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Innovation in Behavioral Health (IBH) Convening Meeting

August 6, 2026

Funded by NEW YORK STATE | Office of Mental Health

Housekeeping

Closed captioning is available via the Zoom toolbar

Slides and additional resources will be shared following the session. This meeting will be recorded and be made available to the convening structure and workgroup members.

Please use the Zoom chat feature to submit any questions, comments, or concerns

Information discussed and shared is accurate as of today.

Please note that our Zoom account does not allow AI Bots to join this webinar. However, we encourage you to take advantage of other functions such as captions and transcripts for today's event.

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Agenda

01	PSYCKES ‘Planning Considerations’ Update
02	IBH Model Timeline
03	Workgroup Updates
04	Open Forum
05	Next Steps

01

PSYCKES "Planning Considerations" Update

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PSYCKES Updates

- Based on new federal regulations for Medicaid coverage, PSYCKES is capturing individuals needing to re-certify their Medicaid coverage via New York State of Health (NYSoH) OR their Local Department of Social Services (LDSS). Updates to the application include:
    - New filters have been added to the Recipient Search – Cohort Search page, identifying individuals whose Medicaid coverage has become inactive within the past 3 months or past year, and those needing to re-certify their Medicaid coverage within the next month or next 3 months
    - In Recipient Search results, the Planning Considerations column includes the Medicaid Eligibility alert along with the expiration date for individuals needing to recertify
    - Users with client-level access (via consent/emergency) can view the client's clinical summary and see the Medicaid Eligibility Alert information in the Notification section, including more information about how to start the recertification process
- Register for the upcoming New PSYCKES Feature Highlights webinar on Wednesday, August 12th 11AM-12PM to learn more

Recipient Search

Individual Search | **Cohort Search**

Limit Number of Results 50

Reset | Cohort Search

Characteristics as of 06/30/2026

Age Range

Race

Ethnicity

Populations & Planning Consic

Popul

High Need Popul

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Homelessness A

Complex N

Plans & Docum

Managed Care Plan & Medicai

Managed Care

MC Product Line

Medicaid Enrollment Status

Medicaid Restrictions

- Active Medicaid
- Inactive Medicaid
- Inactive Medicaid - Expired past year
- Inactive Medicaid - Expired 3 months
- Medicaid Managed Care - Any
- Medicaid Managed Care +SSI
- Medicaid No Managed Care(FFS Only)
- Dual Eligible (Medicaid + Medicare)
- Medicaid (No Medicare)
- Medicaid Recertification Due < 3 mo.
- Medicaid Recertification Due < 3 mo. (renew via NYSOH)
- Medicaid Recertification Due < 3 mo. (renew via LDSS)
- Medicaid Recertification Due < 1 mo.
- Medicaid Recertification Due < 1 mo. (renew via NYSOH)
- Medicaid Recertification Due < 1 mo. (renew via LDSS)

Client Region

Client County

Social Determinants of Health (SDOH) Past 1 Year

SDOH Conditions (reported in billing)

- Problems related to upbringing
- Problems related to social environment
- Problems related to physical environment
- Problems related to other psychosocial circu
- Problems related to medical facilities and ott
- Problems related to life management difficult
- Problems related to housing and economic c
- Problems related to employment and unempl

SDOH Conditions: Selected

Children's Waiver Status

HARP Status

HARP HCBS Assessment Status

HARP HCBS Assessment Results

My QI Report | Statewide Reports | Recipient Search | Provider Search | Registrar | Usage | Utilization Reports | MyCHOIS | Dashboards

Modify Search

629 Recipients Found

View: Standard | PDF | Excel

	Medicaid Enrollment Status	Medicaid Recertification Due < 1 mo.
AND	[Provider Specific] Provider	MAIN STREET AGENCY

Maximum Number of Rows Displayed: 50

1

Name (Gender - Age)	Medicaid ID	Date of Birth	Race & Ethnicity	Medicaid Managed Care Plan	Medicaid Quality Flags	Planning Considerations	Current PHI Access
QVJIQUrVSEQi Uq7BSUi KEq LQ NDQf	RbMqNp6p OFI	MDElMDEl MTauM6	Asian	Fidelis Care New York	Adher-AP, No Engage after MH IP, No MH Inpt F/U 7d (DOH), No MH Inpt F/U 7d (DOH) - Adult, No Outpt Medical	**Notifications:** MH Plcmt Consid, Medicaid Recertification Alert (expires: 07/31/2026)	All Data - Emergency
QVJOTqnELA VEFOQVbB KEY LQ M9Qf	RE6nODAn NbY	MDalM9lIM 9AmMQ	Black	Independent Health's MediSource	2+ ER-Medical, Chlamydia Screen Overdue (DOH), No SUD Tx Engage (DOH), No SUD Tx Initiation (DOH), No Utilization of Pharmacotherapy (DOH)	**Notifications:** Medicaid Recertification Alert (expires: 07/31/2026)	PSYCKES Consent
QVRBTUzISq7BSUmi TaF0SUE KEY LQ ND2f	SEYoN9Mp NVY	MDUlMDlIM TatOQ	White	UnitedHealthc are Community Plan	2+ ER-Medical	**Notifications:** Medicaid Recertification Alert (expires: 07/31/2026)	PSYCKES Consent
QVbBTEEi QqFSTUVO KEY LQ NDQf	QaEoMTYs Nba	MDUlMT6l MTauM6	Hispanic or Latinx	Fidelis Care New York	2+ ER-Medical, 4+ Inpt/ER-Med	**Notifications:** MH Plcmt Consid, Medicaid Recertification Alert (expires: 07/31/2026)	PSYCKES Consent
QVbBTEEi RVRUSUVOTaU RQ KEq LQ NTMf	QbYuMTMt MF6	MTElMDQl MTatM6	Hispanic or Latinx		2+ ER-Medical	**Notifications:** MH Plcmt Consid, Medicaid Recertification Alert (expires: 07/31/2026)	No Access Enable Access
QVbBTEFHTqRFT8m SaVTUqbDQQ KEY LQ NDAf	RUlmMD2n MbY	MD2lM9Ml MTauNQ	Hispanic or Latinx	Fidelis Care New York	Adher-AD - Acute (DOH), Cervical Cancer Screen Overdue (DOH)	**Notifications:** Medicaid Recertification Alert (expires: 07/31/2026)	Verbal PSYCKES Consent
QaFJTEVZLA VaVSTqvJQqE KEY LQ N9Qf	QVlmOT6o MaM	MTElMDEl MTasMQ	Black	VNSNY Choice Select Health		**Notifications:** Medicaid Recertification Alert (expires: 07/31/2026)	PSYCKES Consent

Recipient Search

QUFLQVbXSUnTTqui SrJJUq7BVqu U6

As of 6/30/2026 Data sources

PDF EXCEL

Sections

Brief Overview | Full Summary

Data with Special Protection Show Hide
This report contains all available clinical data.

General

Name
QUFLQVbXSUnTTqui SrJJUq7BVqu U6

DOB
XX/XX/XXXX (XX Yrs)

Address
MpUrNQ QabWTqvB UrQ MTZK, QbJPTb6, Tba, MTAqNpU

Medicaid ID
UbYtNT6tMaY

Medicaid Aid Category
MA-SAFETY NET

Medicaid Eligibility Expires on
08/31/2026

Medicare
No

Managed Care Plan
Healthfirst PHSP, Inc. (HARP)

MC Plan Assigned PCP
N/A

HARP Status
HARP Enrolled (H1)

HARP HCBS Assessment Status
Never Assessed

Notifications

Prescription Prior Authorization	This client has been taking a prescription medication in the past 3 months that may require NYRx prior authorization: Buprenorphine Hcl-Naloxone Hcl. To obtain a prior authorization call (877) 309- 9493 or fax the appropriate Prior Authorization Form to (800) 268-2990. Standard PA Form : https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PA_Fax_Standardized.pdf Other Specialized PA Forms: https://newyork.fhsc.com/providers/pa_forms.asp
Mental Health Placement Consideration due to	Any history of mental health diagnosis or treatment in jail; Evidence of Supplemental Security Income (SSI) or SSD AND Any OMH Specialty MH Service in past 5 years
Medicaid Eligibility Alert	This client must re-certify their Medicaid enrollment through their County Local Department of Social Services (LDSS) (Expiration: 08/31/2026) For more information visit How to Renew Your Health Insurance | County LDSS Or contact the client's county LDSS New York State Local Departments of Social Services (LDSS) If the client needs help with this process, please contact a Facilitated Enroller.
CORE Eligibility	This client is eligible for Community Oriented Recovery and Empowerment (CORE) services. For more information on CORE, visit: https://omh.ny.gov/omhweb/bho/core

02

IBH Model Timeline

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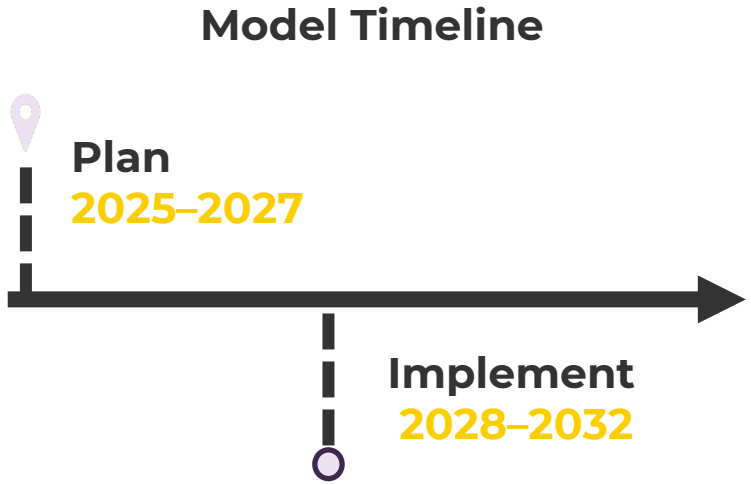
IBH Model Timeline

IT Implementation
Care Delivery Framework
Medicaid Payment Approach

2026 – Drafting Model Components
2027 – Refining for Implementation



03

Work Group Updates

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Health IT Workgroup

- Collaboration with HEALTHeLINK
- SSO Integration between PSYCKES
- Enhancing ADT alerts and Developing Complex Needs Alerts
- Behavioral Health One-Page Summary
- Reporting Measures – Exploring population health platform and MyCHOIS
- Shared Care Plan
- Review of Crisis Environment Scan and the role of crisis providers in IBH

Key Feedback

- Data Governance
  - Community providers not sending complete and/or accurate patient information in their CCDs
- Burden of multiple platforms
  - Preference to work in provider's EMR
- EMR integration of data for reporting
- Shared Care Plan created by BH in the BH EMR
  - Shared with primary care via BH One-page Summary?
  - What information does primary care want from BH?

Questions, Comments, Any Additional Feedback?

Care Delivery Framework Workgroup

1. Care Integration
2. Care Management
3. Preventive Health and Health Promotion

Flexibilities- What they could mean for development

CMMI Care Delivery Framework Flexibilities Webinar - 6/24/26

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Interprofessional Care Team Requirements

Each Practice Participant must ensure care teams include:

Behavioral Health Billing Practitioner

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

Physical Health Consultant

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

Care Team - Flexibilities

Behavioral Health Billing Practitioner

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

Physical Health Consultant

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

Example Care Team Members

- Care Coordinator / Nurse Navigator
- Mental Health Professionals (psychologist, LCSW, LMSW, LMHC)
- Social Worker / Case Manager
- Peer Support Specialist
- Credentialed Alcohol & Substance Abuse Counselors (CASAC)
- Nurses (Nurse Practitioner (NP), RN, LPN)
- Physician / Physician Assistant / Primary Care Provider (PCP)
- Specialists (e.g., Cardiologist, Oncologist, Endocrinologist)
- Behavioral Health Prescriber (e.g., psychiatrist, NP in psychiatry)
- Care Manager – (e.g., HH, CCBHC TCM)

Workgroup Proposed:

Family Nurse Practitioner
Community Health Worker
Other Navigator Roles

Care Integration - Required Services

Welcome Visit Components:

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

Reassessment Visits:

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

Care Integration – Flexibilities

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

Care Management - Required Services

Care Coordination and Closed-Loop Referrals:

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

Care Plan Maintenance:

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

Care Management – Flexibilities

Example Flexibilities:

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

Preventive Care and Health Promotion – Required Services

Track Priority Health Conditions:

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

Preventive Care and Health Promotion Services:

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

Preventive Care and Health Promotion – Flexibilities

Example Flexibilities

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

Key Feedback

Areas of interest include:

- Effective approaches for coordinating and communicating among Behavioral Health, Primary Care, and Social Needs providers.
  - Closing the loop on referrals
  - Sharing patient status info, including missed appointments and other support needs
  - EMR-centric solutions, whenever possible
- Processes for capturing and reporting on IBH quality measures
  - Hepatitis-C
- Integration of Care Management services and activities (Health Home, CCBHC Targeted Case Management, Navigators, etc.)
  - Contractual / In-house
  - Embedded, Co-located, Virtual

Addressing feedback through:

- Attentive Model Design
- Continued Workgroup Sessions
- Targeted Discussions with Practice Participants
- Availability and follow-up outreach

Questions, Comments, Any Additional Feedback?

Medicaid Payment Workgroup

Workgroup meeting held on: July 17 ,2026

- Reviewed the proposed Medicaid Payment Approach
- NYS calculated costs for IBH-eligible population
- The four WNY MCOs with the largest IBH-eligible population reviewed the Cost Data
- These MCOs identified IBH-eligible populations already in primary care VBP arrangements
- Review of practice-based and state-based performance measures.
- Sought feedback from Primary Care IPAs
- Continued to engage with MCOs on VBP design, based on the IBH Model

NYS Medicaid Payment Approach Will Address:

Infrastructure Funding
Service Funding (Leveraging Existing Medicaid Services)

Value Based Contracting

- Attribution
  - For the IBH Demonstration
  - For Value Based Contracting Arrangements

- Performance-Based Payment Strategy (Medicaid)
  - Required Practice-based Measures
    - Pay for Reporting- Required Practice-based Measures
    - Pay for Performance-Upside Bonus/Shared Savings tied to TCOC and Quality
  - Risk Adjustment

- Oversight and Monitoring
  - Confirming contracts comply with IBH Requirements

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. Costs and Utilization ~ 3x higher than average Mainstream enrollees
2. Aligns with national study findings - Milliman Research Report 2018
3. Savings estimates from Milliman suggest potential of 8% - 15%

"...even if the current supply of psychiatrists and psychologists were doubled in order to support effective IMBH programs, the savings from those programs would more than offset that investment" (Milliman, 18).

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

MMC Enrollment & 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.

Key Feedback

- Considerations/challenges with attribution and how money will flow
- More comprehensive data sharing through IBH is key for timely intervention and cost reductions.
- Accessing claims data and reconciliation to support determination of VBP success
- Importance of Behavioral Health in Collaboration with Primary Care to foster integration within a value-based arrangement.
- Communication on patient status is critical for supporting care across provider types: i.e. missed appointments, declining status, etc.
- Prospective MCO Investment aligns with the CMS IBH Model design.

Questions, Comments, Any Additional Feedback?

04

Open Forum

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05 Next Steps

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Next Steps

The next Convening Meeting will be held on November 4th (in-person).

The next workgroups meetings will take place in September and October

Resources

- CMS IBH Model
- DOH Award Announcement
- MCTAC IBH Special Initiatives Page
- To contact MCTAC: mctac.info@nyu.edu
- To contact OMH IBH Team: NYS-IBH-Mode@omh.ny.gov

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