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IBH Medicaid Payment Approach Workgroup

July 17, 2026

Funded by NEW YORK STATE | Office of Mental Health

Housekeeping

Closed captioning is available via the Zoom toolbar

Slides and recording will be shared following the session and posted on our website.

Please use Zoom features to “Raise Hand” or use the Chatbox if you have any questions, comments, or concerns

*Please Note: The information shared in today's meeting is accurate as of July 17, 2026

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Welcome and Introductions

Co-Leads for the ***Medicaid Payment Approach Workgroup:***

Value Network IPA, LLC:

Andrea J. Wanat, CEO

NYS Office of Mental Health:

Laura Foss, Deputy Bureau Director, Finance and Data Analytics

Next Steps from March Workgroup

Activities:

- Determine process for secure data transmission of IBH eligible members to Plans.
  - Propose using Health Commerce System (HCS)
- Compare cost data IBH eligible members.
- Identify the number of IBH-eligibles in each of their existing primary care/hospital based VBP arrangements.
- Identify practices/IPAs involved in VBP arrangements involving IBH-eligible enrollees.
- Present a Summary to Workgroup.

Goals:

- Validate each plan's healthcare costs for IBH-eligible enrollees.
- Determine primary care practices/IPAs to prioritize for VBP arrangements involving IBH-eligible enrollees.
- Inform IBH VBP design options.

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Medicare Payment Approach

Value-Based Payment/Alternative Payment Models and Medicaid/Medicare payment alignment

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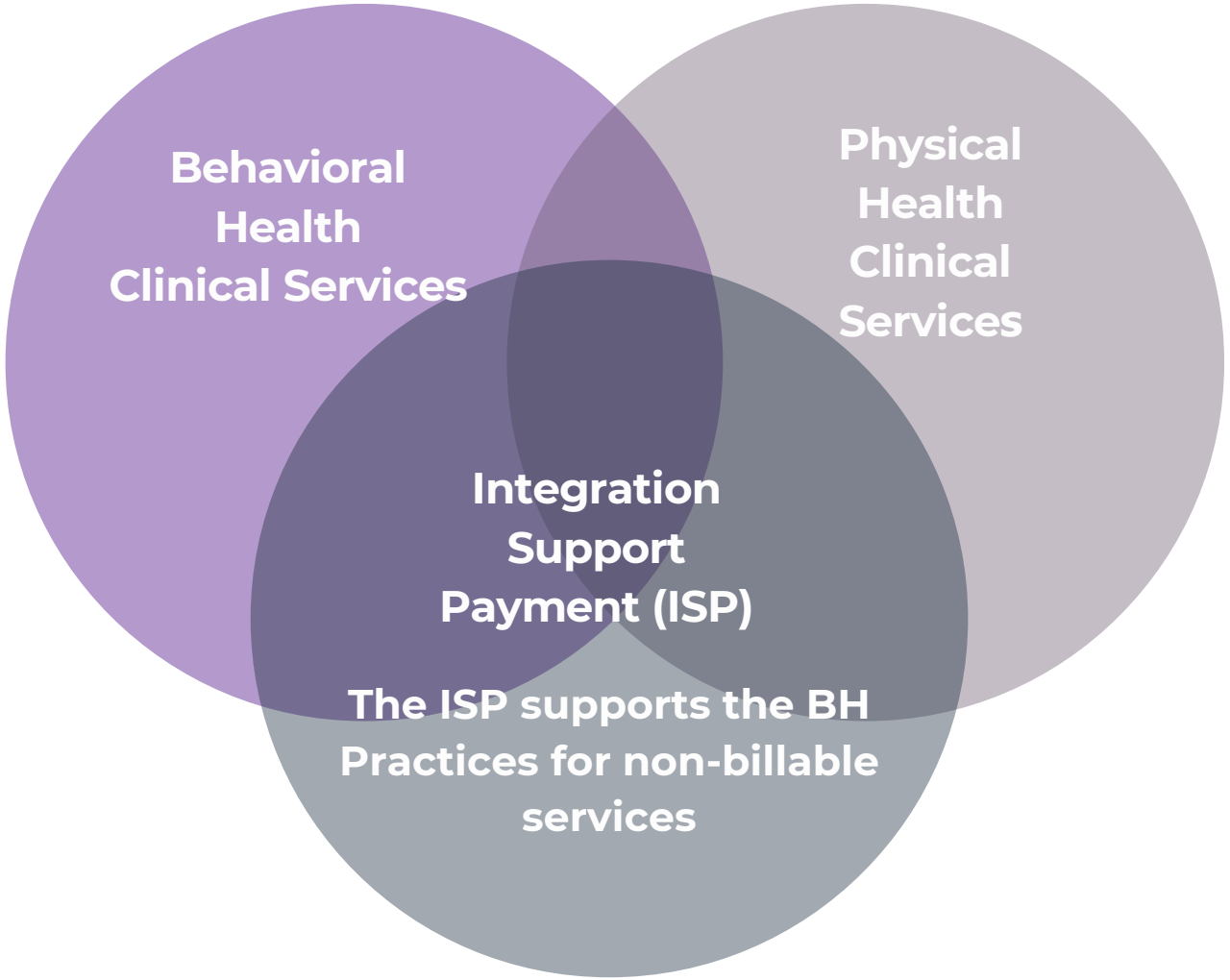
Innovations in Behavioral Health Medicare FFS Payment Structure Model



- **The Medicaid Payment Structure needs to directionally align with the Medicare Model**
- **Care Management codes that duplicate the ISP are not allowed to be billed separately (this included the Collaborative Care Model).**

Medicare Attribution Methods Include

Voluntary Selection

Beneficiaries may select a specific IBH Model Medicare Practice Participant on a quarterly basis using Medicare.gov or via a paper form. Voluntary attribution with a particular provider takes precedence over claims-based attribution

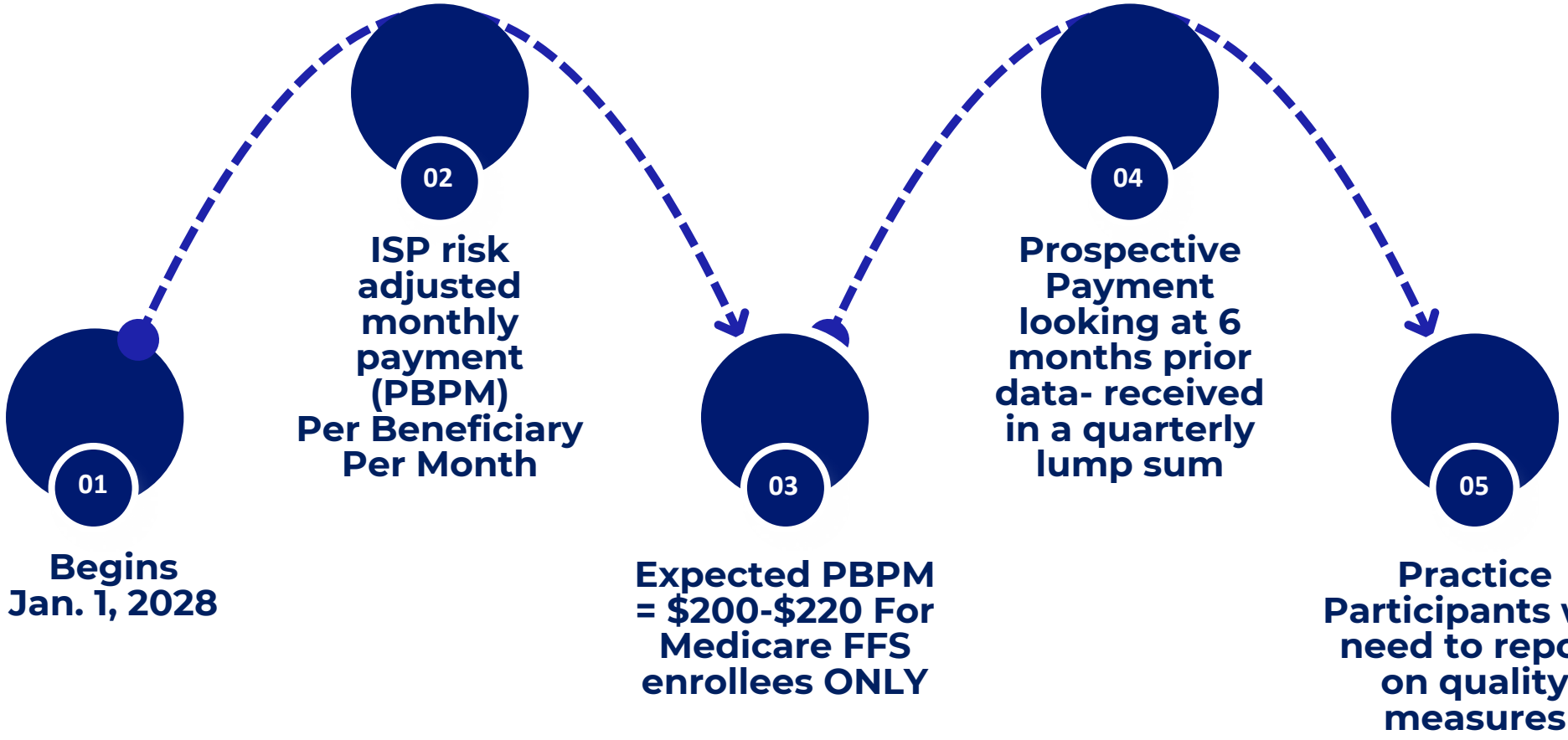
Claims-Based Attribution

If a beneficiary does not voluntarily select a Medicare Practice Participant, CMS will attribute them to the Medicare Practice Participant who delivered the most outpatient mental health or SUD services in the prior six months, based on claims data.

On-the-spot Attribution

A Medicare Practice Participant may enroll a beneficiary into the IBH Model in real time, provided the beneficiary consents and meets all eligibility criteria.

Overview of the IBH Medicare Payment Structure



VBP IBH Practice-Based Measures

Practice-Based Measures	
Acute Hospital Utilization (Observed Rates)	Emergency Department Utilization+
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Glycemic Status Assessment for Patients with Diabetes
Controlling high blood pressure	Patient-reported outcomes and Measurement based care attestation
Hepatitis C	

VBP IBH State-Based Measures

State-Based Measures	
Acute Hospital Utilization (AHU): Age 18 and Older	~~Plan All Cause Readmissions (PCR-AD)~~
Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD)	Follow up after Hospitalization for Mental Illness: Age 18 or older (FUH-AD)
Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)21
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	~~Colorectal Cancer Screening (COL-AD)*~~
~~Breast Cancer Screening (BCS-AD)*~~	

**Performance measures with strikethroughs indicate CMS has removed these measures as required for reporting.*

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Medicaid Payment Approach

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Care Delivery Payment Approach

The State is proposing to leverage existing Medicaid service array to implement the IBH model such as:

- Health Home
- Certified Community Behavioral Health Clinics
- Article 31/32 Programs

Eliminates the need for new federal authority and minimizes the reconfiguration burden on Plans and Providers

May consider new billing component to support identification of IBH enrollees

OMH Coding Crosswalk under development to demonstrate the capacity for performing the IBH Model services within the NYS Medicaid service array.

NYS Medicaid Payment Approach Considerations

UNDER DEVELOPMENT AND SUBJECT TO CHANGE

Component	NYS Approach
Attribution	MMC VBP attribution + FFS clinical engagement
Risk Adjustment	MMC risk adjustment
Performance Measures	Practice-based measures (P4P and P4R)
VBP Payment	Upside Bonus/Shared Savings tied to TCOC and Quality

NYS Premium and Calculated Cost Analysis for IBH-Eligible Population

	Mainstream	HARP
WNY MMC Monthly Premiums (SFY 2025-2026)	$307.19	$1,356.68
NYS Calculated Average MMC PMPM Cost (9/1/2024-8/31/2025)	$826.08	$1,886.28

1. NYS calculated costs for IBH-eligible population
2. The four WNY MCOs with the largest IBH-eligible population reviewed the Cost Data
3. These MCOs identified IBH-eligible populations already in primary care VBP arrangements
4. State and Value Network continue to engage with MCOs to design a VBP structure based on the IBH Model

Note: Premium and costs excludes pharmacy and carved-out BH services.

MMC Enrollment and VBP Attribution Analysis

Plan Name	Total IBH-Eligible Population	Total IBH-Eligible Attributed to Primary Care IPA	Percent Attributed to Primary Care IPA	Highlights
Fidelis	12,125	9,127	75%	8 Primary Care IPAs have 97.4% of attribution
IHA	3,857	3,803	90%	5 Primary Care IPAs have 90.8% of attribution
Molina	1,892	1,778	94%	2 Primary Care IPAs have 99.8% of attribution
Total	17,874	14,708	82%	Of the 82% in a VBP, 96% of them are with 11 Primary Care IPAs.

VBP Review and Discussion

Guiding Principals

Model Details

Discussion

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Guiding Principles

COSTS

Better Care at Lower Costs

Utilization

Improvement on Metrics/Utilization

TCOC

Total Cost of Care Reductions

Achieve lower TCOC for by comparing historical costs for previous 3-5 years for similar patients/diagnoses

Model Details

- Allocate resources to support BH IPA practices and enhanced and non billable services
- Support the People, Processes and Technology to improve Clinical Outcomes
- Develop a TCOC agreement with BH IPA, PCP IPAs and MCOs or directly with BH IPA

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DISCUSSION – PCP IPAs and MCOs

- Any experience with BH cohorts carved out of VBP? Or other specialty services?
- Do PCP IPAs have accurate data showing medical expenses for patients with and without BH diagnoses (BH,PH)?
- Thoughts on developing a collaborative VBP approach that integrates BH & Primary Care IPA and has cost sharing elements?
- Can we learn from the collaborative care model?

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Keys to Success

Investment

- MCO investment in the project and goals
- Providers and IPAs commitment to meet outcomes and cost savings
- Investment in shared data/IT tools

PMPM Allocation

- A Per Member per Month Allocation to support development and ensure positive health outcomes

Incentives

- Incentives to be provided for metric performance and TCOC savings

Communication and Collaboration

- Communication is key
- Sharing of data across the system of care (PH/BH and upstream drivers of health)

Next Steps

August 6th – Convening Structure from 12-2pm

- Review Care Delivery flexibilities from CMS
- Provide updates on workgroup feedback

September 24th Workgroup from 2:30-4pm

- Present and discuss draft of Payment Approach framework
- Review the service crosswalk