Behavioral Health Business

Inside CMS' Pilot to Expand VBC in Mental Health, Integrated Services

By Ashleigh Hollowell | January 21, 2026

New York, Michigan and South Carolina were among the first states to pilot a federal initiative aimed at transitioning mental health providers from fee-for-service models toward value-based payment structures. There's also new money on the table — up to $7.5 million each through the Center for Medicare and Medicaid Innovation (CMMI) — for five new states to join the next cohort, soon bringing the total participants in this effort to eight.

Year one was all about moving mental health care out of historical, systemic silos into integrated care hubs. Now, pilot states will enter phase two of the process to build mature data practices and further strengthen infrastructure.

New states won't be selected until later in 2026, but there's a lot to prepare for if they're interested, industry insiders told Behavioral Health Business.

That funding is an opportunity for states to overhaul their behavioral health infrastructure sustainably. It signals that even the Centers for Medicare and Medicaid Services (CMS) has realized that fee-for-service models may have reached the end of their usefulness in the profession.

A gradual shift to scalable, integrated value-based care

CMS first launched the Innovation in Behavioral Health (IBH) model in 2024; however, the initial group of states did not begin their pilot programs until January 2025. The overarching goal is to better integrate mental health care and substance use treatment with physical health care across the country — which has long been a focus of the behavioral health sector that's often easier said than done in practice. But IBH is designed to make it feasible.

"There are requirements about value-based payments [in the model]," Mindy Lipson, managing director of health strategies for Manatt, Phelps and Phillips, told BHB. "So providers are required to think about, do they have the sophisticated capabilities necessary to be successful in a value-based environment? What do their analytic capabilities look like? Their population health management capabilities etc. … I think also it's important for them to assess whether the care model that's being required by the state is something that's financially viable and sustainable for them to operate."

Manatt, Phelps and Phillips is a New York City-based law firm.

When states are accepted into the program, they receive funding to support investments in health IT technologies, including electronic health records. CMS also provides technical assistance, offering help with data infrastructure planning and interoperability standards.

The state-led IBH program uses cooperative agreements to encourage specialty clinics to serve as centralized hubs for mental health and comprehensive patient care. It also prioritizes addressing social

determinants of health and modernizing technology systems to enable better data sharing and power care integration.

When selected, the new states will enter into a seven-year cooperative agreement divided into two phases: two years of pre-implementation and a five-year period to solidify delivery of integrated care and transition to value-based payments.

“Providers should be paying close attention to the information that the states are going to be releasing about their care models, and they should be engaged in that process and providing input into the state about how they want to see the model shaped,” Lipson said. “That’s really important for them to be doing, to make sure that what the state is developing is something that is realistic for them to be achieving, and it’s something that they’re interested in participating in.”

CMS pitches it as a “no wrong door” care model, encouraging specialty behavioral health providers to serve as an entry point to identify various health needs beyond just mental health or substance use issues, and help facilitate handoffs with primary care and other practitioners as needed.

The needs of Medicare and Medicaid populations are generally disproportionate to their peers when it comes to rates of substance use disorders (SUDs) and mental health conditions and related comorbidities. Against that backdrop is where CMS sees an opportunity to build IBH models as access points that will ideally improve outcomes and prevent premature deaths.

Bringing behavioral health into the fold

Dr. Nick Bach, a psychologist at Louisville, Kentucky-based Grace Psychological Services, told BHB, that although Kentucky is not participating yet, he has followed the progress of the IBH model since its inception because what it means for the behavioral health field is powerful.

“What I have observed with my colleagues and community health centers in several states is increased comfort with integrating primary care along with behavioral support and less red tape,” Bach said. “In rural counties where clinics join the IBH model, prevention becomes more emphasized over crisis management due to screening activities and team-based interventions moving forward. … If IBH’s operation is acceptable, many front-line workers with whom I spoke feel that some of the initial changes are helping to rebuild trust in a system of health that many had given up on.”

As the model matures further and additional states are brought on, he said enhancements to data-sharing tools, reimbursement flexibilities and workforce support will be the most necessary to address for long-term viability.

Providers that may be interested in working with IBH models in their state should “anticipate a culture shift,” Bach said. “True integration means viewing behavioral staff as equals.”

The American Medical Association told BHB that its work with these models has primarily been indirect on the integrated care side and with directing value-based care efforts. However, the organization said from its lens, the most important lesson for providers is to be on the same page and level set with integration or co-location expectations.

“What’s so exciting about this model is behavioral health professionals have really been left out of this value-based care journey for the most part, as opposed to primary care, who have had some a longer lead time in terms of getting experience in doing kind of these value-based care approaches,” an AMA subject-matter expert shared with BHB. “This is a very different way for many folks to get paid.”

With that, thoughtfulness about care delivery design and how the value-based payment mechanisms are rolled out will be just as important as educating the newly integrated workforce on doing the extra work to be able to track quality metrics across their care, the AMA explained.

As more states join the next cohort of IBH model implementations, the AMA will also be working to further education around value-based models. If moving toward value-based care is the direction the health care system is truly headed and will grow into, making sure “that behavioral health clinicians and teams don’t get left out of that conversation,” will be key, the AMA’s subject-matter expert shared.

It’s an opportunity to learn what works for specific clinician populations and use lessons learned to engage and transition the industry to value-based care at larger scales, the AMA source explained.

The IBH model’s payment design will gradually shift toward greater predictability and accountability with infrastructure and capacity-building payments to per-member, per-month and other outcomes-based components, according to CMS.

What’s ahead for states that are already invested

In New York, where the state has now piloted the IBH model for one year, Justin Mason, a spokesperson for the New York State Office of Mental Health, told BHB the state has successfully completed all of its milestones for the first year of its CMS funding agreement.

“New York State is fully committed to developing a dynamic integrated model of health care to improve overall outcomes for New Yorkers with serious mental illness enrolled in Medicaid or Medicare,” Mason said. “Through this initiative, we hope to create an integrated system of care aimed at comprehensive integrated treatment of the physical and behavioral health problems that individuals enrolled in these programs experience at disproportionately higher rates.”

Mason and his team just completed an assessment to identify eight counties in Western New York as the demonstration area to slowly introduce the IBH model’s components throughout the rest of the seven years. The state has also developed a partnership with the Value Network Behavioral Health Care Collaborative to help identify providers that can become participating practices.

As Mason and his team embark on year two of the IBH model implementation, the focus will be on refining its data sharing and interoperability practices between physical and behavioral health systems, defining best practices and exploring pathways to make behavioral health a core focus of value-based contracts.

States looking to take advantage of the funding and infrastructure the IBH model provides have until June 3, 2026, to submit their applications.