AR CoCM Community Stakeholder's Meeting

Location: Zoom **Date:** March 31, 2026 **Time:** 12:00-1:00

Attendees:

1. Kim Shuler
2. Caitlyn Johnson
3. Miste Trent
4. Patty Gibson
5. Tucker Martin
6. Michael Keck
7. Teresa Hudson
8. Susan Ward-Jones
9. David Jones
10. Tisha Deen
11. Caddo Wright
12. Virna Little
13. Kristin Martin

Agenda:

1. Welcome/Updates/Announcements
2. IBHA Executive Committee Meeting Update
3. ABHIN Update
4. DHS Update
5. UAMS Update
6. CoCM Events and Resources

Meeting Notes:

Meeting purpose and transition to policy topics:
Kim restated the meeting's objectives, which are to connect sites, surface pain points, and address policy issues for the AR CoCM grant. She invited Virna to present federal updates given her active advocacy role and recent coordination efforts.

Federal advocacy and reimbursement updates by Virna Little:

- Virna Little and collaborators have been meeting regularly with senior CMS leaders to advance collaborative care reimbursement.
- The advocacy proposal requests higher collaborative care rates and changes to the RVU attached to those codes.
- Over 80 organizations have signed endorsement letters supporting the proposed reimbursement changes.
- A recommendation summary is being prepared for Dan Brillman at CMS to inform state action on collaborative care.
- A lobbyist has been hired to secure federal meetings and pursue CARES Act opportunities to support collaborative care.
- Current RVUs for collaborative care were about 33% lower in comparison analyses.
- Advocacy will next target reimbursement differences affecting mid-level providers, which impact rural practices.

Medicaid Payments, Policies, & Procedures:
Participants opened by stressing that reimbursement is critical for spreading collaborative care and that advocacy efforts are underway with CMS and state Medicaid to activate billing codes. The state acknowledged ongoing discussions about where collaborative care would fit in Medicaid and introduced the need for policy and procedure development before codes can be enabled.

The state explained Arkansas Medicaid's flat budget constraint and that any reimbursable codes must be budget neutral, requiring data to show savings elsewhere in Medicaid spending. The team questioned whether savings must come from behavioral health only, and it was clarified that savings can be shown in broader areas such as ER visits or hospitalizations.

Tracking patients and data sources while codes are inactive:
Clinicians asked how the state will track patient volume and outcomes when codes are not turned on. The state replied that the Medicaid billing system cannot track services without codes, so the state will rely on grant partners and insurer data. Multiple participants offered data solutions: Virna/Concert offered to share claims and clinical outcome data from Mercy, and UAMS confirmed they track services & can provide collected data if DHS requests it.

The team noted examples of other states (e.g., Texas, North Carolina, Florida) that used budget-neutral impact statements to pass codes and suggested studying their approaches. The group discussed the idea of building internal tracking to estimate Medicaid patient percentages and potential costs to support the state's decision-making.

MLN changes, FQHCs, advanced primary care, and payer considerations
Participants reviewed 2026 MLN updates that enable FQHCs to use regular CPT codes and add G codes for advanced primary care, which may simplify billing and affect financial outcomes. The team discussed trade-offs of advanced primary care (per-member-per-month rates versus minute-based add-ons), payer mix impacts (including Medicare Advantage carve-outs), and operational algorithm needs for routing patients between access and collaborative care.

Grant Updates:

- Teresa summarized enrollment totals, stating roughly 700 total enrollments with about 300 active participants across sites and noting uptake is slower than anticipated. She framed the trend as gradual progress despite earlier expectations.
- The team described a sequence of FFR submissions and corrections that delayed discussion of carry-forward funds, but ultimately an extra ~$400,000 was authorized for current-year spending. This funding will allow non-UAMS sites to increase budgets back to original estimates and accelerate site activations.
- UAMS reported operating six clinics and evaluating additional sites, while East Arkansas plans to expand to nine clinics as of April 9th to increase patient reach, particularly in rural Delta areas. The group emphasized targeted outreach efforts and recruitment in underserved areas.
- Tisha reported difficulties implementing billing because Epic's behavioral health builds exist but UAMS will not purchase the behavioral health module, forcing manual workarounds that complicate billing operations. The team acknowledged these technical and procurement hurdles as major implementation pain points.

Team Discussion

- The group clarified payer interactions for dual-eligible patients and billing sequencing (e.g., Medicaid managed care vs. Medicare) as factors affecting reimbursement and tracking. One participant asked whether the Arkansas state hospital admissions are funded by Medicaid; but the state clarified that the state hospital is funded by state general revenue due to IMD rules, not by Medicaid.
- Participants discussed sharing the CMS sign-on letter and urged rapid member sign-on to support proposed RVU changes, with Kim and Miste committing to distribute the letter and related minutes to the group. The group viewed policy engagement as time-sensitive and a route to amplify Arkansas's needs nationally.
- The meeting closed with promotion of the BHI conference on April 16th, highlighting sessions on billing and coding, AMA perspectives on behavioral health integration, COCM implementation examples, and a maternal health panel, and attendees were encouraged to register and invite colleagues.

Resources Shared:

- Advocacy proposal, shared by Virna Little**:** https://forms.gle/3LoTjCLwE9H3CAxW6
    - **Recommendation for the CY 2027 Fee**

Code	Rec. wRVUs
99492	3.67
99493	2.99
99494	1.50

- https://www.filesbff.org/CoCM_Total_Healthcare_Costs_Issue_Brief.pdf
- UAMS Case Study:
    - UAMS PATIENT SUCCESS STORY
        - PHQ9: 20 --> 0
        - GAD7: 15 --> 0 –
        - Time in treatment: 10 weeks, 3 sessions, 3 psychiatric case reviews
          In just 10 weeks of collaborative care, a patient achieved a 100% reduction in both PHQ-9 and GAD-7 screening scores. This result reflects not only meaningful symptom relief but a significant improvement in quality of life. This patient's progress was made possible through the close collaboration of the Behavioral Health Care Manager (BHCM), Primary Care Provider (PCP), and Psychiatric Consultant working together to identify memory gaps the patient had been experiencing and explore how those gaps were affecting their mood and overall wellbeing. The team took a whole-person approach and recognized that something

deeper may be contributing to the patient's presentation and were able to encourage a thorough lab workup.
    - The workup led to a new diagnosis and targeted treatment, which became a turning point in the patient's care. With a clearer understanding of what they were facing and confidence in their treatment team, the patient felt safe to begin exploring trauma-focused therapy. The patient continues to adhere to medication recommendations and has maintained their remarkable clinical improvement. This case illustrates what the CoCM model makes possible: a primary care setting where behavioral health, medical, and psychiatric expertise work together and patients get better.

Key Takeaways:

- The core meeting purpose is to connect sites, surface pain points, and address policy issues for the AR CoCM grant.
- Payment is essential for broad adoption of collaborative care; without reimbursement, uptake will be challenging.
- Arkansas requires policy and procedures plus data demonstrating budget neutrality before turning Medicaid codes on.
- Without billing codes present in the Medicaid system, the state cannot track service volume through Medicaid claims and must rely on grant partners' internal data.
- The state must show cost offsets (for example reduced ER visits or hospitalizations) to justify reimbursements under a flat Medicaid budget.
- Recent MLN changes allow FQHCs to use standard CPT codes and add some G codes for advanced primary care, affecting billing strategy.
- Advanced primary care payment can simplify billing by using a per-member-per-month approach, but its financial benefit depends on minutes-per-enrollee and payer mix.
- The grant now has a new, more engaged project officer with regular meetings and faster responses to questions.
- Total enrollment since the grant began is about 700 people, with roughly 300 active participants currently across sites.
- Authorization was granted to spend approximately $400,000 this year, enabling restoration of budgets at non-UAMS sites.
- The BHI conference on April 16th will include sessions on billing/coding, BHI value, COCM implementation, and maternal health panels.

Action Items:

- Meeting participants will sign the collaborative care advocacy letter using the open link
- Virna Little:
    - will share the federal collaborative care advocacy agenda with the group
    - Virna Little will share the campaign comparison table and related documentation about RVU changes
    - Virna Little (Concert) will share claims and clinical outcome data from Mercy with the group, subject to data-use conversations.
- David will reach out to Paula to determine the best approach for collecting Medicaid-related data from grant participants to support reimbursement analysis.
- Teresa Hudson will:
    - send written information announcing the funding authorization and related details to the team.
    - ask David to tutor her on correcting FFR errors to avoid future delays.
- Miste Trent will include the CMS sign-on letter in the meeting minutes and send it out.

Key Questions:

- What were the RVUs for collaborative care before the proposed change?
- How can the state track the number of Medicaid patients receiving collaborative care and their outcomes if billing codes are not yet enabled?
- Does Arkansas Medicaid require cost offsets to come specifically from the behavioral health budget, or can savings from other areas count?

Important Date(s):

- **April 16th,** 9:00 – 3:30**,** Little Rock, AR – 4th Annual BHI Conference, Better Together: The Power of Team-Based Care in Behavioral Health Integration

CoCM Resources:

- ABHIN CoCM Training & Resource webpage
- ABHIN CoCM Monthly Office Hours
- AIMS Center: Collaborative Care Monthly Finance Office Hours
- AIMS Center: Collaborative Care Monthly Implementation Office Hours
- AIMS Center's BHCM Learning Community