
- Statewide infrastructure necessary to implement the IBH Model.

A4.6 Convening Structure

A4.6 Section Requirements:

Pre-implementation period requirements	Implementation period requirements
<i>During the pre-implementation period, Recipients must:</i> • Alongside CMS, identify a third-party convener to host the IBH Model-related efforts six months after the start of the pre-implementation period. • The convening structure must begin meeting no later than the end of Q2 of MY1 (BP1). • It is strongly recommended to meet with the convening structure on no less than a quarterly basis. ○ Use the convening structure to develop the Medicaid Payment Approach among the relevant parties. ○ Use the convening structure to develop the Medicaid care delivery framework among the relevant parties. ○ Provide updates on convenings in quarterly progress reports.	<i>During the implementation period, Recipients must:</i> • Implement the convening structure: ○ Provide necessary technical assistance for Practice Participants. ○ Develop strategies to improve performance on the state and Practice-based measures. ○ Develop performance improvement projects at the state or sub-state level. ○ Troubleshoot issues with data sharing among model partners. ○ Share best practices among payers, Practice Participants, and other interested parties.

In cooperation with CMS, Recipients will identify a third-party convener within three months after the start of MY1 (BP1). The third-party convener is intended to serve as a neutral forum to bring together IBH Model stakeholders including the State, CMS, Practice Participants, community organizations, and others to drive consensus on model design elements and shared priorities. If a

third-party convener is not readily identifiable, Recipients may act as conveners for up to the first 1.5 years of the model. During this time, CMS will work with states/territories to identify a third-party convener to support this effort – thus reducing state burden and allowing states to come to the table with stakeholders on prioritizing outcomes, measures, and model design. As a party to the convenings, Recipients will sustain or build upon or support the development of convening initiatives. Examples of neutral conveners envisioned in this work include but are not limited to Quality Improvement Organizations, academic or philanthropic organizations, or other organizations focused on aligned care transformation and improvement efforts.

Section [A4.6.1 Members of the Convening Structure](#) exhibits essential and recommended interested parties for the convening structure. Recipients will aid in garnering alignment from the essential and recommended members listed below.

The convening structure will align interested parties on efforts to improve key BH outcomes through priority setting, operational support, and learning activities. The convening structure must begin meeting no later than June of MY1 (BP1) Q2, and it is strongly recommended that the convening structure must meet no less than quarterly, thereafter. In the Pre-Implementation Period, the interested parties in the convening structure will collaborate to design model components and ensure specific components reach directional alignment, where applicable (Section [A4.4.4 Multi-Payer Alignment](#)).

At a minimum, Recipients are expected to use the convening structure along with support from CMS to:

- Improve data collection and sharing efforts among payers, Practice Participants, and community-based organizations (where applicable).
- Provide a channel for CMS, SMAs, and MCOs, State Mental Health authorities and Single state agencies for SUDs, (or other intermediaries) to communicate technical assistance to Practice Participants.
- Accelerate the development and implementation of the Medicaid Payment Approach.
- Identify additional model priority health conditions in addition to diabetes, hypertension, and tobacco use, such as the human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), sexually transmitted infections, intellectual/developmental disabilities, asthma, heart disease, obesity/overweight, and hepatitis.
- Identify additional practice-based and state-based quality measures (where applicable).
- Design the Recipient's Population Needs Assessment as specified in Section [A4.3.3 Care Delivery Framework Requirements](#)
- Collaborate with CMS to make corrections and improve data in a timely manner.

Example funded activities:

- Support implementation and operational activities of the convening structure.
- Support to share best practices among the convening structure.

A.4.6.1 Members of the Convening Structure

The convening structure will optimally use a collective impact approach to drive alignment among the Recipient, Practice Participants, and other interested parties regarding their shared visions and measurements and mutually reinforcing activities. The convening structure will also optimally incorporate continuous communication among members as a core backbone group that will

provide ongoing support, drive momentum, and advance model development by guiding vision and strategy.

Table 4.6.1: Members of convening structure.

Essential members	Recommended members
• State/territorial Medicaid agencies • State, local, tribal, and/or territorial and public health agencies • State Mental Health Authorities and Single State Agencies for SUDs • Licensing agency • Managed care organizations (or other intermediaries) • Specialty behavioral health provider organizations • Physical health providers • Social service agencies • Beneficiaries from the geographic focus area (states are encouraged to consider a variety of participating beneficiaries, and compensation for participation). • Family members and caregivers • Federally recognized tribes and tribal governments (where applicable).	• Patient advocacy organizations • Commercial payers • Criminal justice • Faith-based entities • Major employers • Crisis system service providers • Community based organizations and social services providers which address food, transportation, etc. • Data service organization (e.g., relevant health information networks) • State/territorial primary care association • Other tribes and tribal governments (where applicable) • Other government agencies such as those working on education and employment • State or community substance use prevention coalitions.

A4.7 Data, Quality, and Evaluation

Section Requirements:

Pre-implementation period requirements	Implementation period requirements
<i>During the pre-implementation period, Recipients must:</i> • Facilitate data sharing agreements between providers and payers • Provide data-related technical assistance to Practice Participants • Submit relevant claims and encounter data • Facilitate data alignment across interested parties in the model.	<i>During the implementation period, Recipients must:</i> • Report on required state and practice-based quality measures • Continue to facilitate alignment in data sharing, reporting, and decision making. • Provide technical assistance to Practice Participants • Work with Practice Participants to use quarterly data to make necessary course corrections within the model. • Submit relevant claims and encounter data • Participate in the state-wide quality improvement program

CMS, through the Innovation Center, with its federal partners and external stakeholders, has started building the foundation toward a health system that achieves equitable outcomes through high-quality, affordable, person-centered care. To make this lasting change, the Innovation Center is incorporating patient and caregiver perspectives across the lifecycle of its models, implementing more patient-reported outcome measures (PROMs) to quantify and qualify what matters to beneficiaries, and to evaluate patient and caregiver experience in models.

Recipients are required to submit the quality measures listed in Table A4.7.1 State Based Measures (see Section [A4.7.2.1 State-based and Practice-based measures](#)) to CMS on a quarterly and annual basis for their Medicaid population.

Example funded activities:

- Hire an IBH Model Data Analyst, or other relevant data staff
- Practice transformation activities to improve the flow and usage of data for decision making.
- Activities to support data sharing among payers and providers needed to support model operations.
- Data warehousing and management.
- Support for the development of admission, discharge, and transfer (ADT) systems.

A4.7.1 Data Collection, Reporting, and Analysis

Recipients play a pivotal role in arranging efforts related to model data collection, sharing, and analysis. Recipients must ensure that monitoring and evaluation data is collected, analyzed, and shared in a timely fashion to support IBH Model goals in collaboration with MCOs, PIHPs, PAHPs, intermediaries, and State Mental Health authorities and Single state agencies for SUDs, CMS, and CMS contractors for monitoring and evaluation.

Recipients must hire or leverage data expertise to assist in data coordination and analysis. CMS encourages states to consider the scope of their implementation, such as the potential number of Practice Participants, and statewide versus sub-state implementation, to decide the full level of effort needed for model data activities. Recipients are also responsible for taking any steps required under applicable laws to engage in data sharing under the model, including obtaining required authorizations. As previously noted, Recipients are allowed to use cooperative agreement funding to support model data efforts. Recipients are also required to:

- **Facilitate data sharing agreements between providers and payers:** In the Pre-Implementation Period, Recipients must prepare to share quality measure and process data (e.g., by connecting to an HIE or health information network) with Practice Participants that enables them to improve care delivery and achieve model-specified performance outcomes such as care coordination. Partnering MCOs, PIHPs, and PAHPs, (or intermediaries) are required to contribute to data sharing efforts. Where applicable, the Recipient shall coordinate data sharing strategies with State Mental Health authorities and Single state agencies for SUDs.
- **Provide technical assistance to Practice Participants:** The Recipient will use the Pre-Implementation Period to provide technical assistance to Practice Participants to capture model data. Also, applicable MCOs, PIHPs, PAHPs, or other intermediaries may provide this technical assistance to Practice Participants. CMS will provide technical assistance to Recipients on capturing and reporting data as well as improving key outcomes.

- **Submit relevant claims and encounter data:** Recipients or partnering MCOs, PIHPs, PAHPs, or intermediaries are required to submit timely and accurate Medicaid claims and/or encounter data through the Transformed Medicaid Statistical Information System (T-MSIS). If necessary, an alternative mechanism will be approved by CMS, to ensure compliance with the requirements for data submission for model monitoring and evaluation under 42 C.F.R. § 403.1110. Recipients must work with Practice Participants and CMS to address any issues or questions on sharing such data.
- **Facilitate data alignment:** The Recipient is required to streamline the data reporting requirements at the state and federal level. For example, the Recipient shall align IBH Model quality reporting with other state or federal initiatives, to the extent possible, to limit practice burden. This includes alignment with MCOs, PIHPs, or PAHPs (or intermediaries) and state agencies for mental health and/or substance abuse.

A4.7.2 Quality Strategy

Measures are core to the IBH Model’s quality strategy, which seeks to evaluate the Model’s ability to achieve the goals of improving quality of care, increasing access to care, achieving improved health outcomes for all beneficiaries, reducing avoidable emergency department and inpatient utilization (thereby reducing Medicare and Medicaid program expenditures), and strengthening health information technology (health IT) systems capacity. The Model’s quality strategy strives to advance Recipients and Practice Participants alike toward achieving the Model’s desired outcomes, enabling quality improvement, reaching greater alignment among payers, as well as assisting in facilitation of model evaluation. CMS will use several measures, including at least one PROM, to monitor Recipient performance in the implementation and operation of the Model, as well as patient care delivered by Practice Participants.

CMS will keep Recipients abreast of any new measures that are developed or prioritized through the annual Measures Under Consideration¹⁸ list and may explore changing the measure set as the Model evaluation policy develops (adding, modifying, and/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 Recipients with advance notice and will work with Recipients to modify reporting requirements.

The Model’s quality strategy will measure several key areas, including:

- Health outcomes targeted by the Model
- Care coordination
- Beneficiary utilization of services
- Other needs that impact health
- Patient-reported outcome measures
- Physical health screening

These measures areas will be addressed through a combination of state-based and practice-based measures. *Table A4.7.1* below shows state-based measures to be included in the Model. *Table A4.7.2* shows practice-based measures to be included in the Model.

¹⁸ As part of the CMS Pre-Rulemaking process for programs under Section 3014 of the Affordable Care Act, the Department of Health and Human Services (DHHS) must annually issue a Measures under Consideration List (MUC List)

Recipients must report state-based measures data and practice-based measures data, for Medicaid beneficiaries, directly to CMS in a process to be outlined in the Cooperative Agreement Program Terms and Conditions. The anticipated level of burden for reporting on quality measures, including the number of hours and cost, is available in [Appendix III: State-Based Quality Measure Data Reporting Burden](#). Applicants shall consider model reporting requirements in their decision to implement the model across their entire state or in a sub-state region. For example, applicants shall consider the capacity and infrastructure available in the area they intend to operate the model in. Data submission requirements will include the following:

- Data submitted must be beneficiary level-data, unless noted otherwise. Reporting data in the aggregate will not be sufficient to effectively evaluate model outcomes.
- Please see details on performance-based payments in the Medicare payment appendix for more information on what practice-based measures must be included in the Medicaid Payment Approach.

Practice Participants participating in the Medicare side of the IBH Model will submit Practice-based measures for Medicare beneficiaries directly to CMS.

A4.7.2.1 State-based and Practice-based measures

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.**

Table A4.7.1: State-based measures

Measure	Description	Steward	CBE ¹⁹ endorsement number	CMIT ²⁰ 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

¹⁹ 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.

²⁰ 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 ¹⁹ endorsement number	CMIT ²⁰ measure family ID
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)	Percentage of ED visits for beneficiaries aged 18 and older with a principal diagnosis of a SUD, or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported: * Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) * Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	NCQA	3488	264
Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Percentage of emergency department (ED) visits for beneficiaries aged 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: * Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) * Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	NCQA	3489	265
Plan All-Cause Readmissions (PCR-AD)	For beneficiaries ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: • Count of Index Hospital Stays (IHS) • Count of Observed 30-Day Readmissions • Count of Expected 30-Day Readmissions	NCQA	N/A	561

Measure	Description	Steward	CBE ¹⁹ endorsement number	CMIT ²⁰ measure family ID
Follow up after Hospitalization for Mental Illness: Age 18 or older (FUH-AD)	Percentage of discharges for adults ages 18 and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported. Percentage of discharges for which beneficiary received follow-up within 30 days of discharge Percentage of discharges for which the beneficiary received follow-up within 7 days of discharge	NCQA	0576	268
Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)²¹	The percentage of members 18-75 years of age with diabetes (type 1 or type 2) who had a HbA1c at the following levels: HbA1c Control (<8.0%) and HbA1c Poor Control (>9.0%)	NCQA	0059 and 0575	204/148
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Percentage of Medicaid beneficiaries ages 18 to 64 with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA	1932	202
States will pick one of the following two measures to include in their model to better capture the importance of screenings for PH conditions in the IBH Model.				
Colorectal Cancer Screening (COL-AD)	Percentage of beneficiaries ages 45 to 75 who had recommended screening for colorectal cancer.	NCQA	0034	139
Breast Cancer Screening (BCS-AD)	Percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer.	NCQA	2372	093

²¹ The Diabetes Control measure is now known as *Glycemic Status Assessment for Patients with Diabetes*.

Table A4.7.2: Practice-based measures

Measure	Description	Steward	CBE endorsement number	CMIT measure family ID
Acute Hospital Utilization (Observed Rates)	Reports the observed acute hospitalization utilization rates for the population	NCQA	N/A	14
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 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	0028/0028e	596
Controlling high blood pressure	Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period	NCQA	N/A	236
Emergency Department Utilization+	Reports the observed and expected ED utilization rates for the population.	NCQA	N/A	1755
Glycemic Status Assessment for Patients with Diabetes	The percentage of members 18-75 years of age with diabetes (type 1 or type 2) who had a HbA1c at the following levels: HbA1c Control (<8.0%) and HbA1c Poor Control (>9.0%)	NCQA	0059 and 0575	204 and 148
Patient-reported outcomes and Measurement-based care attestation	Measure under development by CMS.			

Note: Practice Participants will be required to screen for upstream drivers of health and report aggregate data in a form and manner and by the date(s) specified by CMS.

A4.7.2.2 State Quality Improvement Program

Recipients will participate in a quality improvement program (tied to state-based measures) separate from the performance-based payment component of the Medicaid Payment Approach for Practice Participants (tied to practice-based measures).

- During the Implementation Period, ten percent of the annual cooperative agreement funding will be restricted, not guaranteed, and subject to achievement on reporting and performance improvement on the IBH Model state-based measures (detailed in Section [A4.7.2.1 State-based and Practice-based Measures](#)). In MY6 (BP6), CMS will increase this restriction to twenty percent. In MY7 (BP7), CMS will increase this restriction to thirty percent.
- Throughout MY6 (BP6) and MY7 (BP7), the cooperative agreement funding withhold will maintain at 10 percent if there is satisfactory performance on model performance measures in the first years of model implementation.²²
- The performance benchmarks for the state-based measures will include partial and full achievement categories that correspond to earning a certain proportion of the cooperative agreement funding available for each measure.
- CMS, along with its contractors, will provide support to both Recipients and their Practice Participants on the state-wide quality improvement program.

A4.7.3 Evaluation

The independent evaluation of the IBH Model will consider the model pre-implementation and implementation periods, along with key outcomes related to model goals. This will be accomplished through using a mixed-methods approach that incorporates both qualitative and quantitative data. In support of gathering the necessary data for these analyses, Recipients are required to ensure compliance and participation with the IBH model evaluation by all model participants and partners in model evaluation, including:

- the Recipient;
- any MCOs or intermediaries with whom the Recipient forms memorandum of understandings (MOUs); and
- clinical delivery site providers and staff, patients, and any other individuals or entities in the Model's evaluation conducted by CMS.

Specifically, the Recipient shall attest to its capacity to participate and help facilitate individual patient- and program-level data provision and qualitative evaluation tasks, which may include:

- arranging site visits, observations, interviews and focus groups with providers and patients as well as program staff;
- tracking data from screening patients for other health related needs;
- submitting patient medical information through a system that complies with all applicable privacy requirements, including HIPAA and 42 C.F.R. Part 2 and applicable state requirements;

²² Guidance on the precise benchmarks will be issued by CMS at a later date. Recipients will be expected to show a reasonable decrease in total cost of care, acute hospital utilization, and emergency department utilization among Medicaid beneficiaries enrolled in the IBH Model when compared to Medicaid beneficiaries with moderate-to-severe behavioral health diagnoses who are not enrolled in the IBH Model. CMS will incorporate relevant and timely research, literature, and data available from similar ongoing models when determining the benchmarks.

- gathering required patient consent/authorization;
- and other activities as needed.

All Recipients must be able to provide personal identifiers that will allow all Practice Participants to be identified in Medicaid claims. Recipients are solely responsible for any necessary procedures and approvals needed by Institutional Review Boards (IRBs). Recipients are also solely responsible for obtaining any other permissions from beneficiaries, their organizations, or state entities that may be needed to share or analyze internal data. These procedures and approvals shall not hinder cooperation with evaluation activities, data collection, or data sharing and submission to CMS or its contractors related to this award. Recipients may use award funds to pay for a full-time equivalent staff member with data and evaluation experience to help in accomplishing such tasks and ensuring full cooperation.

A5. Technical Assistance and Information for Prospective Applicants

Prior to the application deadline, CMS hosts a series of webinars to provide details about the IBH Model to answer questions from potential applicants regarding this funding opportunity. Information about the webinars will be posted on the IBH Model website at <https://www.cms.gov/priorities/innovation/innovation-models/innovation-behavioral-health-ibh-model>.

B. Federal Award Information

Federal Award Information:

B1. Total Funding	\$37.5 million
B2. Award Amount	Up to \$7.5 million to each Recipient Pre-implementation period: \$1,500,000 in MY1 (BP1), \$1,250,000 in MY2 (BP2). Implementation period: \$1,000,000 in MYs 3-6 (BPs 3-6). \$750,000 in MY7 (BP7).
B3. Anticipated Award Dates	January 1, 2027
B4. Period of Performance	Overall: January 1, 2027, through December 31, 2033 After the initial award, continued funding is distributed via Non-Competing Continuation Awards Seven total budget periods: Budget Period 1: January 1, 2027 – December 31, 2027 Budget Period 2: January 1, 2028 – December 31, 2028 Budget Period 3: January 1, 2029 – December 31, 2029 Budget Period 4: January 1, 2030 – December 31, 2030 Budget Period 5: January 1, 2031 – December 31, 2031 Budget Period 6: January 1, 2032 – December 31, 2032 Budget Period 7: January 1, 2033 – December 31, 2033 **Each budget period corresponds to a MY (BP) as detailed in the chart below. For example, budget period 1 reflects the same dates as MY1.
B5. Number of Awards	Up to 5 awards
B6. Type of Award	Cooperative Agreement Statutes, regulations, policies, that apply to grants also apply to cooperative agreements, unless the award itself provides otherwise. References throughout this NOFO to grants also apply to cooperative agreements unless this NOFO states otherwise. Please refer to section F4. Cooperative Agreement Terms and Conditions of Award.
B7. Type of Competition	Open to All Eligible Applicants

Cohort II

Model Year (MY)/Budget Period (BP)	Calendar Year	Maximum Cooperative Agreement Funding
Pre-Implementation Period		
MY1 (BP1)	January 1, 2027 – December 31, 2027	\$1,500,000
MY2 (BP2)	January 1, 2028 – December 31, 2028	\$1,250,000
Implementation Period		
MY3 (BP 3)	January 1, 2029 – December 31, 2029	\$1,000,000
MY4 (BP 4)	January 1, 2030 – December 31, 2030	\$1,000,000
MY5 (BP 5)	January 1, 2031 – December 31, 2031	\$1,000,000
MY6 (BP 6)	January 1, 2032 – December 31, 2032	\$1,000,000
MY7 (BP 7)	January 1, 2033 – December 31, 2033	\$750,000

C. Eligibility Information

C1. Eligible Applicants

Eligible applicants are state Medicaid agencies (SMAs) with the authority and capacity to accept the Cooperative Agreement award funding. Eligible applicants are all 50 states, Washington DC, and U.S. territories. Eligible U.S. territories include American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the United States Virgin Islands. Applicants may select to participate at the state level or designate a sub-state region, subject to CMS approval during the application review.

(Select all that apply)

Government Organizations

✓ **State governments**

C2. Cost Sharing or Matching

This program has no cost-sharing requirement. If you choose to include cost-sharing funds, we will not consider it during review. However, we will hold you accountable for any funds you add, including the requirements for grant reporting.

C3. Letter of Intent

CMS requests that interested applicants submit Letters of Intent (LOIs); this is optional and will not impact application scoring. Applicants may email LOIs to the following address: IBHModel@cms.hhs.gov. LOIs must include:

1. An expression of interest, including the proposed regions of participation.
2. A brief description of the interested organization.
3. Contact information, including the organization's street address and a contact person's name, position, email, and phone number.

LOIs are due April 1, 2026.

C4. Ineligibility Criteria

Non-applicable

C5. Single Application Requirement

Applicants may submit only one application.

C6. Continued Eligibility

Recipients must demonstrate satisfactory progress during the previous budget period to be issued additional year funding through a non-competing continuation award. Non-competing continuation funding is a Recipient's request for additional funding for the next subsequent Budget Period within an approved competitive segment (i.e., period of performance). Such funding is requested either through an application or a performance report, as explained in the terms and conditions of the award. A non-competing continuation application does not compete with other applications for support.

Continued funding is contingent on satisfactory progress, compliance with the terms and conditions, and the availability of funds. Satisfactory progress will include, but is not limited to, meeting milestones described in Section [F6.3 Performance Milestones](#). Expectations for satisfactory progress will also be included in the Cooperative Agreement terms and conditions.

At any time in the period of performance, Recipients could receive decreased funding, or their award could be terminated in accordance with [2 CFR 200.340](#) “Termination” if they fail to perform the requirements of the award.

C7. EIN, UEI, Login.gov and SAM Registrations

Every applicant organization must have the following five registrations in place to submit an application:

1. Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN);
2. Unique Entity Identifier (UEI) registration;
3. System for Award Management (SAM.gov) registration;
4. Login.gov account; and
5. Grants.gov registration

See [How to Apply for CMS Grants](#) on our website.

C8. Faith-Based Organizations

Faith-based organizations are not eligible to apply.

C9. Other Eligibility Requirements

Non-applicable

D. Application and Submission Information

D1. Address to Request Application Package

You must submit your application through Grants.gov. See “How to Apply for Grants” at Grants.gov for electronic submission instructions. Refer also to [How to Apply for CMS Grants](#) on our website.

D2. Content and Form of Application Submission

D2.1 Application format

Disqualifying Factors

Any application that is ineligible, incomplete, or non-responsive will not move forward.

CMS may not consider an application that:

- Is from an organization that does not meet eligibility conditions.
- Requests funding above the award ceiling shown in the funding range.
- Is not submitted through Grants.gov.
- Is incomplete based on the initial screening.

The Division of Grants Management Director and/or Deputy Director may continue the review process for an ineligible application if it is in the best interests of the government to meet the objectives of the program.

Each application must include all contents of the application package, in the order indicated, and conform to the following formatting specifications:

- Page size is 8.5” x 11” (one side only), 1” margins (top, bottom, and sides).
- All pages of the project and budget narratives as well as other required narrative documents must be paginated in a single sequence.
- Font size must be at least 12-point with an average of 14 characters per inch (CPI).
- The Project Narrative must be double-spaced. The page limit for this document is 60 pages.
- Program Duplication Documentation. The page limit for this document is 5 pages.
- The Budget Narrative may be single-spaced. The page limit for this document is 15 pages.
- The Business Assessment of Applicant Organization may be single spaced. The page limit for this document is 12 pages.
- Tables must have a font size of at least 12-point with a 14 CPI and may be single spaced. Tables are counted towards the applicable page limits.
- The project abstract is restricted to a one-page summary that may be single-spaced.
- The following required application documents are **excluded** from the page limitations described previously:
 - Standard Forms, (SF-424, SF-424A, SF-LLL)
 - Application Cover Letter/Cover Page (if applicable),
 - Project/Performance Site Location(s) Form, and
 - Indirect Cost Rate Agreement/Cost Allocation Plan.
 - Copy of the Letter of Intent, if applicable.
- The total number of additional appendices per application may be no more than 20 to include MCO, PIHP, PAHP, or other fiscal intermediary as well as State Mental Health

authorities and Single state agencies for SUDs letters of support (where applicable), resume and/or curriculum vitae, job descriptions, and organization chart. Refer also to Section [D2.4.4 Appendices](#).

D2.2 Standard forms

You must complete the five standard forms identified below. You can also view them and see their instructions at [Grants.gov \(Forms\)](#).

1. Project Abstract Summary

Write a one-page summary of the proposed project including the purpose and outcomes. Do not include any proprietary or confidential information. We will use this document for information sharing and public information requests if you get an award. Be succinct and use plain language. Include:

- The name of your organization
- Goals of the project
- Total budget amount
- Description of how funds will be used.

2. SF-424: Official Application for Federal Assistance

You must complete all sections of the SF-424. **The Authorized Organizational Representative (AOR) must complete and electronically sign this form.**

Note: The signature of the individual that submits the application to Grants.gov populates throughout the application. The signature must match the name of the AOR. Other signatures will not be accepted. The AOR is the applicant's designated representative, who can make legally binding commitments for your organization. When the AOR authorizes an application, they agree that the organization will assume all award obligations.

Special instructions include:

☐ **In Item 15 "Descriptive Title of Applicant's Project":**

HHS awarding agencies must establish detailed and accurate award descriptions at the time they make a federal financial assistance award. Award descriptions are:

- critical to ensuring accountability and transparency and
- a primary means to inform the public of the purpose of the federal funding that is distinct from the programmatic level information in the Assistance Listings.

Elements of a Strong Award Description

Robust award descriptions provide an understanding of the award's purpose and include a description of award-specific activities and purpose. A strong award description will have all the following elements:

- Specifics about the award purpose
- Activities to be performed
- Expected deliverables and outcomes
- Intended beneficiaries or Recipients

- Subrecipient activities, (if known)

Characteristics of a Strong Award Descriptions

A strong award description will have the following characteristics:

- Uses plain language an average reader can fully understand
- Is brief and succinct
- Is unique on USA Spending
- Does not use or limits abbreviations or acronyms

Examples of Strong Award Descriptions:

The Council of Inspectors General on Integrity and Efficiency's Pandemic Response Accountability Committee (PRAC) shared the following examples of effective award descriptions. These, or other agency-specific examples, can be shared with applicants to assist them in developing their award descriptions.

- **Example One:** Construction of pedestrian & bicycle facilities on the Broadway corridor. Broadway @ St. James St- Foxhall Ave. Streetscape improvements & enhancements include sidewalks, curbing, bike lanes, ped bump-outs, and lighting.
- **Example Two:** Levittown Beauty Academy, LLC is creating distance education for students affected by Covid-19. Schools cannot use physical location, and students are now doing their schoolwork online.

☐ Check "No" to item 19c. as review by State Executive Order 12372 does not apply.

3. SF-424A: Budget Information Non-Construction

Refer to our [website](#) for more information on completing this form.

4. SF-LLL: Disclosure of Lobbying Activities

You must complete and submit the SF-LLL form. If you do not engage in lobbying, please insert "Non-Applicable" on the form (fields 10a and 10b) and include the required AOR name, contact information, and signature. Please note that the application kit available online on the Grants.gov website is used for many programs and therefore Grants.gov may designate this form as optional to allow for flexibility amongst programs. However, this form is **required** as part of the application package and must be submitted for the application to be considered eligible for review.

5. Project/Performance Site Location(s) Form

This form is required as part of the application package and must be submitted for the application to be considered eligible for review. Please note that the application kit available online in Grants.gov is used for many programs and therefore Grants.gov may designate this form as optional to allow for flexibility amongst programs.

D2.3 Application cover letter or cover page (optional)

The applicant may choose to include a cover letter or cover page to detail its interest in participation in the IBH Model.

D2.4 Program Requirements and Expectations

D2.4.1 Project Narrative

The project narrative must give a clear and concise description of your project. Articulate in detail the proposed goals, measurable objectives, and milestones in accordance with the instructions and content requirements provided below, consistent with the criteria described in Sections [A4. Program Requirements](#) and [E1. Criteria](#). Review these sections carefully to make sure you answer all questions and cover all topics the reviewers will look at.

Below are the required and optional elements of the project narrative including a brief description of the type of information required within each specific section. The project narrative is double-spaced and cannot exceed 60 pages in length. This page limit does not include resumes for key personnel, job descriptions, budget narrative, or organizational charts.

1. Characteristics of the proposed model service area and model population (required):

- a. Applicants shall clearly propose whether the IBH Model would be implemented on a statewide/territory-wide or a sub-state/-territory basis. If the applicant wishes to implement within a sub-state/-territory region they must provide justification and rationale for this selection, including consideration of the demands of implementation at a state-wide level and the benefits to evaluation from sub-state/-territory implementation. Furthermore, applicants shall specify the geographic area(s) in which they propose to implement the Model.
 - Descriptions could include ZIP codes; identification of political subdivisions such as counties, parishes, or cities; census tracts; any other unit that will unambiguously specify the boundaries of the geographic focus area.
 - Applicants proposing to implement within a sub-state/-territory region are encouraged to include in their application a potential appropriately matched comparison group within another region of the state/territory. This comparison group is intended to aid in facilitation of a robust evaluation by providing a population that does not receive the Model's services to compare outcomes to. CMS, the Recipient, and the evaluation contractor would work closely to further specify this comparison group in the Pre-Implementation Period.
- b. In addition to information about the existing treatment and network capacity, the applicant must provide as much of the information outlined below as possible for adult Medicaid beneficiaries with MSBH conditions residing in the proposed model service area for the period 2020-2022. Where feasible, applicants shall disaggregate these statistics by age, sex, race, and ethnicity. Data must be submitted in aggregate format and be fully de-identified in accordance with the HIPAA Privacy Rule standard at 45 C.F.R. § 164.514(b). The tables provided in [Appendix IV: Model context data templates](#) are provided as a guide for applicants. Applicants must detail the sources used to calculate the data presented as well as limitations of the data sources used in the tables. When data are unavailable, applicants can use proxies but shall state the potential limitations of the data.
 - *Prevalence of Mental Illness and SUDs:*
 - Beneficiaries with mental illness
 - Beneficiaries with SUDs

- Beneficiaries with co-occurring mental illness and SUDs
- *Co-occurring PH and BH conditions:*
 - With one or more PH conditions
 - With diabetes
 - With hypertension
- *Utilization:*
 - 30-day all-cause readmissions
 - Emergency department visits with a principal diagnosis of mental illness or a SUD
 - All-cause emergency department visits

2. Organizational capacity of applicant organization (required): Applicants must demonstrate their capacity to organize and manage the IBH Model, and to work collaboratively across key state agency, payer, practice, and community-based partners. The following information is required:

- a. Describe existing staff capacity (e.g., providing job descriptions including positions that may be currently vacant for all key staff that will be involved in the project).
- b. Identify the individual who will be the Project Director (primary liaison to CMS for the model) and provide a resume or CV for that person.
- c. Provide an organizational chart that identifies lines of authority and names the AOR.
- d. Describe the anticipated role of any subrecipients or contractors that may be engaged to develop and/or implement the IBH Model. Subrecipients or contractors may be already identified or could be identified later.
- e. Applicants shall describe the current state of service provision for integrated behavioral and PH care for beneficiaries with MSBH, including but not limited to detail on:
 - i. Gaps in care delivery and funding for beneficiaries with MSBH conditions to further illustrate how the applicant would leverage the IBH Model infrastructure, learning, and funding to improve care.
 - ii. Their experience designing and implementing VBP initiatives and Medicaid BH programs, including but not limited to, Medicaid health homes, CCBHC demonstrations and/or grants, or other state led initiatives.
 - iii. The provider network including network administrators like MCOs, PIHPs, PAHPs, or other fiscal intermediaries used to deliver BH services in the state.
 - iv. The current healthcare provider and treatment capacity serving adult Medicaid beneficiaries with MSBH conditions, including information about Medicaid beneficiary access to relevant providers and treatment facilities within the proposed model service area for the types of care listed in Section [A4.3 IBH Care Delivery Framework](#).

3. Model intervention (required): Applicants must attest they understand all requirements laid out in Section [A4.3.3 Care Delivery Framework Requirements](#), and are committed to meeting the requirements, if awarded a cooperative agreement.

Recipients will have time during the pre-implementation period along with technical assistance from CMS to fully develop their care delivery framework. In this section, applicants must

detail their intended process for developing the IBH care delivery framework in their proposed geographic service area, if awarded a cooperative agreement. Applicants shall detail:

- a. The stakeholders they intend to work with to design the care delivery framework and the role of the interested parties (State Mental Health authorities and Single state agencies for SUDs, MCOs, members of the convening structure, community-based organizations, clinical state SMEs).
- b. Intermediate steps and processes in developing the care delivery framework (Development of landscape analyses, publishing guidance documents for Practice Participants, hiring clinical SMEs, or hosting meetings with the IBH convening structure).
- c. How cooperative agreement funding would be used to support the development of the care delivery framework (Consultant support in developing the care delivery model, supporting the convening structure).
- d. Areas of care delivery framework design where the Recipient would anticipate needing technical assistance (If awarded).

Applicants are encouraged to reference the below care delivery requirements in detailing their intended process for developing the care delivery framework. For example, applicants can detail the process they would follow to help facilitate relationships between social service agencies and Practice Participants.

- Map current service provision and workflows to IBH Model requirements. Determine how best to adapt existing clinical workflows to accommodate new services – this shall include specific detail on attribution, screening and identification of PH conditions, care planning, procedures for tracking and follow-up on identified conditions, and supporting adherence to the care plan for model participants.
 - Oversight and provider compliance for Practice Participant requirements across the core elements of the Model: Care Management, Care Integration, and Preventive Care and Health Promotion.
 - Provide evidence-based guidelines for BH and PH screenings to Practice Participants as needed.
 - Provide state-specific guidance to Practice Participants on utilization of any state-based data warehouse or care management tools for health care and social service navigation.
 - Facilitate relationships between social service agencies and Practice Participants through introductions, shared meetings, and appropriate connections to facilitate warm hand-offs (leveraging convening structure as appropriate).
 - Provide Practice Participants with a population needs assessment detailing the health disparities experienced by the Practice Participant's service population.
- 4. Medicaid Payment Approach (required):** Applicants must attest they understand all requirements laid out in Section [A4.4.2 Medicaid Payment Approach Requirements](#), and are committed to meeting the requirements, if awarded a cooperative agreement. The Medicaid

Payment Approach must include all services outlined in Section [A4.3.3 Care Delivery Framework Requirements](#).

The applicant is not required to determine the final federal or state authorities at the time of application; however, during the Pre-Implementation Period, the Recipient will work with CMS and CMCS to determine which federal or state authority will work best for the Recipient's context and goals. In addition, CMS and CMCS will provide technical assistance to aid Recipients in developing technical aspects of their payment approach with alignment to the Medicare Payment Approach including the ISP and PBP.

Similar to the previous section, applicants must detail their intended process for developing the Medicaid Payment Approach, including:

- a. The stakeholders they intend to work with to design the Medicaid Payment Approach and the role of interested parties. (State Mental Health authorities and Single state agencies for SUDs, MCOs, members of the convening structure, community-based organizations, clinical state SMEs).
- b. Intermediate steps and processes in developing the Medicaid Payment Approach (Conducting rate setting analyses, onboarding actuarial consultants (Where relevant), or hosting meetings with the IBH convening structure).
- c. How cooperative agreement funding would be used to support the development of the Medicaid Payment Approach (Actuarial support in developing the Medicaid Payment Approach, supporting the convening structure).
- d. Areas of Medicaid Payment Approach design where the Recipient would anticipate needing technical assistance (If awarded).

Applicants are encouraged to reference the key areas in Table D2.4.1 in their applications. For example, applicants shall describe how they would intend to develop a performance-based payment strategy that is aligned with the Medicare PBP and meets the needs of intended Practice Participants.

Table D2.4.1: Medicaid Payment Approach requirements and alignment principles

Category	Payer alignment principle(s)
1. How the applicant plans to create, leverage, or redesign an existing payment approach	Applicants are encouraged to leverage existing delivery system architecture to build or adapt their payment approaches and bolster sustainability.
2. The types of Practice Participants to be reimbursed under the payment approach	The proposed Practice Participants meet the provider eligibility criteria outlined in Section A4.2 Recruitment of Practice Participants .
3. The service types, units, or costs to be paid under the payment approach	Applicants are not required to use the same service, procedure, or G codes used in the Appendix VI: Medicare Payment Approach Details ; however, the applicant must ensure that services and procedures reimbursable in the Medicaid Payment Approach cover care management, care coordination, preventive care and health promotion, in their Medicaid Payment Approach.

Category	Payer alignment principle(s)
4. The rate determination methods the applicant anticipates using to develop the Medicaid Payment Approach	Not applicable
5. Performance based payment strategy	At a minimum, the Medicaid performance-based payment strategy must start with pay-for-reporting in MY3 (BP3) and evolve into pay-for-performance by MY4 (BP4). By MY6 the performance-based payment strategy must have a withhold tied to quality and an upside bonus payment.
6. Quality measures	- The applicant must include all measures in <i>Table A4.7.2: Practice-based measures</i>, in their Medicaid performance-based payment strategy. - Please note, applicants are only required to use the Practice-based measures for their performance-based payment component.

5. Behavioral health practice recruitment strategy (required): Recipients must outline their practice recruitment strategy for the IBH Model that meet the eligibility criteria specified in Section [A4.2 Recruitment of Practice Participants](#). CMS encourages states to collaborate with their State Mental Health authorities and Single state agencies for SUDs, MCOs, PIHPs, or PAHPs in developing their Practice Participant recruitment strategy (where applicable), given their experience managing provider networks. The applicant's BH practice recruitment strategy shall include:

- A plan for recruiting Practice Participants into the IBH Model, including key partners and how they may support recruitment activities.
- Plans to include outreach with rural safety-net specialty BH providers, under-resourced providers, tribal providers, and providers serving vulnerable populations in the recruitment strategy.
- An estimated number of Practice Participants to be enrolled in the IBH Model by the end of MY3 (BP3).
- An estimated number of total Medicaid enrollees with MSBH conditions to be attributed to the IBH Model for the entire duration of the Implementation Period.

6. Health IT implementation plan (required): Applicants must describe the current and future state of data and health IT infrastructure in the proposed model service area. Model participants shall detail how cooperative agreement funding including health IT funding to Practice Participants would aid in achieving the anticipated future state of health IT and data infrastructure and capacity. Furthermore, the applicant shall detail:

- Existing data infrastructure to support integration between BH and PH;
- Existing and projected (if awarded) staff capacity;

- c. Existing and projected (if awarded) data analytic capabilities to support BH integration;
 - d. Experience supporting value-based payment and quality reporting;
 - e. Intermediate steps and processes in developing the Health IT implementation plan;
 - f. Anticipated technical assistance needs in meeting model requirements related to data and health IT; and
 - g. In describing the future state of data and health IT, applicants shall describe their ability and plans to meet the requirements laid out in [Appendix II: Health IT Capabilities and Support for Practice Participants](#) as well as additional Health Information Technology requirements located [here](#) and described below:
 - i. Facilitate data sharing agreements between Practice Participants and payers.
 - ii. Provide data and health IT technical assistance to Practice Participants.
 - iii. Enable Practice Participants to use quarterly data to make necessary course corrections within the Model.
 - iv. Submit relevant claims and encounter data.
 - v. Facilitate data alignment between payers, MCOs, PIHPs, PAHPs, intermediaries and Practice Participants.
 - vi. Support health information exchange to identify admissions, discharges, transfers, and other events important to care coordination.
- 7. Sustainability Plan (required):** Applicants shall clearly describe their commitment to ensuring the IBH Model is sustainable after the IBH Model concludes (see Section [B4 Period of Performance](#)). Specifically, applicants shall address how they will design specific model components with sustainability in mind. For example, the applicant must describe how they would build sustainability planning into the design of their Medicaid Payment Approach.
- 8. Budget impact analysis (required):** The applicant shall include a section to exhibit the IBH Model's potential impact on health outcomes and Medicaid spending for beneficiaries with MSBH conditions. More specifically applicants shall:
- a. *Impact on health outcomes:* Exhibit how IBH Model implementation in the applicants proposed geographic service area will impact health outcomes. This includes a description of how they will maximize the effect of their proposed intervention on the Model aims set out in Section [A1 Purpose](#).
 - b. *Cost savings projection:* Applicants must use this section to provide a financial model that illustrates anticipated Medicaid spending for the Model population, comparing a projection of the intervention to a projection in the absence of the intervention, over the same period.
- 9. Identify additional priority health conditions to include in the Model (optional):** As part of their application, applicants have the option of identifying additional priority health conditions outside of diabetes, hypertension, and tobacco use, such as HIV/AIDS sexually transmitted infections, intellectual/developmental disabilities, asthma, heart disease, obesity/overweight and hepatitis. Should an applicant choose to include additional priority health conditions they shall also include data to support the addition of such conditions in *Characteristics of the proposed model service area and model population*. In addition, the

applicant shall include proposed quality measures to track key outcomes of the priority health condition(s) in the *Medicaid Payment Approach requirements*. The additional conditions and quality measures are subject to CMS review and approval. CMS would not include any additional measures as part of the State Quality Improvement Program.

D2.4.2 Budget Narrative

The budget narrative supports the information you provide in Standard Form 424A. It includes added detail and justifies the costs you ask for. As you develop your budget, consider:

- If the costs are reasonable and consistent with your project's purpose and activities.
- The restrictions on spending funds. See [D5.3. of this NOFO, Prohibited Uses of Award Funds](#).
- HHS now uses the definitions for [equipment](#) and [supplies](#) in [2 CFR 200.1](#). The new definitions change the threshold for equipment to the lesser of the recipient's capitalization level or \$10,000 and the threshold for supplies to below that amount.
- This program has no cost-sharing requirement. If you choose to include cost-sharing funds, we will not consider it during review. However, we will hold you accountable for any funds you add, including the requirements for grant reporting.

To create your budget narrative, see [detailed instructions and a template](#) on our website. NOTE: The directions on our website address a period of performance up to 5 years. **Since the total Period of Performance is 7 years, then the Applicant must submit two SF-424A Forms to support the Budget Narrative.**

- **(Form 1) SF-424A Form – Costs for Years 1-4**
- **(Form 2) SF-424A Form – Costs for Years 5-7**

In your budget narrative, you will:

- Identify a principal investigator or project director (PI/PD) who will dedicate sufficient time and effort to manage and provide oversight of the grant program.
- Include a yearly breakdown of costs for each line item in your SF-424A.
- Describe the proposed costs for each activity or cost within the line item.
- Define the proportion of the requested funding designated for each activity.
- Justify the costs, including how you calculated them.
- Explain how you separate costs and funding administered directly by you as the lead agency, from funding you subcontract to other partners.
- Be clear about how costs link to each activity and the goals of this program.

Program-specific guidance

For this program, keep the following requirements and considerations in mind:

- Associate each cost with either Pre-Implementation Funding or Implementation Funding.
- To ensure administrative oversight, the Budget Narrative must identify a Project Director who is an employee of the applicant organization.

- This narrative must provide assurances that this individual will dedicate sufficient time to this award, funded through this award or cost sharing, to perform the required roles and responsibilities and ensure effective monitoring of funds under this award.
- The percentage FTE proposed by the applicant must ensure effective monitoring by the Project Director and is subject to review by CMS.
- Medicaid-only Practice Participants cannot receive Infrastructure funding from CMS and, instead, must receive Infrastructure Funding from the Recipient as available under this cooperative agreement.
 - Funding allocated towards infrastructure costs on behalf of the Practice Participant(s) will remain restricted until the Recipient submits a detailed budget for these costs and subsequently receives CMS approval. For more information, see Section A4.5 Infrastructure Development and Funding.

D2.4.3 Program Duplication (maximum 5 pages)

Applicants must provide an explanation of how they would use IBH Model funds to provide new and distinct care integration, care management, preventive care and health promotion for Medicaid beneficiaries with MSBH in the proposed model service area. The explanation shall identify how they would build upon current programs and initiatives, if applicable, while avoiding duplication with Medicaid, Title V, and any other federal, state, or local funding used for care coordination expenses for or related to the attributed population. In addition, applicants must describe their strategy for avoiding program duplication if they are simultaneously participating in a similar program serving Medicaid beneficiaries with MSBH in the proposed model service area including with a Medicaid health home, or CCBHC initiative.

D2.4.4 Appendices

- Letter of support from at least one MCO, PIHP, or PAHP. The letter of support must indicate commitment from the MCO, PIHP, or PAHP to assist with model implementation activities and operationalize the Medicaid Payment Approach (**required** for states administering BH services through MCOs, PIHPs, or PAHPs).
- Letters of support from State Mental Health authorities and/or Single state agencies for SUDs (**required**)
- Other letters of support from community and governmental partners (**optional**)
- Resumes and/or curriculum vitae (**required** for identified managers, Project Director, and all other Key Personnel identified at the time of application)
- Job Descriptions for key model personnel (**required**) (Can be provided in the project narrative or this appendix)
- Organization Chart (**required**) (Can be provided in the project narrative or this appendix)
- Letters of Support (from the applicant's governor or state legislators, hospitals, primary care providers, others) (**optional**)
- Letters of interest from specialty BH practices (**optional**)

D2.4.5 Business assessment of applicant organization (maximum 12 pages)

We must assess your organization's risk before we can make an award. This analysis includes your organization's:

- Financial stability.
- Quality of management systems.
- Internal controls.
- Ability to meet the management standards in [2 CFR 200](#).

For us to complete your assessment, you must review, answer, and attach the completed business assessment questions found on our website at [Business Assessment of Applicant Organization](#).

D3. Submission Dates and Times

All applications must be submitted electronically and received through [Grants.gov](#) by the date and time below. Applications received after 11:59 pm, Eastern Time, may not be reviewed or considered for award.

Due Date for Applications

June 3, 2026

11:59 PM Eastern U.S. Time (Baltimore, MD)

See also [How to Apply for CMS Grants](#) on our website.

D4. Intergovernmental Review

Program is not subject to Executive Order 12372, "Intergovernmental Review of Federal Programs" (45 CFR 100). Please check box "C" on item 19 of the SF 424 (Application for Federal Assistance) as Executive Order 12372 does not apply to these cooperative agreements.

D5. Cost Restrictions

Cooperative Agreement funding is to be used for Recipient's costs in developing and operationalizing the IBH Model.

Cooperative Agreement funds may **not** be used to pay providers for services covered under Medicare, Medicaid, and/or CHIP, including services already covered under such programs or any newly covered services under this model. Recipients are encouraged to leverage other Medicaid funding sources, such as Medicaid 90/10 funding, to advance the Model aims.²³

Recipients will be required to develop the Medicaid Payment Approach in accordance with CMS and state-based Medicaid policy but will **not** receive cooperative agreement funding to finance the care delivery services provided under the Model (see Section [A4.4 IBH Payment Strategy](#)).

Recipients may fulfill the Care Delivery Framework requirements themselves and may also work with managed care entities or other state entities like State Mental Health authorities and Single state agencies for SUDs to ensure these tasks are completed.

²³ Medicaid 90/10 funding refers to funding available for health information exchange activities through the Medicaid Electronic Health Records Incentive Program. [SMD Letter #11-004](#) further details Medicaid 90/10 funding.

D5.1 Direct Costs

Funding under this NOFO can only cover functions of the IBH Model and is to be used for the Recipient's costs in developing and operationalizing the IBH Model. Funding may be used for statewide infrastructure, health IT, staffing, interoperability projects, and the convening structure.

Salary rate limitation

The salary rate limitation in the current appropriations act applies to this program. As of January 2025, the salary rate limitation is \$225,700. We will update this limitation in future years.

D5.2 Indirect Costs

Indirect costs are those shared across multiple projects and not easily separated. Costs included in the indirect cost pool must not be charged as direct costs. See Section [F2. Administrative and National Policy Requirements](#) for more information on indirect costs.

If you include indirect costs in your budget using an approved rate, include a copy of your current agreement approved by your cognizant agency for indirect costs. If you use the de minimis rate, you do not need to submit this attachment. See [2 CFR 200.1](#) for the definition of MTDC. You can use this rate indefinitely.

D5.3 Prohibited Uses of Award Funds

CMS supports state flexibility, and the IBH Model may be used to complement existing Medicaid programs. However, the additional federal funding provided under the IBH Model may not be used to replace or duplicate existing Medicaid coverage or payments. All direct care delivery services must be covered by existing state Medicaid funds. Federal funds provided by CMS pursuant to this Model may not be used to fund coverage for additional services. Further, funding provided pursuant to the Cooperative Agreement may not be used to duplicate Medicaid covered services and payments, nor may this funding be used for the purpose of FFP. Recipients may, where necessary, be required to separately submit a State Plan Amendment of 1115 waiver request.

The following activities are not allowable unless an exception is specifically authorized by statute or stated otherwise in this NOFO:

- Pre-award costs.
- Matching requirements to any other Federal funds or local entities.
- Services, equipment, or supports that are the legal responsibility of another party under Federal, State, or Tribal law (e.g., vocational rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
- Goods or services not allocable to the approved project.
- Supplanting or duplicating existing state, local, tribal, or private funding of infrastructure or services, such as staff salaries
- Construction.
- Capital expenditures for improvements to land, buildings, or equipment which materially increase their value or useful life as a direct cost, except with prior written approval.

- The cost of independent research and development, including their proportionate share of indirect costs (unallowable in accordance with 2 CFR 300.477).
- Funds related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive Order proposed or pending before the Congress or any state government, state legislature or local legislature or legislative body.
- Certain telecommunications and video surveillance equipment. See [2 CFR 200.216](#).
- Meals unless in limited circumstances such as:
 - Subjects and patients under study;
 - Where specifically approved as part of the project or program activity (not grantee specific), e.g., in programs providing children's services; and
 - As part of a per diem or subsistence allowance provided in conjunction with allowable travel.
- Funding provided pursuant to the Cooperative Agreement may not be claimed for FFP purposes.
- To pay providers for services covered under Medicare, Medicaid, and/or CHIP, including services already covered under such programs or any newly covered services under this model.
- Costs of any Medicaid-covered service at any time during the Model, nor may they be used to supplant or duplicate existing resources that cover the costs of Medicaid-covered services or administrative expenses.
- Other services that are provided after, or because of, the IBH Model. For example, transportation, travel, or construction expenses.
- ISP payments or any other direct clinical services.
- Other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a state, local, or tribal government in policymaking and administrative processes within the executive branch of that government, funding awarded under this NOFO may not be used for:
 - Paying the salary or expenses of any grant Recipient, or agent acting for such Recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before the Congress or any state government, state legislature, or local legislature or legislative body.
 - Lobbying, but awardees can lobby at their own expense if they can segregate federal funds from other financial resources used for lobbying.

For guidance on some types of costs that we restrict or do not allow, see [2 CFR Part 200 Subpart E - General Provisions for Selected Items of Cost](#).

D5.4 Program Income

Program income is money earned as a result of your award-supported project activities. You must use it for the purposes and under the conditions of the award. Find more about program income at [2 CFR 200.307](#).

D6. Mandatory Disclosures

Submission is required for all applicants, in writing, to CMS and to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to:

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Attn: Director, Division of Grants Management

7500 Security Blvd, Mail Stop B3-30-03
Baltimore, MD 21244-1850

AND

U.S. Department of Health and Human Services
Office of Inspector General
ATTN: Mandatory Grant Disclosures, Intake Coordinator
330 Independence Avenue, SW, Cohen Building
Room 5527
Washington, DC 20201

URL: <https://oig.hhs.gov/fraud/report-fraud/index.asp>
(Include "Mandatory Grant Disclosures" in subject line)
Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or
Email: MandatoryGranteeDisclosures@oig.hhs.gov

Materials must be scanned and emailed to the Grants Management Specialist assigned to this NOFO.

E. Application Review Information

E1. Criteria

Merit reviewers use the NOFO to evaluate each application. Applicants shall pay particular attention to Sections [A4. Program Requirements](#), [D2.4 Program Requirements and Expectations](#), and the criteria in Section [E1 Criteria](#).

The merit review panelists will assess and score applicants' responses with the criteria below, using a scale of 100 total base points.

- Incomplete, unclear, and confusing proposals will receive point reductions.
- Project Narratives with significant content deficiencies may receive a score of zero.
- Proposals that merely restate the content of the NOFO, without responding to the Program Requirements and Application Review Criteria, will receive a score of zero.
- Each part of the Project Narrative is weighted as indicated below.
- The scoring criteria breakdown is reflective of the total possible number of points available, but each item is scored on a range starting from zero. Points are awarded based on the quality of the applicant's response.
- You must document all source material. If any text, language, or materials are from another source, you must be clear if it is a quote and cite it. Also cite any sources if you use numbers, ideas, or other material that are not your own. If you do not follow this requirement, the reviewers will reduce their scores accordingly. They may choose to award no points at all.

Section	Topics	Total Available Points	Scoring Criteria Breakdown
Project Narrative			
1.	Characteristics of the proposed model service area and model population	10	(5 Pts) Description and justification of state/territory OR sub-state/territory region , including summary of health care delivery system redesign in the region and, if proposing sub-state region, rationale for proposed sub-state region. (5 Pts) Provision of required data to exhibit need for the IBH Model , including data on prevalence and utilization for the MSBH population in the proposed model service area.

Section	Topics	Total Available Points	Scoring Criteria Breakdown
2.	Organizational capacity of applicant organization	10	(5 Pts) Description of the entity that will perform the cooperative agreement activities under this funding opportunity, including: • Description of key personnel including identifying one individual to serve as Project Director. • If key personnel have not yet been hired, applicants shall provide a hiring strategy and job descriptions shall be included. • Description of the anticipated role of any subrecipients or contractors that may be engaged to help implement the Model, including State Mental Health authorities and Single state agencies for SUDs. • An organizational chart to be included in the Project Narrative or as an appendix clearly identifies the reporting relationships of key personnel assigned to oversee this intervention. (5 Pts) Description of the current state of service provision for integrated behavioral and physical health care for beneficiaries, including: • Gaps in care delivery and funding • Prior experience and capacity designing and implementing VBP initiatives and behavioral health programs. • The provider network and network administrators.
3.	Model intervention	12.5	(12.5 Pts) Applicants must describe their intended process for developing the IBH care delivery framework. More specifically applicants must detail: • (2.5 Pts) The stakeholders they intend to work with to develop the framework. • (5 Pts) Intermediate steps and processes in developing the framework. • (2.5 Pts) How cooperative agreement funding could support the development of the framework. • (2.5 Pts) Areas where applicants would anticipate needing technical assistance in designing their framework. In describing their intended process applicants shall reference key care delivery requirements.

Section	Topics	Total Available Points	Scoring Criteria Breakdown
4.	Medicaid Payment Approach	12.5	(12.5 Pts) Applicants must describe their intended process for developing the IBH Medicaid Payment Approach. More specifically applicants must detail: • (2.5 Pts) The stakeholders they intend to work with to develop the Medicaid Payment Approach. • (5 Pts) Intermediate steps and processes in developing the Medicaid Payment Approach. • (2.5 Pts) How cooperative agreement funding could support the development of the Medicaid Payment Approach. • (2.5 Pts) Areas where applicants would anticipate needing technical assistance in designing their Medicaid Payment Approach. In describing their intended process applicants shall reference key Medicaid Payment Approach requirements in Table D.2.4.1 Medicaid Payment Approach requirements and alignment principles.
5.	Behavioral health practice recruitment strategy	12.5	• (7.5 Pts) Applicant details their plan for recruiting specialty BH practices in the IBH Model. Applicants must clearly outline their plans to recruit rural safety-net specialty BH providers, under-resourced providers, tribal providers, and providers serving vulnerable populations. • (2.5 Pts) Applicants must provide an estimated anticipated number of Practice Participants in the IBH Model. • (2.5 Pts) Applicants must provide an estimated number of IBH Medicaid enrollees with MSBH conditions to be attributed to the model for the entire duration of the Implementation Period. If an applicant proposes to reach 10,000 Medicaid beneficiaries or more, they are eligible to receive up to 2.5 points. If an applicant proposes to reach fewer than 10,000 beneficiaries, they are eligible to receive up to 1 point.

Section	Topics	Total Available Points	Scoring Criteria Breakdown
6.	Health IT implementation plan	12.5	Description of current state and/or future planned health IT state. This must include: - (2.5 Pts) Description of existing data infrastructure action plans and governance and any gaps that would be addressed under this model. - (2.5 Pts) Description of staff capacity, data analytic capabilities, and experience supporting value-based payment and quality reporting. - (7.5 Pts) Description of ability to leverage health IT to meet Model requirements, including data alignment, sharing/flow/linking capacity across potential partners and participants, sharing data and facilitating data collection for care delivery and monitoring and evaluation purposes. In describing the future state, participants must further describe their ability to use current infrastructure or model funding to: - Facilitate data sharing agreements between Practice Participants and payers. - Provide data and health IT technical assistance to Practice Participants. - Intermediate steps and processes in developing the Health IT implementation plan. - Enable Practice Participants to use quarterly data to make necessary course corrections within the Model. - Submit relevant claims and encounter data including provision of unique Medicaid identifiers. - Facilitate primary data collection from Practice Participants. - Facilitate exchange of information necessary to identify admissions, discharges, transfers, and other events necessary to support care coordination. - Facilitate data alignment between payers, MCOs, PIHPs, PAHPs, intermediaries and Practice Participants.

Section	Topics	Total Available Points	Scoring Criteria Breakdown
7.	Sustainability Plan	10	(10 Pts) Describe the strategy for sustaining the Model after Cooperative Agreement funding ends , including the applicant's commitment to sustainability and their process of including sustainability into specific activities like development of the Medicaid Payment Approach or care delivery framework.
8.	Budget impact analysis	5	(2.5 Pts) Impact on quality of care: Applicants will use this section to describe how IBH could impact quality of care and ultimately health outcomes within their proposed geographic service area. Strategies to make data-driven decisions. (2.5 Pts) Cost Savings Projection: Applicants must use this section to provide a financial model that illustrates anticipated Medicaid and/or CHIP spending for the Model population, comparing a projection including the intervention to a projection in the absence of the intervention, over the same period.
Budget Narrative			
1.	Budget Narrative	15	(5 Pts) Detailed budget , See, Guidance for Preparing a Budget Request and Narrative (7.5 Pts) Reasonableness of requested funding according to tasks proposed: Applicants must exhibit how requested funds are in alignment with the IBH Model goals. • (2.5 Pts) Funds requested are reasonable based on the total available funding and each activity is linked to the goals of this NOFO and consistent with the IBH model requirements. • (2.5 Pts) Funds requested are reasonable to support personnel costs. If utilizing a subrecipient to carry out the Required Core Functions or Optional Functions, then the applicant has described how the subrecipient will operate functions of the intervention. • (2.5 Pts) Funds requested are reasonable based on proposed project goals. The time commitment of the proposed project director and other key project personnel appear sufficient to assure proper direction, management, and prompt completion of the project. • (2.5 Pts) Program Duplication Documentation Recipient clearly identifies areas where there is potential for duplication of funding and describes a strategy for ensuring non duplication of funding.
Total Base Points			100

E2. Merit Review and Selection Process

CMS will consider the geographic range and scale of all applications, as well as the quality of applications, in making final award determinations. In addition, CMS will consider the Recipient's participation in other CMS models, including but not limited to Making Care Primary, States Advancing All-Payer Health Equity Approaches and Development, and Transforming Maternal Health to diversify entities receiving awards. CMS will also consider the estimated number of Medicaid enrollees with MSBH conditions to be attributed to the IBH Model for the entire duration of the Implementation Period.

The application itself is not a legally binding agreement and does not require any applicant or CMS to enter into a cooperative agreement. CMS will select Recipients at CMS's sole discretion unless statutorily prohibited. Such selection will not be subject to administrative or judicial review, per Section 1115A(d)(2)(B) of the Act.

Please refer to [Merit Review and Selection Process](#) on our website for more information on the review and selection process.

E3. Review of Risk Posed by Applicants

Prior to making a Federal award, CMS is required to review eligibility information for applicants and financial integrity information for applicants available in OMB-designated databases in accordance with [2 CFR 200.206](#). We use SAM.gov Responsibility/Qualification to check this history for all awards likely to be over \$350,000. We also check Exclusions.

Recipients that have active federal contract, grant, or cooperative agreement awards with a cumulative value greater than \$10,000,000 are **required** to disclose semi-annual information about criminal, civil, and administrative proceedings that reached final disposition within the most recent five-year period and that were connected with the award or performance of an award. Recipients must also make semi-annual disclosures regarding such proceedings and/or affirm that there is no new information to provide. This information will be made publicly available in **Responsibility and Qualification** records (formerly Federal Awardee Performance and Integrity Information System) on SAM.gov.

If we find a significant risk, we may choose not to fund your application or to place specific conditions on the award.

F. Federal Award Administration Information

F1. Federal Award Notices

If successful, your authorized organizational representative (AOR) will receive an email notification from GrantSolutions, the online grants management system used by CMS and Recipient organizations. You can then retrieve your Notice of Award (NoA). The NoA is the legal document authorizing the cooperative agreement award and issued to the applicant as listed on the SF-424. Any communication between CMS and applicant prior to issuance of the NoA is not an authorization to begin performance of a project. Until you receive the NoA, you don't have permission to start work.

If unsuccessful, CMS notifies the applicant electronically via the email address as listed on its SF-424, within 30 days of the award date of the program.

F2. Administrative and National Policy Requirements

You must follow:

A. All terms and conditions in the Notice of Award. We incorporate this NOFO by reference.

B. National/Public Policy Requirements

By signing the application, the authorized organizational official certifies that the Recipient will comply with all federal statutes and regulations relevant to federal financial assistance, including those highlighted in the HHS Administrative and National Policy Requirements. Each Recipient is responsible for establishing and maintaining the necessary processes to monitor its compliance and that of its employees and, as appropriate, subrecipients and contractors under the award with these requirements.

C. The [HHS Grants Policy Statement \(GPS\) \[PDF\]](#). This document has terms and conditions tied to your award. If there are any exceptions to the GPS, they'll be listed in your Notice of Award.

D. All anti-discrimination laws: By applying for or accepting federal funds from HHS, recipients certify compliance with all federal antidiscrimination laws and these requirements and that complying with those laws is a material condition of receiving federal funding streams. Recipients are responsible for ensuring subrecipients, contractors, and partners also comply.

E. Administrative Requirements

The rules listed in [2 CFR 200](#), Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. As of October 1, 2025, HHS adopts 2 CFR 200, with some modifications included in 2 CFR 300. These regulations replace those in 45 CFR 75.

- All equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the applicant's original application or agreed upon subsequently with CMS and may not be used for any prohibited uses.
- Consumers and other stakeholders must have meaningful input into the planning, implementation, and evaluation of the project.

Uniform Administrative Requirements, Cost Principles, and Audit Requirements

Applicant and Recipients shall take note of the following information found in [2 CFR 200](#):

Uniform Administrative Requirements

In accordance with [2 CFR 200.112](#), all Recipients receiving federal funding from CMS must establish and comply with the [CMS Conflict-of-Interest policy requirements](#) outlined by CMS.

In accordance with [2 CFR 200.113](#), **Mandatory Disclosures**, the non-Federal entity or applicant for a Federal award must disclose, in a timely manner, in writing to the HHS awarding agency or pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Non-Federal entities that have received a Federal award including the term and condition outlined in [Appendix XII to 2 CFR 200](#) are required to report certain civil, criminal, or administrative proceedings to SAM. Failure to make the required disclosures can result in the imposition of any of the remedies described in [2 CFR 200.339](#), including suspension or debarment. (See also [2 CFR Part 180](#) and [2 CFR Part 376](#), and [31 U.S.C. 3321](#)). For specific information on reporting such disclosures to CMS and HHS please see Section F3. Terms and Conditions of this NOFO.

Cost Principles

CMS grant and cooperative agreement awards provide for reimbursement of actual, allowable costs incurred and are subject to the Federal cost principles. The cost principles establish standards for the allowability of costs, provide detailed guidance on the cost accounting treatment of costs as direct or indirect, and set forth allowability and allocability principles for selected items of cost. Applicability of a set of cost principles depends on the type of organization. Recipients must comply with the cost principles set forth in HHS regulations at [2 CFR 200, Subpart E](#) with the following exceptions: (1) hospitals must follow Appendix IX to 2 CFR 300; and (2) commercial (for-profit) organizations are subject to the cost principles located at [48 CFR subpart 31.2](#). As provided in the cost principles in 48 CFR subpart 31.2, allowable travel costs may not exceed those established by the Federal Travel Regulation (FTR).

There is no universal rule for classifying certain costs as either direct or indirect (also known as Facilities & Administration (F&A) costs) under every accounting system. A cost may be direct with respect to some specific service or function, but indirect with respect to the Federal award or other final cost objective. Therefore, it is essential that each item of cost incurred for the same purpose is treated consistently in like circumstances either as a direct or F&A cost to avoid double-charging of Federal awards. Guidelines for determining direct and indirect costs charged to Federal awards are provided in [2 CFR 200 Direct and Indirect Costs](#) (§§200.412 to 200.415) and [2 CFR 200 Special Considerations for States, Local governments, and Indian Tribes](#) (§§200.416 to 200.419). Requirements for development and submission of indirect (F&A) cost rate proposals and cost allocation plans are contained in Appendices III-VII to 2 CFR 200, and Appendix IX to 2 CFR 300.

Indirect Costs

Indirect costs are those shared across multiple projects and not easily separated. Costs included in the indirect cost pool must not be charged as direct costs.

To charge indirect costs you can select one of two methods:

Method 1 — Approved rate. If you currently have an indirect cost rate approved by your [Cognizant Federal Agency](#), you may use that rate.

Method 2 — *De minimis* rate. If you do not have a negotiated indirect cost rate, you may elect to charge a *de minimis* rate (see [2 CFR 200.414\(f\)](#)).

Commercial (For-Profit) Organizations:

- Indirect Costs are allowable under awards to for-profit organizations. The for-profit Recipient must have a federally approved indirect cost rate agreement covering the grant supported activities and period of performance.
- Indirect cost rates for for-profit entities are negotiated by DFAS in the Office of Acquisition Management and Policy, National Institutes of Health (if the preponderance of their federal awards are from HHS), available at <http://oamp.od.nih.gov/dfas/indirect-cost-branch>, or other Federal agency with cognizance for indirect cost rate negotiation.
- If there is no federally approved indirect cost rate for the specific period of performance, then the non-federal entity may elect to charge a de minimis rate of 15% of MTDC.

Cost Allocation

In accordance with [2 CFR 200.416](#) and [Appendix V to Part 200](#) – State/Local Government-wide Central Service Cost Allocation Plans, each state/local government will submit a plan to the HHS Cost Allocation Services for each year in which it claims central service costs under Federal awards. Guidelines and illustrations of central service cost allocation plans are provided in a brochure published by the HHS entitled “A Guide for state, Local and Indian Tribal Government: Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government.” A copy of this brochure may be obtained from the HHS Cost Allocation Services at:

<https://www.hhs.gov/about/agencies/asa/psc/indirect-cost-negotiations/index.html>.

A current, approved cost allocation plan must be provided to CMS if central service costs are claimed.

Public Assistance Cost Allocation Plans

[Appendix VI to Part 200](#) – Public Assistance Cost Allocation Plans, provides that state public assistance agencies will develop, document and implement, and the Federal Government will review, negotiate, and approve, public assistance cost allocation plans in accordance with Subpart E of 45 CFR part 95. The plan will include all programs administered by the state public assistance agency. Where a letter of approval or disapproval is transmitted to a state public assistance agency in accordance with Subpart E, the letter will apply to all Federal agencies and programs. This Appendix (except for the requirement for certification) summarizes the provisions of [Subpart E of 45 CFR part 95](#).

Audit Requirements

The audit requirements in [2 CFR 200, Subpart F](#), apply to each award Recipient. A non-Federal entity that expends \$1,000,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single or program-specific audit conducted for that year in accordance with the provisions of Subpart F, Audit Requirements.

Commercial (For-Profit) Organizations (including for-profit hospitals) have two options regarding audits, as outlined in [2 CFR 300.218](#).

F3. Terms and Conditions

This Notice of Funding Opportunity is subject to the **Department of Health and Human Services Grants Policy Statement (HHS GPS)**. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the

contrary. Standard and program specific terms of award will accompany the NoA. Potential applicants shall be aware that special requirements could apply to cooperative agreement awards based on the circumstances of the effort to be supported and/or deficiencies identified in the application by the HHS review panel.

HHS regulation (2 CFR 200) supersedes information on administrative requirements, cost principles, and audit requirements for grants and cooperative agreements included in the current HHS Grants Policy Statement where differences are identified. Recipients must also agree to respond to requests that are necessary for the evaluation of national efforts and provide data on key elements of their own grant or cooperative agreement activities.

Material Noncompliance

CMS may terminate any award for material noncompliance. Material noncompliance includes, but is not limited to, violation of the terms and conditions of the award; failure to perform award activities in a satisfactory manner; improper management or use of award funds; or fraud, waste, abuse, mismanagement, or criminal activity.

Bankruptcy. In the event a Recipient or one of its subrecipients enters proceedings relating to bankruptcy, whether voluntary or involuntary, the Recipient agrees to provide written notice of the bankruptcy to CMS. The Recipient must furnish the written notice within five (5) days of the initiation of the proceedings relating to bankruptcy filing and sent to the CMS Grants Management Specialist and Project Officer. This notice includes:

- the date on which the bankruptcy petition was filed,
- the identity of the court in which the bankruptcy petition was filed,
- a copy of all the legal pleadings, and
- a listing of Government grant and cooperative agreement numbers and grant offices for all, and
- Government grants and cooperative agreements against which final payment has not been made.

F4. Cooperative Agreement Terms and Conditions of Award

The administrative and funding instrument used for this program is a Cooperative Agreement, an assistance mechanism used when CMS anticipates substantial CMS programmatic involvement with each Recipient during the performance of the activities. Under each Cooperative Agreement, CMS' purpose is to support and stimulate the Recipients' activities by involvement in, and otherwise working jointly with, the award Recipient in a partnership role. To facilitate appropriate involvement during the period of this Cooperative Agreement, CMS and the Recipient will be in contact at least once a month, and more frequently when appropriate.

The cooperative agreement roles and responsibilities are as follows:

Centers for Medicare & Medicaid Services

CMS will have substantial involvement in program awards, as outlined below:

- Technical Assistance – CMS hosts opportunities for training and/or networking, which may include conference calls, topic-specific webinars, office hours, and other vehicles.
- Collaboration – CMS actively coordinates with other relevant Federal Agencies including,

but not limited to, the Indian Health Service, the Internal Revenue Service, the Department of Homeland Security, the Administration for Children and Families, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control and Prevention, and the Social Security Administration. In this way, CMS facilitates compliance with the terms of the Cooperative Agreement and effectively supports Recipients.

- Learning System – Recipients will be required to participate in and provide support to regional learning in pursuit of a shared vision for population health and whole person health outcomes within the state, including Practice Participants as well as other essential and recommended members of the Convening Structure. CMS will partner with awardees through the learning system to operationalize a data-driven and goal-oriented learning system to enable the success of all participants in the Model that builds from existing infrastructure and capacity within the state. Model participants will also have opportunities to join learning communities with other Recipients and access tools and supports to help them adopt new payment and care delivery methods.
- Project Officers and Monitoring – The Recipient can expect substantial collaboration, participation, and/or intervention in the oversight of the project by CMS. Substantial involvement may include collaboration or participation by CMS program staff in activities specified in the Notice of Award (NoA) and, as appropriate, decision-making at specified milestones related to performance, e.g., requiring CMS approval before undertaking the next phase of a project, collaborating in the design of a service delivery model, etc. Substantial involvement pertains to programmatic involvement **not** administrative oversight.

Recipients

Recipients and assigned points of contact retain the primary responsibility and dominant role for planning, directing, and executing the proposed project as outlined in the terms and conditions of the Cooperative Agreement and with substantial CMS involvement. Recipients must engage in the following activities:

- Comply with the terms and conditions of the award.
- Collaborate with CMS staff to implement and monitor the project.
- Submit performance measures as requested by CMS.
- Submit all required performance assessments, evaluations, and financial reports included in the Terms and Conditions.
- Attend and take part in monthly calls (or more often as needed) with the CMS Project Officer (PO) on progress and challenges. The meetings will include key personnel and the PO.
- Attend and take part in any virtual meetings.
- Participate in targeted learning activities throughout the course of the IBH model, including the period after selection but prior to performance start date; responding to surveys or other mechanisms to assist CMS in identifying Recipient learning needs; and other items listed in Section [F6.5 Learning System Participation](#).
- Cooperate with CMS-organized model audits and initial assessments of Recipient interventions, data collection, data reporting, and other model terms. Model Audits serve as a compliance-based assessment of Recipients' adherence to model policies to be

outlined in the Terms and Conditions. Initial assessments, which occur for the first 12 months of the period of performance, aim to assess whether the Recipients have the operational structures and processes in place to support successful implementation and maintain compliance with certain requirements of the IBH model. Conducting initial assessments during the early stages of model implementation allows for an open dialogue between CMS and Recipients and an opportunity for direct and timely feedback. Audits, starting in month 12 of the period of performance and continuing through the end of the period of performance, occur after basic education and provision of assistance.

- Any IBH Recipients that also participate in the CCBHC demonstration would need to sign a maintenance of effort (MOE) agreement with CMS and the Administration for a Healthy America outlining that they will continue to comply with all requirements and services as part of the CCBHC demonstration or grant programs. The IBH Model will require this documentation in the Recipient Specific terms and conditions of the IBH Model cooperative agreement.

F5. Health Information Technology (IT) Interoperability Language

You are subject to Health Information Technology requirements as stated [here](#) on our website.

Please see [Appendix II](#) for further Health IT Requirements specific to the IBH Model.

F6. Reporting

If you are successful, Federal reporting requirements include:

- Progress Reports
- Federal Financial Report (FFR)
- Federal Funding Accountability and Transparency Act (FFATA)
- Responsibility and Qualification Reports
- Payment Management System (PMS)
- Audit Reporting (Federal Audit Clearing House)
- Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification

Cybersecurity requirements

You must create a cybersecurity plan if your project involves both of the following conditions:

- You have ongoing access to HHS information or technology systems.
- You handle personal identifiable information (PII) or personal health information (PHI) from HHS.

See the [HHS Administrative and National Policy Requirements \[PDF\]](#) for full information.

F6.1 Monitoring

CMS will monitor the performance of each Recipient pursuant to the Terms and Conditions of Award.

Each Recipient will be required to comply fully with CMS' and any CMS contractor's (including, but not limited to, the implementation and monitoring, learning, and evaluation contractors) efforts to monitor the IBH Model. CMS will primarily monitor awards through data collection and reporting. CMS's goal is to monitor and measure model activities in a manner that optimizes its

usefulness for both Recipients and the CMS. CMS will closely track model progress through project officers and an implementation and monitoring contractor.

Each Recipient will be required to participate in model monitoring activities that include, but are not limited to:

- Submission of Quarterly Progress Reports
- Regular communications with CMS project officers
- Regular learning system event attendance and participation

F6.2 Progress Reports

Each Recipient will be required to submit Semi-Annual reports each calendar year to CMS. CMS will provide the Recipient with guidance and/or a template for Semi-Annual Report submissions. These reports will include narrative updates on model activities as well as information on operational and performance milestones in accordance with the IBH Model cooperative agreement.

- CMS will use the Semi-Annual reports to track progress on model goals, identify technical assistance needs, and inform learning activities for all Recipients.
- The operations and performance milestones will support CMS efforts to confirm that each Recipient is able to meet program requirements and deliver high quality care to beneficiaries.
- CMS will also share these findings with Recipients individually on an ongoing basis for quality improvement purposes.
- Recipients must maintain records of all source data used to calculate program milestone measures and make such data available to CMS for periodic audits.
- CMS will consider Recipients for remedies of non-compliance and resulting enforcement actions including funding restrictions, withholding of funds not yet awarded, or termination, if they do not meet the Model reporting requirements outlined in F6.3 Performance Milestones.

F6.3 Performance Milestones

The following milestones, included in *Table F6.3* below, will be included in the Cooperative Agreement Program Terms and Conditions. These milestones are shared to provide applicants an understanding of the requirements for Recipients; however, these milestones and deadlines may be subject to change by CMS.

The milestones are captured under the Implementation Plan. The Implementation plan is due by the end of MY1 (BP1). The Recipient will use their application as the basis of their Implementation Plan and update it on a yearly basis with key updates including progress or challenges in reaching performance milestones. For example, the Recipient can note progress on developing their care delivery framework.

Specific remediation activities and enforcement actions are up to CMS discretion. These activities may include, but are not limited to, more frequent engagement with and updates to CMS, reprioritization of activities to address identified challenges, developing a plan to address non-compliance, restricting funds already awarded and/or withholding funds not yet awarded. CMS will support each Recipient in achieving the operational milestones. If a Recipient needs assistance meeting any milestone, the Recipient will contact CMS for technical assistance or other types of

support. CMS may also contact Recipients to set up check in calls, technical assistance, or other types of support as needed.

Recipients will not be held accountable if they miss milestones due to the actions of CMS (e.g., CMS delays in approval of authorities and methodologies), assuming the state has demonstrated readiness to meet the milestone by the deadline(s) described in the Cooperative Agreement Program Terms and Conditions.

Table F6.3 Operational Milestones

Implementation Plan			
Requirement	Description	Milestones	Due date
Practice participant recruitment strategy	The Recipient is required to draft and implement a practice recruitment strategy as described in Section A.4.2	Develop a draft Practice Participant recruitment strategy, including an estimated number of total Medicaid enrollees with MSBH conditions to be attributed to the IBH Model for the entire duration of the Implementation Period	As part of this model application
		Where applicable, secure a letter of intent from a participating MCO, PIHP, PAHP, or other intermediary	As part of this model application
		Update the Practice Participant recruitment strategy annually, as needed	As part of the annual implementation plan update.
		Provide updates on practice recruitment progress and challenges	In semi-annual progress reports.
Care delivery framework	The Recipient is required to draft and implement the IBH Model care delivery framework as described in Section A.4.3.	Work with key stakeholders including Practice Participants, State Mental Health authorities and Single state agencies for SUDs, and MCOs to design the IBH Model care delivery framework	No later than December 31, 2027
		Implement the IBH Model care delivery framework	Starting on January 1, 2028.
		Provide semi-annual updates on the status of designing the Medicaid Payment Approach	In semi-annual progress reports.
Medicaid Payment Approach	The Recipient is required to develop and implement a Medicaid Payment Approach as described in Section A.4.2	Develop a Medicaid Payment Approach using appropriate state or federal authority	No later than December 31, 2027
		Implement the Medicaid Payment Approach among IBH Model Practice Participants	Starting on January 1, 2028.
		Provide semi-annual updates on the status of designing the Medicaid Payment Approach	In semi-annual progress reports.

Implementation Plan			
Requirement	Description	Milestones	Due date
Health IT Implementation Plan	The Recipient will be expected to submit an Implementation Plan outlining the type of health IT investments as described in section A4.6 and how these investments will impact the overall goals of the model.	Develop a draft health IT implementation plan, which includes current and future state of health IT	As part of this model application
		Finalize the health IT implementation plan	No later than November 1, 2026
		States will confirm upfront funding for health IT investments has been distributed. States will provide information regarding what kind of health IT investments have been made by the participants, what kind of capabilities these investments are intended to address, and what barriers the participants identified when looking to invest in health IT.	End of the Implementation Period
		States will submit the following information: Certified Health IT Capabilities: Did participants use funds to invest in certified health IT? If yes, what capabilities did participants invest in (ex. capturing demographic information, supporting care coordination by sending and receiving summary of care records, providing timely access to view, download, or transmit their health information, utilizing decision support tools, or conducting electronic prescribing).	- Assessment of Health IT Investments (annual) - In semi-annual progress reports.

Implementation Plan			
Requirement	Description	Milestones	Due date
Health IT Implementation Plan (cont.)		- Health Information Exchange: Did participants engage in health data sharing (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 in order to receive electronic notifications for patient transitions of care? - Needs impact health including food, housing, and transportation: Did practice participants use IBH Model upfront funding to update existing EHRs to be able to track other health needs screening information and link to social service agencies for referral and follow up? - Best Practices/Barriers: Did participants/states identify any best practices/barriers in the overall implementation of the IBH model when investing in health IT? How did the health IT purchased help accomplish the goals of the IBH model? - Provide semi-annual updates on the status of implementing the health IT implementation plan	
Convening Structure	The Recipient is required to work alongside CMS to identify a convening structure to operationalize IBH Model components as described in section A.4.7.	The Recipient will work with CMS to identify a convener to host the IBH Model	March 31, 2026.
		The Recipient will begin convenings for the IBH Model (no less than quarterly is recommended).	May 31, 2026.
Program duplication documentation	The Recipient will ensure non-duplication of services and payment	The Recipient will implement a strategy to ensure non-duplication of services and payment with other federal and state programs	As part of this model application
		The Recipient will update its program duplication documentation annually	Starting October 1, 2026

Implementation Plan			
Requirement	Description	Milestones	Due date
Compliance plan	The Recipient will develop or adapt an existing compliance plan to monitor Practice Participants	The Recipient shall develop compliance standards under the direction of the designated compliance officer (and committee). Training and retraining of the applicable staff on a routine basis with an emphasis on compliance. The compliance plan must be aligned with the DOJ General Compliance Program Guidance⁽⁴¹⁾	No later than December 31, 2026
		Conduct internal monitoring and auditing of the compliance elements with reports readily available.	No later than quarterly

F6.4 Evaluation

Pursuant to Section 1115A(b)(4) of the Social Security Act, CMS will conduct a formal and concurrent evaluation of each Recipient's performance to assess model impact on spending and quality domains, with the necessary requirements for cooperation in data collection by model participants. The primary goal of the evaluation will be to assess the implementation and effects of the integrated care delivery framework and its supporting payment approach on care utilization and quality of care, along with analysis of any associated impacts on Medicare and Medicaid expenditures, where more robust impacts would be expected under a sub-state implementation scenario. This evaluation will look at all Practice Participants and their attributed beneficiaries, with particular focus on those with moderate to severe BH conditions.

The evaluation will focus on measures of health (both PH and BH) and well-being among the priority population, as well as tracking measures of care coordination, including referrals to PH providers and to address other identified needs that impact health. Associated measures of progress in health IT infrastructure advancement will also be analyzed. Further, the evaluation will examine the efficacy of implementation based on Practice Participant and beneficiary characteristics and experiences. To the extent possible, given sample size and available data, CMS will additionally investigate whether the intervention reduces emergency department use and hospitalizations, along with tracking other cost and utilization metrics.

This evaluation is expected to cover the model's two-year Pre-Implementation Period in addition to the five-year Implementation Period. Innovation Center models are exempt from IRB approval. If IRB approvals are necessary at the state or local-level for such actions as managing/handling/transferring clinical or other administrative data, consenting patients to participate, or for collecting measures included in the model beyond claims data, Recipients are solely responsible for any procedures and approvals or any other permissions from their participating organizations or their state that may be needed to submit the relevant data and cooperate with CMS and its contractors on this award. This includes that Recipients may need to develop Medicaid beneficiaries' consent/authorization forms that comply with all applicable federal, state, and local laws governing the access, use, and disclosure of patient data for this model. CMS cannot develop or provide consent/authorization forms for Recipients.

CMS will evaluate each Recipient using the most rigorous evaluation design feasible, applying appropriate quantitative and qualitative methods to examine program outcomes and the processes that lead to successes or challenges. As authorized under 42 C.F.R. § 403.1110, CMS will require Recipients to provide the CMS evaluation contractor with data including, but not limited to:

- Claims and encounter data: Recipients must provide all Medicaid claims and encounter data with unique, longitudinally traceable identifiers for the individual beneficiaries attributed to Practice Participants in the Model. Recipients may submit these data through T-MSIS; however, if CMS does not receive all necessary claims and encounter data for attributed beneficiaries through T-MSIS, the Recipient is responsible for obtaining and submitting the required individual-level beneficiary enrollee claims and encounters through an alternative mechanism approved by CMS. This may require coordinating and working with participating MCOs, PIPs, and PAHPs to ensure proper data availability and submission, depending on the structure of payment for BH in the Recipient's state.
- Electronic health record data: The evaluation may need practices to report data elements

from EHRs that are not available from or reliable in other sources (e.g., results of health screenings such as for tracking diabetes a1c levels) for all model enrolled beneficiaries. Whether this data is submitted at the individual or aggregate level will depend on the measure.

- Non-claims-based health and utilization data: Such data may include, but is not limited to, referrals (to other physicians and referrals to address other needs that impact health), patient follow-up on recommended services, interactions with community-based services, and measurement-based care tracking data. Whether this data is submitted at the individual or aggregate level will depend on the measure.
- Qualitative data: Recipients will assist the Model evaluation contractor with the acquisition of qualitative data from Practice Participants, beneficiaries and caregivers, and associated state-level staff, or other relevant stakeholders. Data collection activities that may require the Recipient to cooperate and participate in, include, but are not limited to, arranging and granting interviews; assisting in recruiting for focus groups and individual interviews with model associated state-level staff (i.e. State Medicaid Agency staff), relevant state BH agency staff, Practice Participants, beneficiaries, and beneficiary caregivers; allowing observations of any cooperative agreement or integration capitated payment funded activities; providing program documents such as beneficiary education and staff training materials, and community needs assessments; and surveys of staff at Practice Participants and/or beneficiaries. Advanced payment model-related information may include interviews with an MCO, and state personnel associated with implementation, as well as care delivery staff experiencing payment approach implementation.
- Retrospective list of attributed beneficiaries: On an annual basis, the Recipient will provide CMS with a retrospective list of those beneficiaries attributed to Practice Participants to confirm beneficiaries' Medicaid coverage status, which must contain a unique Medicaid identifier that the CMS evaluators can use to longitudinally link beneficiaries to claims and encounter data acquired through T-MSIS (or a backup method approved by CMS).

The evaluation assesses administrative data (e.g., Medicaid claims, encounter data) on an annual basis. Evaluation site visits are no more frequent than annually. Other data (e.g., EHR, screenings, site level) may need to be provided more frequently (e.g., quarterly) in accordance with overall program needs such as model monitoring. The desired data requirements to evaluate this model most effectively will require coordination and effort on the part of the Recipient. For instance, it is likely this will include the development or enhancement of data systems and the development or implementation and facilitation to ensure agreements are in place for data sharing across providers and partners, such as between specialty BH providers and PH providers or with CBOs.

F6.5 Learning System Participation

CMMI will design, implement, and manage a learning collaborative that is tailored to the needs of model awardees and participants. CMS will partner with Recipients through the learning collaborative to operationalize a data-driven and goal-oriented approach to enable the success of all participants in the Model and will incorporate Practice Participants as well. The goals of the learning collaborative are to accelerate the implementation and improve the success of the Model through achieving Model Aims. The primary function of the learning collaborative will be to support participants in the identification and exchange of new knowledge, tools and resources to improve integration, access and outcomes for individuals with moderate to severe mental health conditions or substance use disorder (SUD).

F6.6 Financial Reports

Recipients are required to record their expenses in real-time as well as submit semi-annual FFRs.

Recipients must submit a Federal Financial Report (FFR) SF-425 at least annually via the Payment Management System. Frequency of required expenditure reporting, whether semi-annually or annually, is stipulated in the Program Terms and Conditions of the Notice of Award. Instructions on how to complete the FFR can be found [here](#). (after logging on)

F6.7 Federal Funding Accountability and Transparency Act (FFATA) Reporting Requirements

Recipients are required to report certain information about themselves and their first-tier subrecipients for awards. A specific term is included on your NoA. If your organization is a Recipient of grants or cooperative agreements, you must report on subawards of \$40,000. There are additional reporting requirements if:

- 80% or more of your prior year annual gross revenues are from federal awards;
- \$25 million or more in annual gross revenues are from federal awards; or
- The public does not have access to compensation information filed under Securities and Exchange Commission (SEC) and IRS requirements.

Additional Guidance on FFATA

- Prime Recipients report their own executive compensation if they meet all the criteria, as part of their profile at [System for Award Management \(SAM\)](#)
- Prime Recipients report subaward information at [System for Award Management \(SAM\)](#). As of March 8, all new subaward reporting and viewing functionality will be available in SAM.gov. Users will be required to have the correct role in SAM.gov to be able to access the new subaward reporting capabilities. They will need their SAM.gov entity administrator to assign them the new role. Steps are outlined on [SAM](#).

F6.8 Responsibility and Qualification Reporting

Recipients that have active federal contract, grant, or cooperative agreement awards with a cumulative value greater than \$10,000,000 at any time during the period of performance are **required** to disclose semi-annual information about criminal, civil, and administrative proceedings that reached final disposition within the most recent five-year period and that were connected with the award or performance of an award. For more information see Section E3. Review of Risk Posed by Applicants and SAM.gov.

F6.9 Audit Requirements

The audit requirements in [2 CFR 200, Subpart F](#), apply to each award Recipient. A non-Federal entity that expends \$1,000,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single or program specific audit conducted for that year in accordance with the provisions of Subpart F, Audit Requirements.

For specific questions and information about the submission process, call the FAC toll-free number at 800-253-0696.

F6.10 Payment Management System Reporting Requirements

Once CMS issues an award, the funds are posted in Recipient accounts established in the Payment Management System (PMS). Recipients may then access their funds by using the PMS funds request process.

The PMS funds request process enables Recipients to request funds using a Personal Computer with an Internet connection. The funds are delivered to the Recipient via Electronic Funds Transfer (EFT). If you are a new Recipient, please go to PMS Access Procedures to find information to register in PMS. If you need further help with that process, please contact the One-DHHS Help Desk via email at pmssupport@psc.gov or call (877) 614-5533 for assistance.

F6.11 Government-wide Suspension and Debarment Reporting Requirements

Debarment, Suspension, Ineligibility, and Voluntary Exclusion Certification;

- i. You certify on behalf of the applicant organization, by submission of your proposal, that neither you nor your principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
- ii. Failure to make required disclosures can result in any of the remedies described in [2 CFR 200.339](#), including suspension or debarment. (See also [2 CFR Part 180](#) and [2 CFR Part 376](#), and [31 U.S.C. § 3354](#)).
- iii. If you are unable to attest to the statements in this certification, you must include an explanation and insert in “Other Relevant Documents.”

G. CMS Contacts

G1. Programmatic Questions

For Programmatic questions about this funding opportunity, please contact: IBHModel@cms.hhs.gov

G2. Administrative and Budget Questions

For administrative or budget questions about this funding opportunity, please contact: IBHModel@cms.hhs.gov

H. Other Information

Publication of this NOFO does not oblige CMS to award any specific project or to obligate any available funds. CMS may cancel or withdraw this NOFO at any time. Award decisions are discretionary and are not subject to appeal to any CMS or HHS official or board.

- Applicants must identify proprietary information.

Appendix I. Application Check-off List

Required Contents

A complete application consists of the materials organized in the sequence below. Please ensure that the project and budget narratives are page-numbered and the below forms are completed with an electronic signature and enclosed as part of the application. **Everything listed below must be submitted through <https://www.grants.gov/>. Placeholders are designated in the application kit available on Grants.gov. Documents without specific placeholders shall be uploaded under “Other Attachments Form.”**

- ☐ SF-424: Application for Federal Assistance
- ☐ SF-424A: Budget Information for Non-construction Programs
- ☐ SF-LLL: Disclosure of Lobbying Activities
- ☐ Project/Performance Site Location Form(s)
- ☐ Applicant’s Application Cover Letter (optional, **excluded from page limitations**)
- ☐ Project Abstract
- ☐ Project Narrative
 - Characteristics of the proposed model service area and model population
 - Organizational capacity of applicant organization
 - Model intervention
 - Medicaid Payment Approach
 - Behavioral health practice recruitment strategy
 - Health IT implementation plan
 - Sustainability Plan
 - Budget impact analysis
 - Identify additional priority health conditions to include in the Model
- ☐ Business Assessment of Applicant Organization
- ☐ Budget Narrative
 - Detailed budget
 - Program duplication documentation
- ☐ Appendices
- ☐ Negotiated Indirect Cost Rate Agreement (NICRA) or Cost Allocation Plan (CAP), if applicable (excluded from page limitations)

CMS will not review or consider applications that do not meet the application due date. Technical and other issues can occur. We recommend that you submit your application at least three to five days before the due date.

Grants.gov can take up to 48 hours to notify you of a successful submission.

Appendix II: Health IT Capabilities and Support for Practice Participants

Supporting interoperability among providers, as well as patient engagement, will be important components to the IBH Model’s care delivery framework. Health information exchange allows providers to securely and efficiently transmit and exchange patient health information at the point of care, often in real time; thereby enabling better follow-up care through electronic transmission of data. This system integration increases coordination and quality of care while improving efficiency in health care delivery. All Practice Participants will be eligible to participate in the Model even if they have not yet connected to a HIE; however, they will be encouraged to connect to an HIE or other Health Information Network (HIN) as part of their model participation. Additionally, all Practice Participants are required to adopt and use health IT certified under the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program over the course of the Model period, unless exempted through the process specified below.

Health IT Requirements Table

This table describes the health IT requirements for IBH Model Recipients. Recipients will also have to comply with certain interoperability requirements under the terms of the IBH Model cooperative agreements and Participation Agreements. The proposed requirements below provide the minimum necessary health IT capabilities, and participants are encouraged to further evolve capabilities over the course of the Model.

Table VII: Health IT Requirements for IBH Model Recipients and Practice Participants²⁴

Requirement	Notes
Certified Health IT Capabilities	
At a minimum, support care coordination by sending and receiving summary of care records.	See certification criterion for “Transitions of care.” ²⁵
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 personal health app of their choice.	See certification criteria for “View, download, and transmit to 3rd party” ²⁶ and “Standardized API for patient and population services.” ²⁷
Utilize decision support tools.	See certification criterion for “Decision support interventions.” ²⁸
Conduct electronic prescribing, if applicable.	See certification criterion for “Electronic prescribing.” ²⁹
Exchange information in accordance with a current version or versions of the United States Core Data for Interoperability (USCDI) adopted for use in the ONC Health IT Certification Program ³⁰	Incorporated as part of health information exchange criteria.

Requirement	Notes
Information Blocking	
Practice participants in the model must comply with applicable law, including but not limited to, the information blocking provisions of the 21st Century Cures Act.	Under the definition of information blocking, ³¹ a health care provider that conducts information blocking 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. 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.

²⁴ CMS reserves the right to update Health IT requirements in future MYs.

²⁵ 45 CFR 170.315(b)(1), see <https://www.healthit.gov/test-method/transitions-care>

²⁶ See <https://www.healthit.gov/test-method/view-download-and-transmit-3rd-party>

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

²⁸ 45 CFR 170.315(b)(11), see <https://www.healthit.gov/test-method/decision-support-interventions>

²⁹ 45 CFR 170.315(b)(3), see <https://www.healthit.gov/test-method/electronic-prescribing>

³⁰ 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>

³¹ See Public Health Services Act section 3022(a)(1)(B)(ii).

Requirement	Notes
Other Health Related Needs	
Track needs that impact health (screening information) and link to social service agencies 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 update existing EHRs to be able to track screening information for needs that impact health and link to social service agencies for referral and follow up.

Exceptions

State Medicaid Agencies may exempt potential Practice Participants from these certified health IT requirements on a case-by-case basis if the state determines that certified health IT is not applicable to the BH services provided by the participant.

For these Practice Participants, the State Medicaid Agency shall define alternative requirements for these Practice Participants to ensure they are effectively coordinating care with other providers and capture these requirements in the initial Health IT Implementation Plan and/or in subsequent quarterly/annual reports. CMS will provide technical assistance, guidance, and best practices on how to address the health IT needs of these Practice Participants. Note that any Infrastructure Funding used for health IT technology by these Practice Participants must continue to meet the requirements below for use of HHS-adopted standards where applicable.

Infrastructure Funding

Recipients are expected to use a portion of the cooperative agreement funding to make Infrastructure Funding payments to Medicaid-only Practice Participants who participate in the Model and meet the eligibility criteria. These funds may be used to invest in health IT infrastructure, EHRs, and telehealth tools, which are required as part of the IBH Model's care delivery requirements.

CMS has developed the minimum guidelines above for participation in the IBH Model, which will be supported through funding described under Section [A4.4.3 Practice Participant Infrastructure Funding](#). Where used for health IT activities, funding must meet the interoperability requirements described in Section [F5. Health Information Technology \(IT\) Interoperability Language](#).

Appendix III: State-Based Quality Measure Data Reporting Burden

This appendix provides information on the potential data burden for participating in the state-based quality measure program under the IBH Model. CMS has included this information to respond to state requests to understand quality measure data reporting burden in the Model application phase. The estimates are informed by the Medicaid Program and CHIP; Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting Final Rule.³² The table includes a range of cost estimates (lower and upper bounds) and serves as a resource for state planning. Please note, this table solely represents burden estimates associated with quality reporting and does not account for burden associated with other state reporting requirements under the Model. **Table 1** exhibits the estimated annual state burden for reporting 13 quality measures for the IBH population.

Table 1: State-based quality measures annual reporting burden:

Quality Reporting Staff	Activity	Model Hours Estimate	Wage Rate	Cost Estimate (Lower Bound)	Cost Estimate (Higher Bound)
Computer Programmer	Data programming and synthesis	115	\$98.84	\$12,459.54	\$13,771.07
Statistician	Data sampling	20	\$101.46	\$2,224.32	\$2,458.45
General operations manager	Data analysis	76	\$118.14	\$9,841.97	\$10,877.97
Data entry / Information Processing Worker	Data input and aggregation and disaggregation across intermediaries, where applicable	212	\$37.94	\$8,816.67	\$9,744.74
Chief executive	Verification, certification, and approval	6.5	\$236.96	\$1,688.34	\$1,866.06
<i>State Hours for Quality</i>		429.5		\$35,030.84	\$38,718.30
Total*		1718		\$140,123.36	\$154,873.19

*Initial estimates are multiplied by four. This assumption is based on quarterly, individual patient-level data submission for the IBH Model population.

Table 2 Exhibits potential estimated burden with vendor contract modifications for the IBH Model. These estimates are not applicable for Recipients that do not use a vendor. Please note, Recipients may want to consider additional annual vendor related fees that are not accounted for in burden calculations.

³² 88 FR 60278. Centers for Medicare and Medicaid Services. Available at <https://www.federalregister.gov/documents/2023/08/31/2023-18669/medicaid-program-and-chip-mandatory-medicare-and-childrens-health-insurance-program-chip-core-set>

Table 2: Quality measure vendor associated data burden.

Vendor Contract Modifications for IBH (One-time fee)	Activity	Model Estimate	Hours	Cost Estimate (Lower Bound)	Cost Estimate (Higher Bound)
General operations manager	Contract Modifications	6		\$673.40	\$744.28
Chief executive	Approval	2		\$450.22	\$497.62
Total		8		\$1,123.62	\$1,241.90

Appendix IV: Model context data templates

Table 1: Total number (and percent) of beneficiaries with MSBH conditions

	2020			2021			2022		
Subgroup	With mental illness	With a SUD	With co-occurring mental illness and a SUD	With mental illness	With a SUD	With co-occurring mental illness and a SUD	With mental illness	With a SUD	With co-occurring mental illness and a SUD
Age									
18-21									
21-26									
27-45									
46-64									
65+									
Sex									
Female									
Male									
Race									
American Indian or Alaska Native									
Asian									
Black or African American									
Native Hawaiian or Pacific Islander									
White									
Disability Status									
Disability category									
Non-disability category									
Total									

Table 2: Total number (and percent) of beneficiaries with MSBH with co-occurring chronic conditions

	2020				2021				2022			
Sub-group	With one or more physical health conditions	With diabetes	With hypertension	With tobacco use or nicotine use disorder	With one or more physical health conditions	With diabetes	With hypertension	With tobacco use/nicotine use disorder	With one or more physical health conditions	With diabetes	With hypertension	With tobacco use/nicotine use disorder
Age												
18-21												
21-26												
27-45												
46-64												
65+												
Sex												
Female												
Male												
Race												
American Indian or Alaska Native												
Asian												
Black or African American												
Native Hawaiian or Pacific Islander												
White												
Total												

Table 3: Utilization among MSBH population.

Year	30-day all-cause readmissions	Emergency department visits with a <i>principal</i> diagnosis of mental illness or a SUD.	All-cause emergency department visits.
2020			
2021			
2022			

Appendix V: Medicaid Payment Scenarios for Health Homes and CCBHCs

Appendix V is relevant for Recipients who intend to adapt their Medicaid Health Homes or CCBHCs to implement the IBH Model. Scenario 1 exhibits components for potential Medicaid health home practices, while Scenarios 2 and 3 exhibit components for potential CCBHC demonstration and grant participants, respectively. Participating CCBHCs and Health Homes will also be required to join the Medicare arm of the model.

Scenario 1: Medicaid Health home practice participation scenario

Opportunity for alignment	Solutions
Payment and billing	
Is there potential alignment of services between health homes and the IBH Model?	Existing health homes may have alignment of services with the IBH Model-required services, depending on what is currently covered by each state. Recipients shall use the below options to align their health home model to the IBH Model care delivery framework and payment model.
How must states adjust their health home payment model, if it doesn't cover one or multiple IBH Model required services?	- The Recipient shall adjust their Medicaid Payment Approach to include the required IBH Model services that are not currently covered by the health home. Recipients will have two options for covering these services: - The Recipient exhibits how their existing or new health home payment model reaches directional alignment to cover the IBH Model's care delivery framework services, including the IBH Model priority health conditions; OR - The Recipient develops a new Medicaid Payment Approach. - Please note that for both options, states are required to meet all requirements laid out in Section A4.4 IBH Payment Strategy. - In either scenario, the payment model must align with the requirements detailed in Section D2.4 Program Requirements and Expectations to be considered an IBH Model Medicaid Payment Approach.

Opportunity for alignment	Solutions
How must existing health homes participate in the IBH Model if they already cover the required services?	- Health homes can still participate in the IBH Model if they already cover the services in their existing payment arrangement. However, health homes would make necessary adjustments to their care delivery framework to ensure they are in alignment with the IBH Model's care delivery framework, and ensure they are in alignment with the service definitions for the health home provision (where these services are not currently being completed). If the Recipient needs to add a service that is not part of the health home authority to align with the IBH Model, this needs to be paid separately from the health home authority as non-health home services cannot be paid under the health home authority. Examples include: - Complete community or other health needs screening and referral - Complete screening and referral for PH conditions, including the IBH Model target PH conditions. - Include the use of closed loop referrals. - Include the use of interprofessional care teams
Infrastructure Funding for Practice Participants	
Can health homes receive Infrastructure Funding?	Health homes are eligible for Infrastructure Funding. However, the Recipient and health home are responsible for ensuring that federal dollars are not duplicated. For example, IBH Model funding to procure an EHR could not be used if a health home has already received federal dollars to procure an EHR. However, health homes could use the IBH Model funding for upgrades or additions to the EHR system that would bolster the care team's ability to conduct IBH Model services.
Quality measurement	
Are health homes required to report on all IBH Practice-based quality measures? Do existing or new health homes continue reporting on the Medicaid health homes measures? Are Recipients required to incorporate a performance-based payment for their health homes?	- Health home providers will be required to report on all measures in the IBH Practice-based measures set. - If the Recipient decides to use the existing health home authority or a new health home authority to implement the IBH Model, they must continue to report or begin reporting on all required health homes measures in addition to the IBH Model measures. - The Recipient is required to include a performance-based payment component for participating health homes that includes all measures outlined in <i>Table A.4.5.2 – Practice-based measures</i>.

Scenario 2: CCBHC demonstration provider participation scenario

Recipients shall consider one of the following scenarios when including one or many of their CCBHCs as Practice Participants in the IBH Model. Please note that the CCBHC Demonstration is jointly administered by CMS and SAMHSA. Clinics given the CCBHC designation are required to provide nine essential services and in states that participate in the Medicaid demonstration receive Medicaid reimbursement for service provision using a prospective payment system (PPS). Any IBH Model Recipients that also participate in the CCBHC Demonstration or grant program would need to sign a maintenance of effort (MOE) agreement with CMS and SAMHSA outlining that the Recipient will continue to comply with all requirements and services as part of the CCBHC Demonstration or grant programs. The IBH Model will require this documentation in the Recipient specific terms and conditions.

Recipients who wish to include their CCBHC Demonstration providers as IBH Model Practice Participants shall consider the following scenarios:

1. Recipients and CCBHCs in the IBH Model participate and demonstrate that the existing CCBHC payment demonstration in their state meets IBH directional alignment as is. Under this scenario, a state needs to ensure that the current CCBHC payment arrangement achieves directional alignment for reimbursing the required IBH care delivery framework services in Medicaid.
2. Recipients and CCBHCs participate in the IBH Model and develop a new payment, outside of their PPS rate for any IBH services they are not currently performing as part of the CCBHC demonstration. IBH model services that are already incorporated into the existing PPS do not receive duplicate payment.
3. The Recipient develops clear parameters for services provided under the IBH Model and exhibits how they differ services provided under the CCBHC PPS rate, where applicable.

Opportunity for alignment	Solutions
Payment and billing	
• Is there potential alignment of services between CCBHC services and IBH Model services provided by CCBHC Demonstration providers?	• Existing CCBHC Demonstration providers could have alignment of services with the IBH Model required services, depending on what is currently covered by each state. • Recipients have the option to require CCBHC Demonstration providers add any IBH Model services that are not already required under each state's demonstration scope.
• How must Recipients adjust their CCBHC Demonstration payment model, if it doesn't cover one or more IBH Model required services?	• The Recipient shall develop an IBH Model Medicaid Payment Approach to include the required IBH Model services that are not currently covered in the CCBHC Demonstration PPS rate. The payment approach shall be on top of or outside of the CCBHC Demonstration PPS rate. Recipients will need to ensure (with support from CMS) non-duplication of payment when developing their payment methodology.
• Can the Recipient include their CCBHC Demonstration providers in the IBH Model	• Yes, the Recipient and their CCBHC Demonstration providers would make necessary adjustments to their

Opportunity for alignment	Solutions
if they already cover the IBH Model required services?	care delivery framework to ensure they are in alignment with the IBH Model’s care delivery framework (e.g., adding IBH Model services that are not currently available). Examples include: - Complete screening and referral community or other health needs - Complete screening and referral for PH conditions, including the IBH-Model priority health conditions. - Include the use of closed loop referrals.
Infrastructure Funding for Practice Participants	
• Can Recipients provide CCBHC Demonstration providers with Infrastructure Funding?	• CCBHC Demonstration providers may be eligible for Infrastructure Funding at the Recipient’s discretion. However, the Recipient and CCBHC Demonstration providers are responsible for ensuring that federal dollars are not duplicated. • For example, IBH Model funding to procure an EHR could not be used if a CCBHC Demonstration provider has already received federal dollars to procure an EHR. • However, CCBHC Demonstration providers could use the IBH Model funding for upgrades or additions to the EHR system that would bolster the care team’s ability to conduct IBH Model services.
Quality measurement	
• Are CCBHC demonstration providers required to report on all IBH Practice-based quality measures?	• CCBHC Demonstration providers are required to report on all measures in the IBH Model Practice-based measures set. The IBH Model measure sets were intentionally designed to align with the CCBHC measures. • CCBHC Demonstration providers and their states must continue to report on all required and optional measures they have committed to as part of the CCBHC Demonstration.

Opportunity for alignment	Solutions
Can CCBHC Demonstration providers earn additional incentive payments for the IBH Model performance-based payments?	- Some Recipients and CCBHC Demonstration providers may already participate in the Quality Bonus Payment for required and optional CCBHC Demonstration measures. The Quality Bonus Payment component under the CCBHC Demonstration meets the directional alignment criteria for performance-based payments in the IBH Model. - Such Recipients will not receive additional performance-based payments (or quality improvement program payments) under the IBH Model if such payments would constitute a duplication of payment. - If the CCBHC is not currently participating in the Quality Bonus Payment component of the Demonstration, then the Recipient must develop an aligned performance-based payment component or participate in the Quality Bonus Payments. - CCBHCs must earn IBH Model Medicaid performance-based payments for measures that are unique to the IBH Model.
Can CCBHC Demonstration providers earn performance-based payments for Medicare beneficiaries.	CCBHC Demonstration providers can earn Medicare performance-based payments for all Practice-based IBH Model Measures for Medicare beneficiaries. CCBHC Demonstration providers that serve Medicare beneficiaries must participate in the Medicare Payment Approach via an executed participation agreement with CMS to be eligible for such payments.

Scenario 3: CCBHC Improvement and Advancement (CCBHC-IA) and CCBHC Community Behavioral Health Clinic Planning, Development, and Implementation Grant (CCBHC PDI) participation scenario

Opportunity for alignment	Solutions
Payment and billing	
Is there potential alignment of services between CCBHC grant providers and the IBH Model?	Existing and new CCBHCs grant providers could have alignment of services with the IBH Model required services, depending on what is currently covered by each state.

Opportunity for alignment	Solutions
How must Recipients adjust their CCBHC payment, if it doesn't cover one or multiple IBH Model required services?	- The Recipient shall develop an IBH Model Medicaid Payment Approach to include the required IBH Model services that are not currently covered by the CCBHC grant provider. - CCBHC grant providers will be required to deliver any new services that are part of the IBH Model's care delivery framework and covered by any such IBH Model Medicaid Payment Approach.
Can CCBHC grant providers still participate in the IBH Model if they already cover the IBH Model required services?	- Yes, the Recipient would aid the grant provider in making necessary adjustments to their care delivery framework to ensure they are in alignment with the IBH Model's care delivery framework (where these services are not currently available). Examples include: - Complete screening and referral community or other health needs. - Complete screening and referral for PH conditions, including the IBH Model priority health conditions. - Include the use of closed loop referrals.
Infrastructure Funding for Practice Participants	
Can CCBHC grant providers receive Infrastructure Funding?	- CCBHC grant providers are eligible for Infrastructure Funding. However, the Recipient and CCBHC are responsible for ensuring that federal dollars are not duplicated. - For example, IBH Model funding to procure an EHR could not be used if a CCBHC has already received federal dollars to procure an EHR. - However, CCBHC grant providers could use the IBH Model funding for upgrades or additions to the EHR system that would bolster the care team's ability to conduct IBH Model services.
Quality measurement	
Are CCBHCs grant providers required to report on all IBH Practice-based quality measures?	CCBHC grant providers will be required to report on all measures in the IBH Model Practice-based measures set.
Are Recipients required to incorporate a performance-based payment for their CCBHC grant providers?	The Recipient is required to include a performance-based payment component for participating CCBHC grant providers that includes all measures outlined in <i>Table A4.5.2 – Practice-based measures</i>.
Can CCBHC grant providers earn performance-based payments for Medicare beneficiaries.	- CCBHC grant providers can earn performance-based payments for all Practice-based IBH Model measures for Medicare beneficiaries. - CCBHC grant providers that serve Medicare beneficiaries must participate in the Medicare Payment Approach via an executed participation agreement with CMS to be eligible for such payments.

Appendix VI: Medicare Payment Approach Details

This appendix includes an overview of the Medicare Payment approach for informational purposes; however, the methodology as described below is subject to change at CMS' sole discretion. This methodology will be detailed further by CMS prior to the start of the MY1 (BP1).

Note, if states are unable to include withhold payments to certain provider types in their Medicaid Approach, CMS will work with states on a case-by-case basis to determine other performance-based accountability features. In these scenarios, Practice Participants will also be required to participate as a Medicare Practice Participant, if applicable.

The IBH Medicare Payment Approach includes three core elements:

1. Infrastructure Funding
2. Integration Support Payment (ISP)
3. Pay-for-reporting and pay-for-performance bonuses

Infrastructure Funding

Infrastructure Funding is critical to building Practice Participants' capacity to develop and maintain the infrastructure necessary to deliver care thru the IBH Model's care delivery framework and to participate in VBP activities. Health IT is critical to promoting integration, enabling specialty BH providers to communicate with other providers on the care team and allowing for the exchange of information in real-time. The Medicare Infrastructure Funding is designed to address the resource gap between specialty BH and other providers, and for those who already have certified EHRs, it may provide funding to improve population management, data sharing, and interoperability features.

CMS will provide Infrastructure Funding to eligible Practice Participants who are enrolled in Medicare and agree to participate in the Medicare Payment Approach. These payments will be made in increments and amounts to be determined by CMS during MY1 (BP1) through MY4 (BP4). Infrastructure Funding for Medicare Practice Participants may be used for activities, including health IT capacity building, such as adopting EHRs and other HIT, and establishing connections with operating state HIEs. Additionally, funds could be used to enhance capacity through hiring and training practice staff in new IT and clinical workflows.

Examples of activities supported by Infrastructure Funding include, but are not limited to:

- Health IT infrastructure, such as obtaining, modifying, or maintaining EHRs
- Patient engagement IT solutions (e.g., portal adoption)
- HIE integration or efforts to advance interoperability of telehealth systems
- Health-IT enabled tools and supports to ensure referrals to address other health related needs are possible (closed loop referrals through interprofessional care teams)
- Population management tools
- Health IT enabling connections with other providers to enhance Practice Participants' ability to refer beneficiaries to PH Providers and/or social needs providers
- Additional staffing to support new clinical and IT workflows and change management
- Practice transformation activities including but not limited to, workflow development, staffing development and retention plans, systemic quality improvement, and strategies for outreach to beneficiaries and caregivers.

Integration Support Payment (ISP)

The IBH Model will support the package of services and activities under the care delivery framework through the development of the Integration Support Payment (ISP) that will be paid to Medicare Practice Participants via a prospective PBPM payment, beginning at the start of MY3 (BP3). The ISP will cover the cost of managing the care for patients attributed under the IBH Model.

The ISP will be calculated based on the values of the pre-existing CoCM model and billing codes (such as CPT codes 99492, 99493, 99494, and HCPCS code G2214), with adjustments made based on the IBH Model's care delivery framework's three core elements of care integration, care management, preventive care, and health promotion.

CMS has calculated the PBPM rate for the ISP based on the CPT and HCPCS codes, and respective payment amounts, that comprise the CoCM Model (such as CPT codes 99492, 99493, 99494, and HCPCS codes G0323 and G2214). The value of the ISP will be calculated using a variation on the CoCM Model codes that has been adjusted for time anticipated for implementing the care delivery framework and adjusted based on the specific provider types who CMS anticipates delivering the IBH Model's care delivery framework services. That value will be further adjusted to account for geographic variation.

This NOFO includes an overview of the ISP financial methodology for informational purposes; however, the methodology as described below is subject to change at CMS' sole discretion. Detailed financial specifications will be provided by CMS during the IBH Model's Pre-Implementation period.

Alignment or Overlaps with Existing Codes

The Model's Medicare Payment Approach is specifically designed to avoid conflict with or duplicate payment of the FFS system. As a condition of entering the Model, Practice Participants must agree not to bill separately for the billing codes outlined in Table 1, below:

Table 1: IBH Model Prohibited Billing Codes

Category	HCPCS Code	Year Added to MPFS	Description	Justification
Chronic Care Management (CCM)	99490	2015	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.	The CCM codes duplicate payment included in the IBH Integration Support Payment, including: - Care management - Care integration
CCM	99439	2021	Add-on code for 99490; additional 20 minutes per month	
CCM	99491	2019	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.	

Category	HCPCS Code	Year Added to MPFS	Description	Justification
CCM	99437	2022	Add-on code for 99491, additional 30 minutes per month	
Complex CCM	99487	2017	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	2017	• Add-on code for 99487, additional 30 minutes per month	

Category	HCPCS Code	Year Added to MPFS	Description	Justification
Principal Care Management (PCM)	99424	2022	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 condition requires 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.	The PCM codes duplicate payment included in the IBH Integration Support Payment, including: • IBH Model welcome visit – Initial screening, assessment, and treatment for BH and PH conditions. • Care management • Ongoing care management
PCM	99425	2022	• Add-on code for 99424, additional 30 minutes per month	
PCM	99426	2022	• Same as 99424 above, performed by clinical staff under the direction and guidance of a physician or QHP	
PCM	99427	2022	• Add-on code for 99426, additional 30 minutes per month	

Category	HCPCS Code	Year Added to MPFS	Description	Justification
Psychiatric collaborative care management services	99492		A provider performs psychiatric collaborative care management (CoCM) for a patient receiving BH treatment and regular psychiatric inter-specialty consultation in collaboration and in conjunction with a patient's treating (or billing) primary care provider. Report 99492 for the initial 70 minutes of CoCM in the first calendar month.	Ongoing Psychiatric CoCM codes overlap with the IBH services covered by the ISP: IBH welcome visit – Initial screening, assessment, and treatment for BH and PH conditions. - Care management
	99493		A provider performs psychiatric collaborative care management (CoCM) for a patient receiving BH treatment and regular psychiatric inter-specialty consultation in collaboration and in conjunction with a patient's treating (or billing) primary care provider. Report 99493 for the first 60 minutes of CoCM in a subsequent month after the first month of care.	Psychiatric CoCM codes overlap with the IBH services covered by the ISP: IBH ongoing screening assessment, treatment for BH and BH conditions.
	99494		A provider performs psychiatric collaborative care management (CoCM) for a patient receiving BH 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 provider. 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.	Psychiatric CoCM codes overlap with the IBH services covered by the ISP. Care management

Category	HCPCS Code	Year Added to MPFS	Description	Justification
Psychiatric collaborative care management services (cont.)	G2214		Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of BH 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.	Psychiatric CoCM Model codes overlap with the IBH Model services covered by the ISP: Ongoing care management.
	G0512		Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of BH 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.	

Category	HCPCS Code	Year Added to MPFS	Description	Justification
Behavioral Health Integration/Care management services for BH conditions	99484		Clinical staff members spend at least 20 minutes each month coordinating and managing a patient's BH services under the direction of a physician or other qualified health care professional.	Duplicates services provided under the IBH ISP, including: - Ongoing screening, assessment, and treatment for BH and PH conditions. - Care management
	G0323	2023	- 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	
Community Health Integration Services	G0019	2024	Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner, 60 minutes per calendar month, in the following 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	Community health integration services duplicated services provided by the IBH ISP, including: Social determinants of health (SDOH) services.
	G0022	2024		

Risk Adjustment Methodology

We anticipate that both clinical and social risk adjustment will be applied to the Medicare ISP. For clinical risk adjustment, CMS expects to use the prospective CMS-Hierarchical Condition Category (HCC) version 28 (V28) as it is expected to better-reflect the clinical risk of the priority population. By CY2026, CMS expects 100% of risk scores to be calculated with V28, aligning with the beginning of IBH's Medicare ISP. For social risk adjustment we expect to use an approach similar to other models within the center. CMS may change the risk adjustment strategies discussed in this document based on further information and research.

Reporting and Outcome Based Payments

The Medicare payment structure will include a performance-based payment (PBP) paid annually for performance measured in MY3 (BP3) - MY7 (BP7). The PBP will start as upside-only before including a performance-linked withhold in MY6 – MY7. The PBP is designed to encourage and reward behaviors such as data reporting, the advancement of care quality and accountability across multiple dimensions including care integration, care coordination, care efficiency, and patient-centered outcomes as demonstrated through performance on selected model quality measures. The PBP is designed to put specialty BH providers on the path to payment approaches with increased risk and accountability. During MY1 (BP1) – MY4 (BP4), Practice Participants will use Infrastructure Funding to establish the tools and capacity that are critical to supporting the data management and reporting necessary for measuring performance towards IBH Model goals.

The PBP will have two components:

- 1) Incentives for achieving reporting attainment thresholds (*pay for reporting*) (MY3 – 4) (BP3 – 4); and
- 2) Incentives for improvements in health outcomes and screenings (*pay for performance*) (MY4 (BP4) (to be determined on 1 – 2 specific measure(s)), and MY5 – 7 (BP5 – 7) for all measures).

For the pay-for-reporting and performance years of the PBP (MY3-MY4) (BP3-BP4):

- Practice Participants must report data at the minimum performance benchmark threshold for their beneficiary population to receive at least a partial PBP.
- Model Year 4 (BP4) will incorporate a small number of TBD measures as P4P.

For the pay-for-performance years (MY5-MY7) (BP5-BP7):

- The model team will work with the I&M contractor to develop performance benchmarks using the prior model year data (e.g., benchmarks for MY5 (BP5) will be developed using, in part, data from MY4 (BP4)).
- MY5 will transition to using the full provider measure slate.
- The performance benchmarks will be calculated using data only from Practice Participants and will not include national or state averages outside of the states and providers participating in the model.
- During the implementation period, the model team will work with the I&M contractor to use data to determine if it is most appropriate to calculate benchmarks at the practice participant, state awardee, or model-wide level.
- In addition to the pay-for-performance bonus payment, starting in MY6, a proportion of the ISP will be withheld. Practice participants may earn the withheld amount back based on improvements in health outcomes and screening.

Table 6.3 exhibits that each measure in P4R will be worth 10 or 20 percent of the total available PBP, giving practice participants the opportunity to earn a partial or full PBP. However, the model team is still exploring differential weighting of screening, process, and outcomes measures in the P4P period. For example, if the total PBP in MY3 (BP3) is worth 3% of the ISP, a practice participant that meets the attainment thresholds on three of the five measures would earn 60% of the available PBP funds, or 1.8 percent of the ISP ($0.60 \times 0.03 = 0.018$). The PBP will not be used to compensate for potential changes to risk adjustment. Any changes to the PBP amount will be made with an ICIP amendment.

Table 2: Practice Participant performance-based payment structure

Measures	Performance Benchmark (% of total PBP)	% of ISP available for PBP
Pay-for-reporting: Model Year 3 (BP3) - 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
Emergency Department Utilization	10%	
Acute Hospital Utilization	10%	
Controlling high blood pressure	20%	
Screening for upstream drivers of health	20%	
Glycemic Status Assessment for Patients with Diabetes		
PROM	20%	
Pay-for-reporting and performance: Model Year 4 (BP4) – 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 at a later date.		
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	20%	4% upside
Emergency Department Utilization	10%	
Acute Hospital Utilization	10%	
Controlling high blood pressure	20%	
Screening for upstream drivers of health	20%	
Glycemic Status Assessment for Patients with Diabetes		
PROM*	20%	
Pay-for-performance: Practice Participants can earn up to a five percent bonus payment for improvements in performance on the below quality measures in MY5		
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	TBD%	5% upside
Emergency Department Utilization	TBD%	
Acute Hospital Utilization	TBD%	
Controlling high blood pressure	TBD%	
Screening for upstream drivers of health	TBD%	
Glycemic Status Assessment for Patients with Diabetes		
PROM ³³	TBD%	
Pay-for-performance with downside risk: Practice Participants can earn the five percent ISP withhold back and then up to a five percent bonus payment for improvements in performance on the below quality measures from MY6 and 7 (BP6 through 7).		

³³ The PROM will continue to be a pay-for-reporting measure throughout the model lifecycle as PROMs are not suited for changes in performance.

Measures	Performance Benchmark (% of total PBP)	% of ISP available for PBP
<i>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</i>	TBD%	5% upside 2% withhold in MY6 5% withhold in MY7
<i>Emergency Department Utilization</i>	TBD%	
<i>Acute Hospital Utilization</i>	TBD%	
<i>Controlling high blood pressure</i>	TBD%	
<i>Screening for upstream drivers of health</i>	TBD%	
<i>Glycemic Status Assessment for Patients with Diabetes</i>		
<i>PROM³⁴</i>	TBD%	

³⁴ The PROM will continue to be a pay-for-reporting measure throughout the model lifecycle as PROMs are not suited for changes in performance.

Appendix VII: CMS Attribution Methodology for Medicare and Dually Eligible Beneficiaries

A primary goal of CMS' Medicare attribution methodology is to identify the beneficiaries who are affiliated with Medicare Practice Participants. Medicare beneficiaries with and without any dual eligibility³⁵ who receive qualifying services³⁶ from a Medicare Practice Participant will be eligible for Medicare attribution if they reside within a participating state where that Medicare Practice Participant is providing services. Practice Participants must be able to support and document the medical necessity of providing IBH Model services to the attributed beneficiary in order to bill Medicare under the IBH Model. The IBH Model will use a quarterly, prospective attribution of Medicare beneficiaries based on claims data from the previous six months and will also include an annual reconciliation component to allow Medicare Practice Participants to enroll new Medicare and dually eligible patients into the model in real-time as needed.³⁷

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;
- Reside in a region of the state where the IBH Model is being implemented;
- Not be attributed to another CMS Innovation Center model that provides comprehensive care coordination;³⁸
- Not have end-stage renal disease (ESRD) or be enrolled in hospice at the time of initial attribution;
- Not be covered under Medicare Advantage or other Medicare health plan;
- Not be institutionalized;
- Not fall within statutory Medicare payment exclusion criteria; and
- Otherwise meet Medicare eligibility criteria, including requirements related to incarceration.

Eligible Medicare or dually eligible beneficiaries will be prospectively attributed to an IBH Model Medicare Practice Participant through one of three mechanisms.

First mechanism, the Model will permit voluntary alignment, as it may be a suitable approach for the Practice Participant and beneficiary population to be attributed based on their chosen alignment to a BH provider or Practice Participant. Under voluntary alignment, a beneficiary could choose a specific IBH Model Practice Participant on a quarterly basis, using Medicare.gov or paper format.

Second mechanism, claims-based attribution will be used for a Medicare or dually eligible beneficiary who has not voluntarily aligned to a Practice Participant. Under this mechanism,

³⁵ As the IBH Model's services are reimbursed 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 Model'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)).

³⁶ 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>).

³⁷ There will be a one- to two-month gap between the end of the six-month look-back period and the start of the quarter, to pull Medicare claims, conduct prospective attribution and send the attribution list to Medicare Practice Participants.

³⁸ See <https://www.cms.gov/files/document/ibh-model-overlaps-fs.pdf> for detail on the IBH Model's overlaps policy.

beneficiaries will be attributed to the Medicare Practice Participant who billed for the most outpatient mental health visits (including such visits using telehealth) or SUD services in the prior six months, based on claims data. In the case of multiple billing providers during the prior six months, the IBH Model will attribute the beneficiary according to a plurality of visits (i.e., the provider visited the most over that time period). If a beneficiary visited two or more providers an equal number of times over the past six months, the most recent visit would be used as the tiebreaker for Medicare attribution purposes.³⁹

Whether attributed using voluntary alignment or claims-based mechanisms, CMS will conduct the beneficiary attribution algorithm and send each Medicare Practice Participant a list of its attributed Medicare and/or dually eligible patients on a quarterly basis during the Model's Implementation Period (MYs 3 – 7) (BPs 3 – 7). CMS will also assess beneficiary provider selections quarterly in Medicare.gov and align these selections with the claims-based file. Note that attributed beneficiaries who transition in and out of higher levels of care (e.g., inpatient, partial hospitalization, etc.) and receive outpatient BH services between those stays remain attributed to the IBH Model unless they have a break of six months without receiving IBH Model services.

The third mechanism for attribution into the IBH Model will allow a Medicare Practice Participant to enroll new beneficiaries into the Model in real-time. Retrospective attribution will be used to determine how many beneficiaries met the attribution criteria during the prior quarter, regardless of whether they were on the preliminary attribution list. Annual reconciliation will be conducted for payment purposes (to reflect differences in the number of beneficiaries attributed prospectively and retrospectively), and for performance-based payments (based only on the beneficiaries who were retrospectively attributed).

CMS, its contractor(s), or both will develop a model implementation policy and guidance for Practice Participants regarding IBH Model covered services, patient eligibility requirements and documentation requirements. Model policy will state that for each beneficiary during a calendar month, only one BH provider can furnish IBH Model services and receive payment. Further, beneficiaries aligned with the Psychiatric Collaborative Care Model (CoCM) during a calendar month may not also receive IBH Model services, given that CoCM services overlap with IBH Model services.⁴⁰

The model implementation guidance will also explain that as part of the initial beneficiary assessment, Medicare Practice Participants will discuss a beneficiary's preferences and care integration needs to determine whether IBH Model services are reasonable and medically necessary. Section 1862(a) (1) (A) of the Social Security Act (the Act) directs the following: “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

³⁹ Further, if a patient sees both providers on the same day, a second tiebreaker is conducted by randomly selecting the record of one of those two visits. For a beneficiary who visits two different providers the same number of times in six months, if one provider participates in the IBH Model and the other does not, the tie breaker still stands.

⁴⁰ Overlapping CoCM HCPCS codes include 99492, 99493, 99494, G2214 and G0512 and are included under Table 1: IBH Prohibited Billing Codes in Appendix VI: Medicare Payment Approach Details.

- 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;
 - Furnished in a setting appropriate to the beneficiary's medical needs and condition;
 - Ordered and furnished by qualified personnel; and
 - One that meets, but does not exceed, the beneficiary's medical need.

For any service reported to Medicare, it is expected that the medical documentation clearly demonstrates that the service meets all the above criteria. All documentation must be maintained in the patient's medical record and be available to CMS or the contractor upon request.

This assessment will be conducted by a physician or other billing practitioner, exercising prudent clinical judgment. If services are not reasonable and medically necessary (i.e., the level of care required by the IBH Model's 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 shall not provide IBH Model services for a beneficiary when those services are no longer reasonable and medically necessary. CMS will monitor and audit Medicare Practice Participants using standard program integrity best practices and will recoup payment for IBH Model services that are not reasonable and medically necessary for the beneficiary, as supported by clinical documentation. (See [Section F6.1 Monitoring](#) for more detail.)

Regardless of the attribution mechanism employed, Medicare Practice Participants will inform their patients in writing about their IBH Model participation. Recognizing the sensitive nature of this information and consistent with other Innovation Center models, patients may opt-out of data sharing. 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 providers (i.e., besides the provider to whom they are attributed). However, when a beneficiary is served by a non-participating practice, that non-participating practice would receive a claim denial for billing any IBH Model's care delivery framework services. Further, the IBH Model will not restrict or change Medicare fee-for-service benefits, though some of the services currently paid through FFS will be incorporated into the per-beneficiary-per-month (PBPM) payment and will not be paid on a FFS basis to Practice Participants. The IBH Model team will not incorporate any cost sharing or co-payment as part of the model design, as it could obstruct model participation, especially for low-income beneficiaries.⁴¹

⁴¹ As cost sharing requirements could potentially block the participation of low-income beneficiaries, the Model team is researching the possibility of including a Medicare cost sharing waiver in the model, and any levers to encourage participating states to waive cost sharing requirements on the Medicaid side.

Appendix VIII: Glossary of Acronyms

ADT	Admission, Discharge, Transfer
AHC	Accountable Health Communities
AOR	Authorized Organizational Representative
APMs	Alternative Payment Models
APR	Annual Progress Report
BCS-AD	Breast Cancer Screening
BH	Behavioral Health
CAH	Critical Access Hospital
CBE	CMS-contracted Consensus-Based Entity
CBO	Community-based Organization
CCBHC	Certified Community Behavioral Health Clinic
CEHRT	Certified Health Information Technology
CFDA	Catalog of Federal Domestic Assistance
CHIP	Children's Health Insurance Program
CMCS	Center for Medicaid and CHIP Services
CMHCs	Community Mental Health Centers
CMIT	CMS Measure Inventory Tool
CMS	Centers for Medicare & Medicaid Services
CoCM	Collaborative Care Model
COL-AD	Colorectal Cancer Screening
CPI	Center for Program Integrity
DHHS	Department of Health and Human Services
DOJ	Department of Justice
ED	Emergency Department
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
E/M	Evaluation and Management
ESRD	End-stage Renal Disease
F&A	Facilities & Administration
FAPIS	Federal Awardee Performance Integrity Information System
FFA	Federal Financial Assistance
FFATA	Federal Funding Accountability and Transparency Act
FFP	Federal Financial Participation
FFR	Federal Financial Report
FFS	Fee-for-Service
FSRS	FFATA Subaward Reporting System
FTR	Federal Travel Regulation
FUA-AD	Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older
FUM-AD	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older
GPS	Grants Policy Statement
HBD-AD	Hemoglobin A1c Control for Patients with Diabetes
HHS	Health and Human Services

HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HRSA	Health Resources and Services Administration
IBH	Innovation in Behavioral Health Model
IRBs	Institutional Review Boards
ISP	Innovation Support Platform
IT	Information Technology
LAN	Health Care Payment Learning & Action Network
LOI	Letter of Intent
MCO	Managed Care Organization
MH	Mental Health
MOE	Maintenance of Effort
MOU	Memorandum of Understanding
MSBH	Moderate to Severe BH
MTDC	Modified Total Direct Costs
MUC	Measures under Consideration
MY	Model Year
NCC	Non-competing Continuation
NCQA	National Committee for Quality Assurance
NICRA	Negotiated Indirect Cost Rate Agreement
NoA	Notice of Award
NOFO	Notice of Funding Opportunity
NPI	National Provider Identifier
OCR	Office for Civil Rights
OIG	Office of the Inspector General
ONC	Office of the National Coordinator for Health Information Technology
OP	Outpatient
OTP	Opioid Treatment Program
PAHP	Prepaid Ambulatory Health Plan
PBP	Performance-based Payments
PBPM	Per Beneficiary per Month
PCR-AD	Plan All-Cause Readmissions
PECOS	Provider Enrollment, Chain, and Ownership System
PH	Physical Health
PIHP	Prepaid inpatient health plan
PIPBHC	Promoting Integration of Primary and Behavioral Health Care
PMS	Payment Management System
PO	Project Officer
PPS	Prospective Payment System
PRAC	Pandemic Response Accountability Committee
PROMS	Patient Reported Outcome Measures
QPRs	Quarterly Progress Reports
RHC	Rural Health Clinic
SAM	System for Award Management

SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SEC	Securities and Exchange Commission
SMA	State Medicaid Agencies
SMI	Serious Mental Illness
SSD-AD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications
SUD	Substance Use Disorder
TIN	Tax Identification Number
T-MSIS	Transformed Medicaid Statistical Information System
UEI	Unique Entity Identifier
VBP	Value-based Payment
USCDI	United States Core Data for Interoperability

Appendix IX: Moderate to Severe Behavioral Health Conditions⁴²

ICD 10 CODE	ICD-10 DIAGNOSIS
F10.10	Alcohol abuse, uncomplicated
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.121	Alcohol abuse with intoxication delirium
F10.129	Alcohol abuse with intoxication, unspecified
F10.14	Alcohol abuse with alcohol-induced mood disorder
F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
F10.151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
F10.159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10.1.80	Alcohol abuse with alcohol-induced anxiety disorder
F10.181	Alcohol abuse with alcohol-induced sexual dysfunction
F10.182	Alcohol abuse with alcohol-induced sleep disorder
F10.188	Alcohol abuse with other alcohol-induced disorder
F10.19	Alcohol abuse with unspecified alcohol-induced disorder
F10.20	Alcohol dependence, uncomplicated
F10.220	Alcohol dependence with intoxication, uncomplicated
F10.221	Alcohol dependence with intoxication delirium
F10.229	Alcohol dependence with intoxication, unspecified
F10.230	Alcohol dependence with withdrawal, uncomplicated
F10.231	Alcohol dependence with withdrawal delirium
F10.232	Alcohol dependence with withdrawal with perceptual disturbance
F10.239	Alcohol dependence with withdrawal, unspecified
F10.24	Alcohol dependence with alcohol-induced mood disorder
F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions
F10.251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.26	Alcohol dependence with alcohol-induced persisting amnesic disorder
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.280	Alcohol dependence with alcohol-induced anxiety disorder
F10.281	Alcohol dependence with alcohol-induced sexual dysfunction
F10.282	Alcohol dependence with alcohol-induced sleep disorder
F10.288	Alcohol dependence with other alcohol-induced disorder
F10.29	Alcohol dependence with unspecified alcohol-induced disorder
F10.920	Alcohol use, unspecified with intoxication, uncomplicated
F10.921	Alcohol use, unspecified with intoxication delirium
F10.929	Alcohol use, unspecified with intoxication, unspecified

⁴² The diagnoses listed in this Appendix are suggested for practice identification. However, they are not definitive, and not everyone with these diagnoses by default has moderate to severe BH conditions. These diagnoses shall not be used as doctrine, nor shall they use it for different purposes.

ICD 10 CODE	ICD-10 DIAGNOSIS
F10.94	Alcohol use, unspecified with alcohol-induced mood disorder
F10.950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions
F10.951	Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations
F10.959	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
F10.96	Alcohol use, unspecified with alcohol-induced persisting amnestic disorder
F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia
F10.980	Alcohol use, unspecified with alcohol-induced anxiety disorder
F10.981	Alcohol use, unspecified with alcohol-induced sexual dysfunction
F10.982	Alcohol use, unspecified with alcohol-induced sleep disorder
F10.988	Alcohol use, unspecified with other alcohol-induced disorder
F10.99	Alcohol use, unspecified with unspecified alcohol-induced disorder
F11.10	Opioid abuse, uncomplicated
F11.11	Opioid abuse, in remission
F11.120	Opioid abuse with intoxication, uncomplicated
F11.121	Opioid abuse with intoxication delirium
F11.122	Opioid abuse with intoxication with perceptual disturbance
F11.129	Opioid abuse with intoxication, unspecified
F11.14	Opioid abuse with opioid-induced mood disorder
F11.150	Opioid abuse with opioid-induced psychotic disorder with delusions
F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
F11.159	Opioid abuse with opioid-induced psychotic disorder, unspecified
F11.181	Opioid abuse with opioid-induced sexual dysfunction
F11.182	Opioid abuse with opioid-induced sleep disorder
F11.188	Opioid abuse with other opioid-induced disorder
F11.19	Opioid abuse with unspecified opioid-induced disorder
F11.20	Opioid dependence, uncomplicated
F11.21	Opioid dependence, in remission
F11.220	Opioid dependence with intoxication, uncomplicated
F11.221	Opioid dependence with intoxication delirium
F11.222	Opioid dependence with intoxication with perceptual disturbance
F11.229	Opioid dependence with intoxication, unspecified
F11.23	Opioid dependence with withdrawal
F11.24	Opioid dependence with opioid-induced mood disorder
F11.250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11.251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11.259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11.281	Opioid dependence with opioid-induced sexual dysfunction
F11.282	Opioid dependence with opioid-induced sleep disorder
F11.288	Opioid dependence with other opioid-induced disorder
F11.29	Opioid dependence with unspecified opioid-induced disorder
F11.90	Opioid use, unspecified, uncomplicated
F11.920	Opioid use, unspecified with intoxication, uncomplicated

ICD 10 CODE	ICD-10 DIAGNOSIS
F11.921	Opioid use, unspecified with intoxication delirium
F11.922	Opioid use, unspecified with intoxication with perceptual disturbance
F11.929	Opioid use, unspecified with intoxication, unspecified
F11.93	Opioid use, unspecified with withdrawal
F11.94	Opioid use, unspecified with opioid-induced mood disorder
F11.950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions
F11.951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
F11.959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
F11.981	Opioid use, unspecified with opioid-induced sexual dysfunction
F11.982	Opioid use, unspecified with opioid-induced sleep disorder
F11.988	Opioid use, unspecified with other opioid-induced disorder
F11.99	Opioid use, unspecified with unspecified opioid-induced disorder
F12.120	Cannabis abuse with intoxication, uncomplicated
F12.121	Cannabis abuse with intoxication delirium
F12.122	Cannabis abuse with intoxication with perceptual disturbance
F12.129	Cannabis abuse with intoxication, unspecified
F12.150	Cannabis abuse with psychotic disorder with delusions
F12.151	Cannabis abuse with psychotic disorder with hallucinations
F12.159	Cannabis abuse with psychotic disorder, unspecified
F12.180	Cannabis abuse with cannabis-induced anxiety disorder
F12.188	Cannabis abuse with other cannabis-induced disorder
F12.19	Cannabis abuse with unspecified cannabis-induced disorder
F12.220	Cannabis dependence with intoxication, uncomplicated
F12.221	Cannabis dependence with intoxication delirium
F12.222	Cannabis dependence with intoxication with perceptual disturbance
F12.229	Cannabis dependence with intoxication, unspecified
F12.23	Cannabis dependence with withdrawal
F12.250	Cannabis dependence with psychotic disorder with delusions
F12.251	Cannabis dependence with psychotic disorder with hallucinations
F12.259	Cannabis dependence with psychotic disorder, unspecified
F12.280	Cannabis dependence with cannabis-induced anxiety disorder
F12.288	Cannabis dependence with other cannabis-induced disorder
F12.29	Cannabis dependence with unspecified cannabis-induced disorder
F12.921	Cannabis use, unspecified with intoxication delirium
F12.922	Cannabis use, unspecified with intoxication with perceptual disturbance
F12.929	Cannabis use, unspecified with intoxication, unspecified
F12.93	Cannabis use, unspecified with withdrawal
F12.950	Cannabis use, unspecified with psychotic disorder with delusions
F12.951	Cannabis use, unspecified with psychotic disorder with hallucinations
F12.959	Cannabis use, unspecified with psychotic disorder, unspecified
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13.120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated

ICD 10 CODE	ICD-10 DIAGNOSIS
F13.121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium
F13.129	Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
F13.14	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder
F13.150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13.181	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder
F13.188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder
F13.19	Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13.220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13.221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
F13.229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13.231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13.232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13.239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F13.24	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder
F13.250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.26	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder

ICD 10 CODE	ICD-10 DIAGNOSIS
F13.281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder
F13.288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder
F1.329	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
F13.90	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
F13.920	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, uncomplicated
F13.921	Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium
F13.929	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified
F13.930	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, uncomplicated
F13.931	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal delirium
F13.932	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal with perceptual disturbances
F13.939	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified
F13.94	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder
F13.950	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13.951	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13.959	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13.96	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting amnesic disorder
F13.97	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.980	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder
F1.3981	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13.982	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sleep disorder
F13.988	Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorder
F13.99	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder
F14.10	Cocaine abuse, uncomplicated
F14.120	Cocaine abuse with intoxication, uncomplicated
F14.121	Cocaine abuse with intoxication with delirium

ICD 10 CODE	ICD-10 DIAGNOSIS
F14.122	Cocaine abuse with intoxication with perceptual disturbance
F14.129	Cocaine abuse with intoxication, unspecified
F14.14	Cocaine abuse with cocaine-induced mood disorder
F14.150	Cocaine abuse with cocaine-induced psychotic disorder with delusions
F14.151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
F14.159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14.180	Cocaine abuse with cocaine-induced anxiety disorder
F14.181	Cocaine abuse with cocaine-induced sexual dysfunction
F14.182	Cocaine abuse with cocaine-induced sleep disorder
F14.188	Cocaine abuse with other cocaine-induced disorder
F14.19	Cocaine abuse with unspecified cocaine-induced disorder
F14.20	Cocaine dependence, uncomplicated
F14.220	Cocaine dependence with intoxication, uncomplicated
F14.221	Cocaine dependence with intoxication delirium
F14.222	Cocaine dependence with intoxication with perceptual disturbance
F14.229	Cocaine dependence with intoxication, unspecified
F14.23	Cocaine dependence with withdrawal
F14.24	Cocaine dependence with cocaine-induced mood disorder
F14.250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14.251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14.259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14.280	Cocaine dependence with cocaine-induced anxiety disorder
F14.281	Cocaine dependence with cocaine-induced sexual dysfunction
F14.282	Cocaine dependence with cocaine-induced sleep disorder
F14.288	Cocaine dependence with other cocaine-induced disorder
F14.29	Cocaine dependence with unspecified cocaine-induced disorder
F14.90	Cocaine use, unspecified, uncomplicated
F14.920	Cocaine use, unspecified with intoxication, uncomplicated
F14.921	Cocaine use, unspecified with intoxication delirium
F14.922	Cocaine use, unspecified with intoxication with perceptual disturbance
F14.929	Cocaine use, unspecified with intoxication, unspecified
F14.94	Cocaine use, unspecified with cocaine-induced mood disorder
F14.950	Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions
F14.951	Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations
F14.959	Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified
F14.980	Cocaine use, unspecified with cocaine-induced anxiety disorder
F14.981	Cocaine use, unspecified with cocaine-induced sexual dysfunction
F14.982	Cocaine use, unspecified with cocaine-induced sleep disorder
F14.988	Cocaine use, unspecified with other cocaine-induced disorder
F14.99	Cocaine use, unspecified with unspecified cocaine-induced disorder
F15.10	Other stimulant abuse, uncomplicated
F15.120	Other stimulant abuse with intoxication, uncomplicated

ICD 10 CODE	ICD-10 DIAGNOSIS
F15.121	Other stimulant abuse with intoxication delirium
F15.122	Other stimulant abuse with intoxication with perceptual disturbance
F15.129	Other stimulant abuse with intoxication, unspecified
F15.14	Other stimulant abuse with stimulant-induced mood disorder
F15.150	Other stimulant abuse with stimulant-induced psychotic disorder with delusions
F15.151	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations
F15.159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
F15.180	Other stimulant abuse with stimulant-induced anxiety disorder
F15.181	Other stimulant abuse with stimulant-induced sexual dysfunction
F15.182	Other stimulant abuse with stimulant-induced sleep disorder
F15.188	Other stimulant abuse with other stimulant-induced disorder
F15.19	Other stimulant abuse with unspecified stimulant-induced disorder
F15.20	Other stimulant dependence, uncomplicated
F15.220	Other stimulant dependence with intoxication, uncomplicated
F15.221	Other stimulant dependence with intoxication delirium
F15.222	Other stimulant dependence with intoxication with perceptual disturbance
F15.229	Other stimulant dependence with intoxication, unspecified
F15.23	Other stimulant dependence with withdrawal
F15.24	Other stimulant dependence with stimulant-induced mood disorder
F15.250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15.251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations
F15.259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15.280	Other stimulant dependence with stimulant-induced anxiety disorder
F15.281	Other stimulant dependence with stimulant-induced sexual dysfunction
F15.282	Other stimulant dependence with stimulant-induced sleep disorder
F15.288	Other stimulant dependence with other stimulant-induced disorder
F15.29	Other stimulant dependence with unspecified stimulant-induced disorder
F15.90	Other stimulant use, unspecified, uncomplicated
F15.920	Other stimulant use, unspecified with intoxication, uncomplicated
F15.921	Other stimulant use, unspecified with intoxication delirium
F15.922	Other stimulant use, unspecified with intoxication with perceptual disturbance
F15.929	Other stimulant use, unspecified with intoxication, unspecified
F15.93	Other stimulant use, unspecified with withdrawal
F15.94	Other stimulant use, unspecified with stimulant-induced mood disorder
F15.950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions
F15.951	Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations
F15.959	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified
F15.980	Other stimulant use, unspecified with stimulant-induced anxiety disorder

ICD 10 CODE	ICD-10 DIAGNOSIS
F15.981	Other stimulant use, unspecified with stimulant-induced sexual dysfunction
F15.982	Other stimulant use, unspecified with stimulant-induced sleep disorder
F15.988	Other stimulant use, unspecified with other stimulant-induced disorder
F15.99	Other stimulant use, unspecified with unspecified stimulant-induced disorder
F16.10	Hallucinogen abuse, uncomplicated
F16.120	Hallucinogen abuse with intoxication, uncomplicated
F16.121	Hallucinogen abuse with intoxication with delirium
F16.122	Hallucinogen abuse with intoxication with perceptual disturbance
F16.129	Hallucinogen abuse with intoxication, unspecified
F16.14	Hallucinogen abuse with hallucinogen-induced mood disorder
F16.150	Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions
F16.151	Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations
F16.159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified
F16.180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16.183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)
F16.188	Hallucinogen abuse with other hallucinogen-induced disorder
F16.19	Hallucinogen abuse with unspecified hallucinogen-induced disorder
F16.20	Hallucinogen dependence, uncomplicated
F16.220	Hallucinogen dependence with intoxication, uncomplicated
F16.221	Hallucinogen dependence with intoxication with delirium
F16.229	Hallucinogen dependence with intoxication, unspecified
F16.24	Hallucinogen dependence with hallucinogen-induced mood disorder
F16.250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16.251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16.259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16.283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16.288	Hallucinogen dependence with other hallucinogen-induced disorder
F16.29	Hallucinogen dependence with unspecified hallucinogen-induced disorder
F16.90	Hallucinogen use, unspecified, uncomplicated
F16.920	Hallucinogen use, unspecified with intoxication, uncomplicated
F16.921	Hallucinogen use, unspecified with intoxication with delirium
F16.929	Hallucinogen use, unspecified with intoxication, unspecified
F16.94	Hallucinogen use, unspecified with hallucinogen-induced mood disorder
F16.950	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions
F16.951	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations
F16.959	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified

ICD 10 CODE	ICD-10 DIAGNOSIS
F16.980	Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder
F16.983	Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)
F16.988	Hallucinogen use, unspecified with other hallucinogen-induced disorder
F16.99	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder
F18.10	Inhalant abuse, uncomplicated
F18.121	Inhalant abuse with intoxication delirium
F18.14	Inhalant abuse with inhalant-induced mood disorder
F18.150	Inhalant abuse with inhalant-induced psychotic disorder with delusions
F18.151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations
F18.159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified
F18.17	Inhalant abuse with inhalant-induced dementia
F18.180	Inhalant abuse with inhalant-induced anxiety disorder
F18.24	Inhalant dependence with inhalant-induced mood disorder
F18.250	Inhalant dependence with inhalant-induced psychotic disorder with delusions
F18.251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18.259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F18.27	Inhalant dependence with inhalant-induced dementia
F18.280	Inhalant dependence with inhalant-induced anxiety disorder
F18.921	Inhalant use, unspecified with intoxication with delirium
F18.94	Inhalant use, unspecified with inhalant-induced mood disorder
F18.950	Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions
F18.951	Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations
F18.959	Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified
F18.97	Inhalant use, unspecified with inhalant-induced persisting dementia
F18.980	Inhalant use, unspecified with inhalant-induced anxiety disorder
F19.120	Other psychoactive substance abuse with intoxication, uncomplicated
F19.121	Other psychoactive substance abuse with intoxication delirium
F19.122	Other psychoactive substance abuse with intoxication with perceptual disturbances
F19.129	Other psychoactive substance abuse with intoxication, unspecified
F19.14	Other psychoactive substance abuse with psychoactive substance-induced mood disorder
F19.150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions
F19.151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations
F19.159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
F19.16	Other psychoactive substance abuse with psychoactive substance-induced persisting amnesic disorder
F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia

ICD 10 CODE	ICD-10 DIAGNOSIS
F19.180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder
F19.181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
F19.182	Other psychoactive substance abuse with psychoactive substance-induced sleep disorder
F19.188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
F19.19	Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder
F19.20	Other psychoactive substance dependence, uncomplicated
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated
F19.221	Other psychoactive substance dependence with intoxication delirium
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19.229	Other psychoactive substance dependence with intoxication, unspecified
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19.231	Other psychoactive substance dependence with withdrawal delirium
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19.239	Other psychoactive substance dependence with withdrawal, unspecified
F19.24	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F1.9250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
F19.251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
F19.259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F19.26	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19.281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19.282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19.288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F19.29	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder
F19.90	Other psychoactive substance use, unspecified, uncomplicated
F19.920	Other psychoactive substance use, unspecified with intoxication, uncomplicated

ICD 10 CODE	ICD-10 DIAGNOSIS
F19.921	Other psychoactive substance use, unspecified with intoxication with delirium
F19.922	Other psychoactive substance use, unspecified with intoxication with perceptual disturbance
F19.929	Other psychoactive substance use, unspecified with intoxication, unspecified
F19.930	Other psychoactive substance use, unspecified with withdrawal, uncomplicated
F19.931	Other psychoactive substance use, unspecified with withdrawal delirium
F19.932	Other psychoactive substance use, unspecified with withdrawal with perceptual disturbance
F19.939	Other psychoactive substance use, unspecified with withdrawal, unspecified
F19.94	Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder
F19.950	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions
F19.951	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations
F19.959	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified
F19.96	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting amnesic disorder
F19.97	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia
F19.980	Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder
F19.99	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder
F20.0	Paranoid schizophrenia
F20.1	Disorganized schizophrenia
F20.2	Catatonic schizophrenia
F20.3	Undifferentiated schizophrenia
F20.5	Residual schizophrenia
F20.81	Schizophreniform disorder
F20.89	Other schizophrenia
F20.9	Schizophrenia, unspecified
F21	Schizotypal disorder
F22	Delusional disorders
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F25.0	Schizoaffective disorder, bipolar type
F25.1	Schizoaffective disorder, depressive type
F25.8	Other schizoaffective disorders
F25.9	Schizoaffective disorder, unspecified
F28	Other psychotic disorder not due to a substance or known physiological condition
F29	Unspecified psychosis not due to a substance or known physiological condition

ICD 10 CODE	ICD-10 DIAGNOSIS
F30.10	Manic episode without psychotic symptoms, unspecified
F30.11	Manic episode without psychotic symptoms, mild
F30.12	Manic episode without psychotic symptoms, moderate
F30.13	Manic episode, severe, without psychotic symptoms
F30.2	Manic episode, severe with psychotic symptoms
F30.3	Manic episode in partial remission
F30.4	Manic episode in full remission
F30.8	Other manic episodes
F30.9	Manic episode, unspecified
F31.0	Bipolar disorder, current episode hypomanic
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
F31.70	Bipolar disorder, currently in remission, most recent episode unspecified
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.74	Bipolar disorder, in full remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.76	Bipolar disorder, in full remission, most recent episode depressed
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.78	Bipolar disorder, in full remission, most recent episode mixed
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission

ICD 10 CODE	ICD-10 DIAGNOSIS
F32.5	Major depressive disorder, single episode, in full remission
F32.81	Premenstrual dysphoric disorder
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.0	Cyclothymic disorder
F34.1	Dysthymic disorder Y
F34.8	Other persistent mood [affective] disorders
F34.81	Disruptive mood dysregulation disorder
F34.89	Other specified persistent mood disorders
F34.9	Persistent mood [affective] disorder, unspecified
F39	Unspecified mood [affective] disorder
F41.0	Panic disorder [episodic paroxysmal anxiety]
F41.1	Generalized anxiety disorder
F41.3	Other mixed anxiety disorders
F41.8	Other specified anxiety disorders
F41.9	Anxiety disorder, unspecified
F42	Obsessive-compulsive disorder
F42.2	Mixed obsessional thoughts and acts
F42.3	Hoarding disorder
F42.4	Excoriation (skin-picking) disorder
F42.8	Other obsessive-compulsive disorder
F42.9	Obsessive-compulsive disorder, unspecified
F43.0	Acute stress reaction
F43.10	Post-traumatic stress disorder, unspecified
F43.11	Post-traumatic stress disorder, acute
F43.12	Post-traumatic stress disorder, chronic
F44.0	Dissociative amnesia
F44.1	Dissociative fugue
F44.2	Dissociative stupor
F44.4	Conversion disorder with motor symptom or deficit
F44.5	Conversion disorder with seizures or convulsions
F44.6	Conversion disorder with sensory symptom or deficit
F44.7	Conversion disorder with mixed symptom presentation
F44.81	Dissociative identity disorder

ICD 10 CODE	ICD-10 DIAGNOSIS
F44.89	Other dissociative and conversion disorders
F44.9	Dissociative and conversion disorder, unspecified
F45.0	Somatization disorder
F45.1	Undifferentiated somatoform disorder
F45.20	Hypochondriacal disorder, unspecified
F45.21	Hypochondriasis
F45.22	Body dysmorphic disorder
F45.29	Other hypochondriacal disorders
F45.41	Pain disorder exclusively related to psychological factors
F45.42	Pain disorder with related psychological factors
F45.8	Other somatoform disorders
F45.9	Somatoform disorder, unspecified
F48.1	Depersonalization-derealization syndrome
F50.00	Anorexia nervosa, unspecified
F50.01	Anorexia nervosa, restricting type
F50.02	Anorexia nervosa, binge eating/purging type
F50.2	Bulimia nervosa
F50.8	Other eating disorders
F50.81	Binge eating disorder
F50.82	Avoidant/restrictive food intake disorder
F50.89	Other specified eating disorder
F50.9	Eating disorder, unspecified
F53	Puerperal psychosis
F53.0	Postpartum depression
F53.1	Puerperal psychosis
F55.2	Abuse of laxatives
F55.3	Abuse of steroids or hormones
F60.0	Paranoid personality disorder
F60.1	Schizoid personality disorder
F60.2	Antisocial personality disorder
F60.3	Borderline personality disorder
F60.4	Histrionic personality disorder
F60.5	Obsessive-compulsive personality disorder
F60.6	Avoidant personality disorder
F60.7	Dependent personality disorder
F60.81	Narcissistic personality disorder
F60.89	Other specific personality disorders
F60.9	Personality disorder, unspecified
F63.81	Intermittent explosive disorder
F68.10	Factitious disorder imposed on self, unspecified
F68.11	Factitious disorder imposed on self, with predominantly psychological signs and symptoms

ICD 10 CODE	ICD-10 DIAGNOSIS
F68.12	Factitious disorder imposed on self, with predominantly physical signs and symptoms
F68.13	Factitious disorder imposed on self, with combined psychological and physical signs and symptoms

Appendix X: References

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