AR CoCM Community Stakeholder's Meeting

Location: Zoom **Date:** April 28, 2026 **Time:** 12:00-1:00

Attendees:

1. Kim Shuler
2. Djuana Smith-McNeely
3. Miste Trent
4. Patty Gibson
5. Ann Sivils
6. Mark Jansen
7. Brea Strong
8. Taylor Davis
9. Rachael Marx
10. Dr. Kristin Martin

Meeting Notes:

KEY TAKEAWAYS:

1. Billing Complexity is a Major Barrier

- There is significant confusion around CoCM, CCM, and BHI billing rules, especially whether services can be billed simultaneously.
- Conflicting guidance exists:
  - Some believe CoCM and CCM cannot be billed together.
  - Others note Medicare may allow it if requirements are met and time isn't duplicated
  - Clear restriction: CoCM and general BHI cannot be billed for the same patient in the same month
- Success depends on accurate coding, modifiers, and persistence with denied claims

2. Workforce Shortages Are Slowing Implementation

- Clinics (e.g., McGehee) are unable to launch or scale CoCM due to lack of social workers
- Hiring qualified, licensed behavioral health staff remains a key bottleneck.

3. Operational & Workflow Challenges

- Implementing CoCM requires:
  - Strong EHR systems and tracking (especially time-based billing)
  - Cross-department coordination (clinical, billing, IT)
- Smooth workflows are essential for both financial sustainability and patient care quality.

4. Scaling CoCM: Successes and Barriers

- Mercy is expanding CoCM across multiple states, aiming for full integration across primary care, pediatrics, and women's health
- Challenges include:
  - Low referral rates in some regions
  - Resistance from established provider networks
  - Gaps in internet access affecting virtual care delivery

5. Virtual Care is Central—but Not Equitable

- Some systems are 100% virtual, improving access and scalability
- However, rural connectivity gaps require in-clinic solutions for virtual visits.

6. Integration of Behavioral Health Across Settings

- Strong emphasis on integrated care models, including:
  - Dental + behavioral health collaboration
  - Use of CoCM in innovative settings (e.g., street medicine, addiction care)
- National examples show improved engagement and retention (up to ~65%) using CoCM approaches

7. Financial Sustainability Concerns

- Practices—especially private clinics—struggle to:
  - Balance staffing costs vs. reimbursement
  - Navigate licensure and billing limitations
- FQHCs often have more flexibility than independent practices.

8. Need for Collective Learning & Advocacy

- Group consensus: progress will require:
    - Sharing real billing experiences
    - Collective advocacy with payers
    - Ongoing collaboration through the stakeholder group

ACTION ITEMS:

- Rachael Marx will email the Georgia Health Policy Center presenter to request permission to share the presentation on codes and billing strategies
- Kristin Martin will obtain and share the exact retention statistics from the LA street-medicine CoCM program
- Kim Shuler will post the meeting/conference recordings for the group

KEY QUESTIONS:

- Is the conference recording available on the program website?
    - The recording and slides should be posted by mid-May
- Why can't some patients be billed for CoCM while they are receiving CCM?
    - Participants reported their billing manager said CCM and CoCM cannot be billed simultaneously because of overlap concerns, but others clarified that CoCM can replace CCM for an episode of care and that billing rules depend on meeting separate requirements and avoiding double-counting of services.
- Can CoCM and CCM (or general BHI) be billed together in the same month?
    - The group referenced CMS and expert guidance indicating CoCM cannot be billed in the same month as general BHI for the same beneficiary; however, CoCM and CCM may be billed in the same month only if both services are independently medically necessary, each requirement is met, consent is obtained, and time/effort is not double-counted.
- Is Mercy delivering CoCM services virtually and, if so, how do you handle areas with poor internet?
    - Yes, Mercy's CoCM services are 100% virtual, and they plan to install telehealth equipment in specific clinics (Waldron, Green Forest) so patients without home internet can attend virtual visits onsite
- Can non-terminally licensed clinicians (LMSWs/LACs) bill psychotherapy or BHI codes in primary care and receive reimbursement from Medicaid or commercial payers?
    - Practices reported variability: some organizations do not use traditional psychotherapy codes for non-terminal clinicians, while FQHC behavioral-health models may reimburse LMSWs under LC supervision; independent clinics face greater constraints and conflicting guidance
- Does anyone in the payer space have suggestions or guidance as we explore and investigate billing codes for CoCM and BHI?
    - Patty Gibson answered that payer rules are complex, recommended billing and questioning denials, noted common denial causes like place-of-service or provider codes, and advised continued troubleshooting and collaboration

Important Date(s):

- __

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