Center for Connected Health Policy

TELEHEALTH & MEDICAID: A POLICY WEBINAR SERIES

Medicaid Telehealth Permanent Policies
October 8, 2021

CENTER FOR CONNECTED HEALTH POLICY (CCHP)
is a non-profit, non-partisan organization that seeks to advance state and national telehealth policy to promote improvements in health systems and greater health equity.
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ABOUT CCHP

• Established in 2009 as a program under the Public Health Institute
• Became federally designated national telehealth policy resource center in 2012 through a grant from HRSA
• Work with a variety of funders and partners on the state and federal levels
• Administrator National Consortium of Telehealth Resource Centers
• Convener for California Telehealth Policy Coalition
NATIONAL CONSORTIUM OF TRCS

TelehealthResourceCenter.org
Telehealth & Medicaid: A Policy Webinar Series

Subscribe to CCHP’s newsletter for news of the next series!

Image source: American Psychological Association

This webinar series was made possible by grant number GA5RH37470 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, U.S. Department of Health & Human Services.
Today’s Webinar

Lori Coyner, MA
Senior Medicaid Policy Advisor
Oregon Health Authority

Shannon Dowler, MD
Chief Medical Officer
North Carolina Medicaid
Department of Health and Human Services

Sara Salek, MD
Chief Medical Officer
Arizona Health Care Cost Containment System
Telehealth in Oregon: the evolving Medicaid policy landscape

Center for Connected Health Policy
October 8, 2021

Lori Coyner, Senior Medicaid Policy Advisor
Today

Overview of Oregon Health Plan and Oregon Health Authority
Telehealth current state, opportunities, and risks
OHA Telehealth Policy Framework
Oregon Medicaid policy landscape
Oregon Health Plan provides coverage for one million Oregonians

OHP provides:
Physical, oral, and behavioral health care
For about one million Oregonians
Of which 41% are children

OHP includes:
Medicaid
Children’s Health Insurance Program (CHIP)
Cover All Kids
Reproductive Health Equity Act (RHEA)
Other related services
Oregon Health Authority’s (OHA) strategic goal is to eliminate health inequities in Oregon by 2030

Health equity defined:

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

The equitable distribution or redistribution of resources and power; and

Recognizing, reconciling and rectifying historical and contemporary injustices.

--Oregon Health Policy Board, Health Equity Committee
Telehealth in Oregon

Current state, opportunities and risks
Telehealth use increased dramatically early in the pandemic, and remains high

*Note: Data reflect claims and encounters submitted to OHA as of 08/03/2021. Data may be incomplete, especially for the most recent month

Telehealth’s second peak, more than a year after COVID hit
About 40% of telehealth visits in Oregon Medicaid occur by audio-only telephone*

*Data source: MMIS. Note – this data includes only audio-visual and audio visits (e.g. does not include other types of telehealth such as e-visits, store and forward, remote patient monitoring). No audits have been performed on this data.
95% of Oregonians live in areas with basic broadband, but the distribution reflects the urban/rural divide

In a recent survey of Oregon WIC participants, the data reflects inequities

90% of those surveyed have a smart phone and use it daily, but...

- **Spanish-speaking** respondents who use a **flip phone daily**
  - 35%

- Respondents who said they use prepaid, **pay-as-you-go** cell phone data
  - 23%

- Respondents who sometimes **run out of data**
  - 44%

- Respondents who said they **don’t have a monthly internet service plan**.
  - 15%

Source: Oregon telehealth readiness study, Oregon WIC Program, OHA Public Health Division
Telehealth has the potential to exacerbate health inequities if **opportunities aren’t realized and risks aren’t avoided**

- Health care access
- Culturally and linguistically responsive care
- In-home care and community-based services

- Inequities in access to telehealth due to lack of access to broadband, devices, data literacy
- Decreased access to in-person visits
OHA Telehealth Policy Framework
OHA’s Telehealth Policy Framework is an internal resource to guide program and policy work.
OHA developed the Telehealth Policy Framework to improve cross-agency alignment, coordination, issue identification, and communication.

- Align under our shared vision to eliminate health inequities
- Identify issues in need of resources or attention
- Coordinate with other staff doing this work
- Communicate our high-level goals and vision
## Framework excerpt: Telehealth Strategy Map

**OHA Telehealth Goal:** to leverage telehealth modalities to eliminate health inequities and improve health

### Inputs (examples)
- Staff and leadership
- Partnerships
- Funding
- Laws/regulations
- Communications
- CCO structure and policies
- Workforce programs
- Tribal consultations
- Committees and Boards

### Activities (examples)
- **Engagement**
  - Listening sessions
  - Support
  - Technical assistance
  - Access to devices
- **Evaluation**
  - Surveys
  - Policy
  - Rules
  - CCO contracts
- **Collaboration**
  - State Health Improvement Plan
  - Multi-State Compact

### Outcomes
- **Improve** Equity
- **Improve** Access
- Ensure **Standard of Care**
- **Ensure** Confidentiality
- Maximize **Patient Choice**
- Practice **Stewardship**
- Maximize **Coordination and Alignment**

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Multi-state compact principles:
- CA, CO, NV, OR, WA
Framework excerpt: Seven questions to center equity in our telehealth policy and program planning

How will the proposed change to a telehealth policy or program…

1. Focus on issues faced by community, in particular communities of color and tribal communities?
2. Address meaningful access to telehealth visits for patients/clients/members, in particular priority populations?
3. Ensure the appropriateness of using telehealth and/or modality (e.g. video call) for services being delivered?
4. Protect privacy of visit and personal information?
5. Incorporate strategies to ensure patient choice of modality, including preference for in-person services?
6. Prioritize equitable access to services given any resource constraints and cost containment goals?
7. Support alignment with other efforts within OHA and by external partners?
Oregon Medicaid Policy Landscape
Medicaid policies as of January 2021

No restrictions on distant or originating sites

Telehealth allowed for new and established patients

Pay parity for telehealth and in-person (interpreters must be paid at parity)

• Audio-only requires modifier, and use if A/V not available or feasible

Patient consent required

Providers ensure meaningful access
Recent telehealth legislation passed in Oregon makes permanent many COVID-19 expansions

**House Bill 2508**
Expands coverage of and pay parity for telemedicine services in Oregon
Applies to commercial plans and Medicaid
Audio-only included

**House Bill 2591**
Funds three telehealth pilot projects for school-based health centers
School-based health center is the distant site that provides telehealth in conjunction with school nurse located at the originating site
Proposed Medicaid rule changes for 2022 focus on patient choice

Strengthen patient choice and options

 Meaningful access considerations

 Consent requirements
Thank You
NC Department of Health and Human Services

Should it Stay or Should it Go?
The Clash of Telehealth Post Pandemic

Shannon Dowler, MD
Chief Medical Officer
NC Medicaid

October 2021
Object (Telehealth) Permanence

- What did we consider?
- How did we make our decisions?
- What did we learn?
- Where did we struggle?
- What was unique?
- What is next?
The Department analyzed 387 flexibilities across multiple functional areas. The summary tables below provide insight into the final recommendations.

<table>
<thead>
<tr>
<th>Workstream Recommendations</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits</td>
<td>133</td>
<td>34%</td>
</tr>
<tr>
<td>Recommended Keep</td>
<td>15</td>
<td>4%</td>
</tr>
<tr>
<td>Recommend keep with changes</td>
<td>38</td>
<td>10%</td>
</tr>
<tr>
<td>Consider Keep</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>Recommend to not keep</td>
<td>67</td>
<td>17%</td>
</tr>
<tr>
<td>Not reviewed through CB</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Finance and Rate Setting</strong></td>
<td>23</td>
<td>6%</td>
</tr>
<tr>
<td>Recommended Keep</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Recommend keep with changes</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Recommend to not keep</td>
<td>14</td>
<td>4%</td>
</tr>
<tr>
<td><strong>LME-MCO</strong></td>
<td>202</td>
<td>52%</td>
</tr>
<tr>
<td>Recommended Keep</td>
<td>18</td>
<td>5%</td>
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<tr>
<td>Recommend keep with changes</td>
<td>23</td>
<td>6%</td>
</tr>
<tr>
<td>Recommend to not keep</td>
<td>161</td>
<td>42%</td>
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<tr>
<td><strong>Member Services</strong></td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td>Recommend to not keep</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td>Recommended Keep</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Recommend to not keep</td>
<td>7</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Provider Operations</strong></td>
<td>7</td>
<td>2%</td>
</tr>
<tr>
<td>Recommend to not keep</td>
<td>7</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Command Center</strong></td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Recommend keep with changes</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Contact Center</strong></td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>Recommended Keep</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>387</td>
<td>100%</td>
</tr>
</tbody>
</table>
What did we learn?

Our early “prediction models” for cost of telehealth grossly overestimated fiscal impact.

A Second Visit Was Less Likely After Teleservices
Total Cost of Care in Two Weeks Following Primary Care Visit

Service Dates (allowing for runout): 3/01/2020 - 3/15/2021

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-person Non-ABD</td>
<td>$364</td>
</tr>
<tr>
<td>Telehealth Non-ABD</td>
<td>$340</td>
</tr>
<tr>
<td>Telephonic Non-ABD</td>
<td>$326</td>
</tr>
<tr>
<td>In-person ABD</td>
<td>$1,140</td>
</tr>
<tr>
<td>Telehealth ABD</td>
<td>$1,563</td>
</tr>
<tr>
<td>Telephonic ABD</td>
<td>$1,227</td>
</tr>
</tbody>
</table>

Reimbursed at 80% Parity
What did we learn?

Our early “prediction models” for cost of telehealth grossly overestimated fiscal impact.

Early adapters had better outreach and outcomes.

Using Teleservices to Close Care Gap

<table>
<thead>
<tr>
<th>Level of Uptake (number of teleservice claims during the pandemic so far)</th>
<th>No. of Practices</th>
<th>No. of Patients Receiving Primary Care During Pandemic</th>
<th>Est. % of Panel Accessing Practice During Pandemic</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH (300+)</td>
<td>308</td>
<td>853,392</td>
<td>121%</td>
</tr>
<tr>
<td>MED (50-299)</td>
<td>567</td>
<td>431,825</td>
<td>97%</td>
</tr>
<tr>
<td>LOW (1-49)</td>
<td>875</td>
<td>315,133</td>
<td>77%</td>
</tr>
<tr>
<td>NONE</td>
<td>488</td>
<td>109,272</td>
<td>80%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2,238</td>
<td>1,709,622</td>
<td>101%</td>
</tr>
</tbody>
</table>
What did we learn?

Our early “prediction models” for cost of telehealth grossly overestimated fiscal impact.

Early adapters had better outreach and outcomes.

Not all our decisions were popular.

(No Further Explanation Required)
What did we learn?

Our early “prediction models” for cost of telehealth grossly overestimated fiscal impact.

Early adapters had better outreach and outcomes.

Not all our decisions were popular.

Unexpected benefits continue to be revealed.
% Using Hospital Within Two Weeks of Primary Care Visit

- Non-ABD:
  - In-person: 1.9%
  - Telehealth: 2.6%
- ABD:
  - In-person: 4.2%
  - Telehealth: 3.2%
  - Telephonic: 4.0%

Admission Dates (allowing for runout): 3/01/2020 - 3/15/2021
What did we learn?

Our early “prediction models” for cost of telehealth grossly overestimated fiscal impact.

Early adapters had better outreach and outcomes.

Not all our decisions were popular.

Unexpected benefits continue to be revealed.

To achieve the quadruple aim we have to be nimble.
Probability of medication use between June 2020-January 2021 was higher for beneficiaries that received some services during March 2020 – May 2020

- **Antipsychotic Fills**
  - In-person Only: 73.5%
  - Telehealth Use: 76.5%
  - No Use: 70.3%

- **Medication for Opioid Use Disorder Fills**
  - In-person Only: 84.1%
  - Telehealth Use: 87.0%
  - No Use: 67.2%
Where did we struggle on permanence?

Telephonic Only Services

Specialized Therapies, Audiology, Optometry

Virtual Wellness and Preventive Care
Telephonic Only

**POSITIVES**

- When all else fails, it may be your only way to reach a patient.
- It is more convenient for provider and patient.
- More people have phones and minutes than don’t (there are “cellular” deserts, but they are not as big as “broadband” deserts)
- For low income and low health literacy this is more accessible.

**NEGATIVES**

- Cost to provide the service (by a practice) MUCH lower.
- Value of the care provided lower.
- Risk of inappropriate clinical care is higher.
- Risk of fraud/abuse is higher.
- Risk of HIPAA noncompliance is higher.
- Potential to exacerbate inequities exists:
  - failure to improve on technology gaps
  - potential to prioritize lower value care
Example: Telephonic Billing Audiology

Virtual Telephonic Claims per Service Provider County

% Telecode Utilization

0.00% 100.00%

NC Medicaid Telecode Utilization

Example: Telephonic Tobacco Cessation

Telehealth Claims Weekly Comparison

Calendar Years: 2020, 2021
Specialized Therapies

Positives

• Parents more engaged and active in therapy
• When care provided through school typically, engaging parents in home a plus
• Number of visits ultimately reduced due to parent engagement (anecdotal)
• Increases access to specialty providers for rural beneficiaries
• ST would not have been on our radar for telehealth modernization if not for the pandemic
• Allows therapists to look at patients function in their home environment
• Therapy sessions more efficient because no “warm up” orientation time in home environment
• Ease of scheduling and making up visits; more flexible hours to work in
• Teletherapy resources available for patient education (software/packages) virtually

Negative

Telephonic only services used more than anticipated and in patterns that were concerning
Lack of data to support from larger studies or pilots; emerging
Not every child/family is able to use this modality effectively (screen distraction)
Lack of access to appropriate technology resources, access, literacy
Some modalities need hands-on care
Safety concerns in home environment for some modalities (has screening been adequate)
Employers directing providers to meet productivity goals using this modality
Virtual Wellness Visits

POSITIVE

• Allows immune compromised members/families easier and safer access to care.
• Convenience for family.
• Reduces transportation burden on physically disabled members.

NEGATIVE

• Often visits involve need for a physical exam component, especially in younger beneficiaries.
• Frequently involves labs or immunizations.
• Need to track growth and vital signs accurately.
  • Creates increased program cost with double visit.
Well Child Visits: Telehealth/Telephonic
What are some unique accomplishments?

- Removing Barriers that contribute to health inequities
- Early Prenatal Care and Risk Screen
- Virtual Lactation Consultation
- Virtual Ventilator Management
- Hybrid Home-Telehealth Visit
Build It and They (may or may not) Come

Claims by Procedure Code Trends

- 99349 - Established Patient Home Visit, Typically 40 Minutes
- 99350 - Established Patient Home Visit, Typically 60 Minutes
- 99348 - Established Patient Home Visit, Typically 25 Minutes
### Description of Temporary Flexibility Made Permanent

- **1A-24:** Diabetes Self-Management Education
- **1-I:** Dietary Evaluation and Counseling and Medical Lactation Services
- **1-M3:** Health and Behavior Intervention
- **1E-7:** Family Planning Services
- **1M-2:** Childbirth Education
- **1A-34:** Dialysis Services
- **1E-6:** Pregnancy Medical Home
- **8-J:** Children’s Developmental Service Agencies (CDSAs)
- **8G:** Peer Supports
- **8A:** Enhanced Mental Health and Substance Abuse Services
- **8A-2:** Facility Based Crisis Services
- **9:** Outpatient Pharmacy
- **8C:** Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
- **3A:** Home Health Services
- **3G-1:** Private Duty Nursing for Beneficiaries Age 21 and Older
- **3G-2:** Private Duty Nursing for Beneficiaries Under 21 Years of Age
- **3D:** Hospice Care
- **3H-1:** Home Infusion Therapy
- **10C:** Local Education Agencies (LEAs)
- **10D-L:** Respiratory Therapy Services
- **5A-2:** Respiratory Equipment
- **5A-3:** Nursing Equipment and Supplies
- **8E:** Intermediate Care Facilities for Individuals with Intellectual Disabilities
- **8F:** Research-based Behavioral Health Treatment for Autism Spectrum Disorder
- **8P:** NC Innovations
- **4A:** Dental Services
- **4B:** Orthodontic Services
- **1E-5:** Obstetrical Services
- **1D-4:** Cor Services Provided in Federally Qualified Health Centers and Rural Health Clinics
Where to Find Me
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@dowlerdoc
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#WomenInMedicine #STD #ThisisOurLane #publichealth #healthequity #sexualhealth

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Excited to be Chief Medical Officer of NC Medicaid @nchhsx Family Doctor @myncafp @aafp Lover of Rhyme, Mom, Wife, Speaker, Writer, Standard disclaimers apply.

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COMING SOON:
STI’s Never Get Old

Videos

Off to the STD Clinic You Go 2015
Shannon Dowler MD
YouTube - Feb 26, 2015

STD’s Never Get Old
Shannon Dowler MD
YouTube - Mar 5, 2017

American Academy of Family Physicians (AAFP) - AAFP Member Monday. Dr ...

Shannon Dowler, MD - YouTube
https://www.youtube.com/channel
Shannon Dowler, MD uploaded a video 2 years ago. 4:29. Play next. Play ... Shannon Dowler, MD uploaded, posted and liked 4 years ago. Celebrating 50 years ...
Arizona Medicaid
Permanent Telehealth Policy Changes

Dr. Sara Salek
Chief Medical Officer, AHCCCS
AHCCCS At A Glance

Largest insurer in AZ, covering over 2 million individuals and families...

...more than 50% of all births in AZ...

...and two-thirds of nursing facility days.

AHCCCS uses federal, state and county funds to provide health care coverage to the state’s Medicaid population.

More than 106,566 health care providers are registered with AHCCCS.

Payments are made to 15 contracted health plans that are responsible for the delivery of care to members.
<table>
<thead>
<tr>
<th>Point</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broadening of POS allowable for distant and originating sites</td>
<td>No restrictions on distant site (where provider is located). Broadening of originating site (where member is located) to include home for many service codes.</td>
</tr>
<tr>
<td>Broadening of coverage for telemedicine, remote patient monitoring, and asynchronous</td>
<td></td>
</tr>
<tr>
<td>No rural vs. urban limitations</td>
<td></td>
</tr>
<tr>
<td>MCOs retained their ability to manage network and leverage telehealth strategies as they determine appropriate</td>
<td></td>
</tr>
</tbody>
</table>
Arizona Medicaid Telehealth Coverage
Pre-Pandemic (October 1, 2019)

Pre 10/1/19
Real-time telemedicine limited to 17 disciplines

Implemented 10/1/19
No restrictions on disciplines
Arizona Medicaid Telehealth Coverage
Pre-Pandemic (October 1, 2019)

Pre 10/1/19
Asynchronous covered in very limited circumstances

Implemented 10/1/19
Dermatology
Radiology
Ophthalmology
Pathology
Neurology
Cardiology
Behavioral Health
Infectious Disease
Allergy/Immunology
Arizona Medicaid Telehealth Coverage
Pre-Pandemic (October 1, 2019)

Pre 10/1/19
Telemonitoring limited to CHF

Implemented 10/1/19
No restrictions on telemonitoring
Arizona Medicaid Telehealth Coverage
Intra-Pandemic (March 2020-Current)

• Created temporary audio-only code set (94 codes)
• Added >150 CPT and HCPCS codes for services delivered via audio-visual and store and forward
• Health plan requirements (not in effect prior to pandemic)
  o Reimburse at the same rate for services provided in-person and services provided audio-only
  o Cover all contracted services via telehealth modalities, including audio-only
Calendar Year 2020 Telehealth Utilization of AHCCCS Members
Most Common Primary Diagnoses Treated
(CRN Count Per 1,000 Enrolled Members)

- DEVELOPMENTAL DISORDER OF SCHOLASTIC SKILLS, UNSPECIFIED (F819) - 42.3
- UNSPECIFIED INTELLECTUAL DISABILITIES (F79) - 47.1
- GENERALIZED ANXIETY DISORDER (F411) - 76.0
- MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE (F331) - 76.9
- ANXIETY DISORDER, UNSPECIFIED (F419) - 85.9
- ATTENTION-DEFICIT HYPERACTIVITY DISORDER, COM (F902) - 87.5
- ADJUSTMENT DISORDER, UNSPECIFIED (F4320) - 98.0
- POST-TRAUMATIC STRESS DISORDER, UNSPECIFIED (F4310) - 98.9
- OPIOID DEPENDENCE, UNCOMPPLICATED (F1120) - 136.0
- AUTISTIC DISORDER (F840) - 141.9
Telehealth Utilization
October 2019 - July 2021
Percentage of enrolled members with one or more telehealth service (rolling 12 month data per month)

Note: Includes real-time audio/visual services, our permanent telephonic services and the expansion of telephonic services in response to the public health emergency.
# AHCCCS Telehealth Coverage Summary

<table>
<thead>
<tr>
<th>WHAT</th>
<th>TECHNOLOGY</th>
<th>TELEHEALTH MODIFIER¹ OR APPLICABLE DENTAL CODE</th>
<th>PLACE OF SERVICE (POS)</th>
<th>CODE SET AVAILABLE</th>
<th>CODE SET AVAILABLE AFTER COVID 19 EMERGENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telemedicine (Synchronous)</td>
<td>Interactive Audio + Video</td>
<td>GT</td>
<td>Originating Site²</td>
<td>Telehealth Code Set</td>
<td>YES</td>
</tr>
<tr>
<td>Asynchronous (Store+Forward)</td>
<td>Transmission of recorded health history through a secure electronic</td>
<td>GQ</td>
<td>Originating Site²</td>
<td>Telehealth Code Set</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>communications system</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remote Patient Monitoring</td>
<td>Synchronous (real-time) or asynchronous (store and forward)</td>
<td>GT-Synchronous GQ-Asynchronous</td>
<td>Originating Site²</td>
<td>Telehealth Code Set</td>
<td>YES</td>
</tr>
<tr>
<td>Teledentistry</td>
<td>Synchronous (real-time) or asynchronous (store and forward)</td>
<td>D9995-Synchronous D9996-Asynchronous</td>
<td>Originating Site²</td>
<td>Teledentistry Code Set</td>
<td>YES</td>
</tr>
<tr>
<td>Telephonic</td>
<td>Audio</td>
<td>None</td>
<td>02-Telehealth</td>
<td>Telehealth Code Set</td>
<td>YES</td>
</tr>
<tr>
<td>Telephonic (Temporary)</td>
<td>Audio</td>
<td>UD</td>
<td>Originating Site²</td>
<td>Telehealth Code Set</td>
<td>NO³</td>
</tr>
</tbody>
</table>

1 All other applicable modifiers apply
2 Location of the AHCCCS member at the time the service is being furnished via telehealth or where the asynchronous service originates
3 Telehealth Advisory Committee voted on permanent audio-only code set at October 17, 2021 meeting
House Bill 2454
36-3607: Telehealth Advisory Committee

• Requires adoption of telehealth best practice guidelines
• Requires recommendations regarding the health care services that may be appropriately provided through an audio-only telehealth format
• Requires the Advisory Committee, before making its recommendations, to:
  1. Analyze medical literature and national practice guidelines;
  2. Consider the comparative effectiveness, safely and benefit to the patient of performing a service through an audio-only telehealth format instead of in person or through an audio-visual format; and
  3. Consider the appropriate frequency and duration of audio-only telehealth encounters.
Telehealth Advisory Committee
Audio-only coverage post pandemic

Total of **37 codes** recommended for audio-only coverage post pandemic
- Maintain 24 codes (out of 94) on temporary audio-only code set
- Maintain 13 codes on permanent audio-only code list
Arizona Medicaid Telehealth Coverage: Post-Pandemic Highlights

• Member access to care
  ○ Broadband and other technology access

• Member satisfaction
  ○ Consumer Assessment of Healthcare Providers and Systems (CAHPS) with supplemental questions for telehealth (results anticipated in late Fall 2021)
Arizona Medicaid Telehealth Coverage: Post-Pandemic Highlights

- Code coverage decisions
- Reimbursement rates
- Network Standards
  - Appointment availability
  - Time and distance
- Telehealth practice guideline adoption
- Ongoing quality monitoring
Arizona Telehealth Resources

- AHCCCS Telehealth Webpage
- COVID Telehealth FAQs
- AHCCCS Contractor Operations Manual (ACOM)
  - Network Standards
  - Appointment availability standards
- Telehealth Advisory Committee
- Arizona Telemedicine Program
- Southwest Telehealth Resource Center
Panel Q&A

Please submit questions using the Q&A function.
Webinar Recordings and Resources

Subscribe to CCHP’s email listserv or stay tuned to CCHP’s resources page for recordings of this webinar and presentation slide decks!
THANK YOU!

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Please don’t forget to fill out your evaluation form!

Thank you and have a great day!