# State Medicaid Advisory Committee (SMAC)

Special Meeting
Wednesday, June 3, 2020
**AHCCCS**
**(To Join by Phone) 602-666-0783 Access ID: 280 601 914 (VIRTUAL MEETING)**
**(To Join by Web)**
**https://azgov.webex.com/azgov/onstage/g.php?MTID=e76791c2a6b02ca41a0dee0989aab9349**
**Event #** 280 601 914
**10:00 AM - 11:00 AM**

| Agenda | |
|---|---|
| I.    **Welcome** | **Director Jami Snyder** |
| II.    **Introductions of Members** | **ALL** |
| **Agency Updates** | |
| III.    **AHCCCS Updates** | **Director Jami Snyder** |
| IV.    **COVID-19** | **Director Jami Snyder** |
| V.    **Telehealth Discussion and Recommendations** | **Telehealth Subcommittee** |
| VI.    **Call to the public** | **Director Snyder** |
| VII.    **Adjourn at 11:00 AM** | **ALL** |

**2020 SMAC Meetings**
Per SMAC Bylaws, meetings are to be held the 2nd Wednesday of January, April, July and October.
***Please note the change for the October meeting date, due to conflicts.***
All meetings will be held from 1 p.m.- 3 p.m. unless otherwise deemed necessary by the Director.

**January 8 , 2020**
**April 8, 2020**
**July 8, 2020**
**October 21, 2020**

**Special SMAC Meeting**
**June 3, 2020**

For information or assistance, please contact Brenda Morris at (602) 417-4029 or Brenda.Morris@azahcccs.gov.

# Good morning!

**We will begin shortly. All lines have been automatically muted.**

Please mute your phone AND computer microphone to avoid feedback.

Please do not put us on hold during today's meeting.

Please hold questions until the Q & A portion of the meeting.

If you are joining via web, there are two ways to ask questions:

1. Utilizing the chat feature

2. Raise your hand to be unmuted

# Arizona AHCCCS COVID-19 RESPONSE

**COVID-19 Response Effort**

Special State Medicaid Advisory Committee Meeting
6/3/2020

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# Where do I find the latest information about COVID-19?

- AHCCCS updates the FAQ document daily to reflect the latest guidance for providers, members and plans.
- Please find guidance at: https://azahcccs.gov/AHCCCS/AboutUs/covid19FAQ.html
- These are in English and Spanish.

# COVID-19 Information

AHCCCS is responding to an outbreak of respiratory illness, called COVID-19, caused by a novel (new) coronavirus. Health officials urge good hand washing hygiene, covering coughs, and staying home if you are sick.

On March 11, Governor Doug Ducey issued a Declaration of Emergency ☐ 📄 and an Executive Order ☐ 📄 regarding the COVID-19 outbreak in Arizona, and subsequent Executive Orders ☐ with further administrative actions.

On March 17, 2020, AHCCCS submitted a request to the Centers for Medicare and Medicaid Services (CMS) to waive certain Medicaid and KidsCare requirements in order to ensure ongoing access to care over the course of the COVID-19 outbreak. As of March 23, AHCCCS has received federal approval to implement programmatic changes to help ensure access to health care for vulnerable Arizonans.

To address Medicaid-related questions from providers and contractors about COVID-19, AHCCCS has developed a list of Frequently Asked Questions Regarding Coronavirus Disease 2019 (COVID-19), updated regularly as more information becomes available.

COVID-19 FAQs

Learn how to protect yourself and stop the spread of COVID-19. Visit azdhs.gov/COVID19 ☐ and cdc.gov/COVID19 ☐.

If you are an AHCCCS member who is experiencing flu-like symptoms, please call the 24-hour Nurse Line for your health plan (listed below):

## 24-Hour Nurse Line Numbers by Health Plan

| Health Plan | Nurse Line Number |
| --- | --- |

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▼ Oversight of Health Plans

▲ Governmental Oversight

Federal and State Requirements

Legislative Sessions

Waiver ⊟

    PCH SNCP Technical Amendment

    COVID-19 Federal Emergency
    Authorities Request

    IMD Waiver Amendment

    SB 1092 Legislative Directive
    Waiver Proposal

    American Indian Initiatives

Mental Health Parity

County Acute Care Contributions

Grants

Hospital Finance & Utilization
Information

# COVID-19 Federal Emergency Authorities Request

On March 17 and March 24, 2020, the Arizona Health Care Cost Containment System (AHCCCS) submitted requests to the Administrator for the Centers for Medicare and Medicaid Services (CMS) to waive certain Medicaid and KidsCare requirements to enable the State to combat the continued spread of 2019 novel coronavirus (COVID-19). AHCCCS is seeking a broad range of emergency authorities to:

- Strengthen the provider workforce and remove barriers to care for AHCCCS members
- Enhance Medicaid services and supports for vulnerable members for the duration of the emergency period
- Remove cost sharing and other administrative requirements to support continued access to services

Arizona's request to CMS is posted below:

- Letter To CMS Administrator on COVID-19 Flexibilities (submitted March 17, 2020)
- Summary of Additional COVID-19 Flexibility Requests (submitted March 24, 2020)
- Summary of Additional COVID-19 Flexibility Requests (submitted April 17, 2020)

- Status of AHCCCS Emergency Authority Requests (updated May 27, 2020)
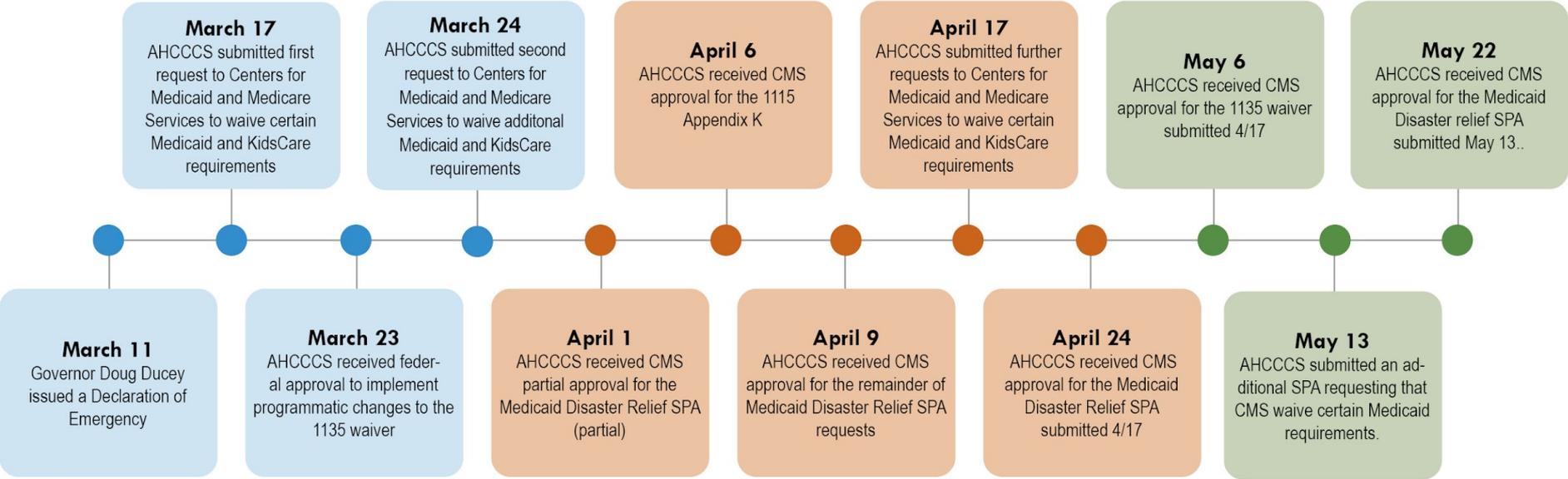
CMS approved components of Arizona's request under the 1135 Waiver, Appendix K and State Plan:

- CMS 1135 Waiver Approval Letter for COVID-19 Flexibilities (received March 23, 2020)
- CMS Medicaid Disaster Relief State Plan Amendment (SPA) Approval (received April 1, 2020)
- CMS 1115 Waiver Appendix K Approval Letter (received April 6, 2020)
- CMS 1115 Waiver Approved Appendix K Document (received April 6, 2020)
- CMS Medicaid Disaster Relief State Plan Amendment (SPA) Approval, #2 (received April 9, 2020)
- CMS CHIP Disaster Relief State Plan Amendment (SPA) Approval (received April 24, 2020)
- CMS 1135 Waiver Approval Letter for COVID-19 Flexibilities (received May 6, 2020)

The allowances from CMS grant broad authority to Arizona to tailor changes to best serve its citizens. AHCCCS will make decisions about how and when these changes will be implemented in the coming days. The agency awaits direction from CMS regarding additional requested flexibilities.

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# COVID-19 Timeline

**March 17**
AHCCCS submitted first request to Centers for Medicaid and Medicare Services to waive certain Medicaid and KidsCare requirements

**March 24**
AHCCCS submitted second request to Centers for Medicaid and Medicare Services to waive additonal Medicaid and KidsCare requirements

**April 6**
AHCCCS received CMS approval for the 1115 Appendix K

**April 17**
AHCCCS submitted further requests to Centers for Medicaid and Medicare Services to waive certain Medicaid and KidsCare requirements

**May 6**
AHCCCS received CMS approval for the 1135 waiver submitted 4/17

**May 22**
AHCCCS received CMS approval for the Medicaid Disaster relief SPA submitted May 13..

**March 11**
Governor Doug Ducey issued a Declaration of Emergency

**March 23**
AHCCCS received federal approval to implement programmatic changes to the 1135 waiver

**April 1**
AHCCCS received CMS partial approval for the Medicaid Disaster Relief SPA (partial)

**April 9**
AHCCCS received CMS approval for the remainder of Medicaid Disaster Relief SPA requests

**April 24**
AHCCCS received CMS approval for the Medicaid Disaster Relief SPA submitted 4/17

**May 13**
AHCCCS submitted an additional SPA requesting that CMS waive certain Medicaid requirements.

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# Key Flexibilities Offered During the Public Health Emergency

- Streamline provider enrollment
- Amend prior and continued authorization processes
- Suspend PASRR assessments (pre-admission and annual resident review)
- Provide continuous eligibility
- Waive premiums and copays
- Coverage for COVID testing
- Expand respite limit
- Electronic method for services (telehealth and telephonic)
  **For a complete list see the table on the AHCCCS website

# AHCCCS Financial Relief

**Payments made April 13, 2020**
Offered $5.3 million in additional payments to Critical Access Hospitals (CAHs)

Advanced supplemental payments to three hard-hit NFs facilities by one month.

**Payments made mid-to-late April 2020**
Made $6 million in additional supplemental payments to Nursing Facilities (NFs).

**Payments to begin in May 2020**
Initiated the provision of retention payments to ALTCS providers who serve individuals who are elderly or have physical disabilities and offer attendant care and/or personal care services. Process initiated in April 2020.

**Payments made early-May 2020**
Advanced over $41M in scheduled payments to Targeted Investments Program providers, including hospitals, primary care, behavioral health outpatient and justice clinic providers.

**Payments in mid-May 2020**
Accelerated $50 million in payments to hospitals which participated in the Graduate Medical Education program in 2019.

**April 2020**

**May 2020**

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# Staying Connected with Stakeholders

- Arizona Council of Human Service Providers - every two weeks
- Tribal Consultation - every two weeks
- MCO meeting - weekly
- Smaller MCO Provider Viability Meeting - weekly
- State Medicaid Advisory Committee - monthly
- OIFA Advisory Council - monthly
- Telehealth Webinars - as needed
- Behavioral Health Taskforce - weekly
- Homeless Strategies - weekly
- MCO CMOs - weekly
- ADHS - Modelling Workgroup - weekly

# Next Steps

- Defining which flexibilities we want to maintain
  - Currently receiving recommendations specific to telehealth and telephonic services
- Ongoing conversation with CMS regarding retainer payments
- Ongoing conversation with CMS regarding AHCCCS' overarching 1115 waiver
- Continuing open dialogue with our stakeholders
- Assessing timelines moving forward

APEP go live 8/31/2020

EVV go live 1/1/2021

CMDP go live no later than 4/1/2021

2020

2021
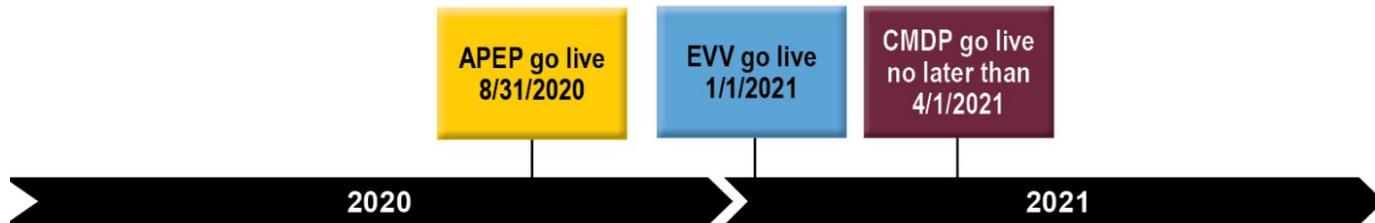
# Arizona's 1115 Waiver Renewal
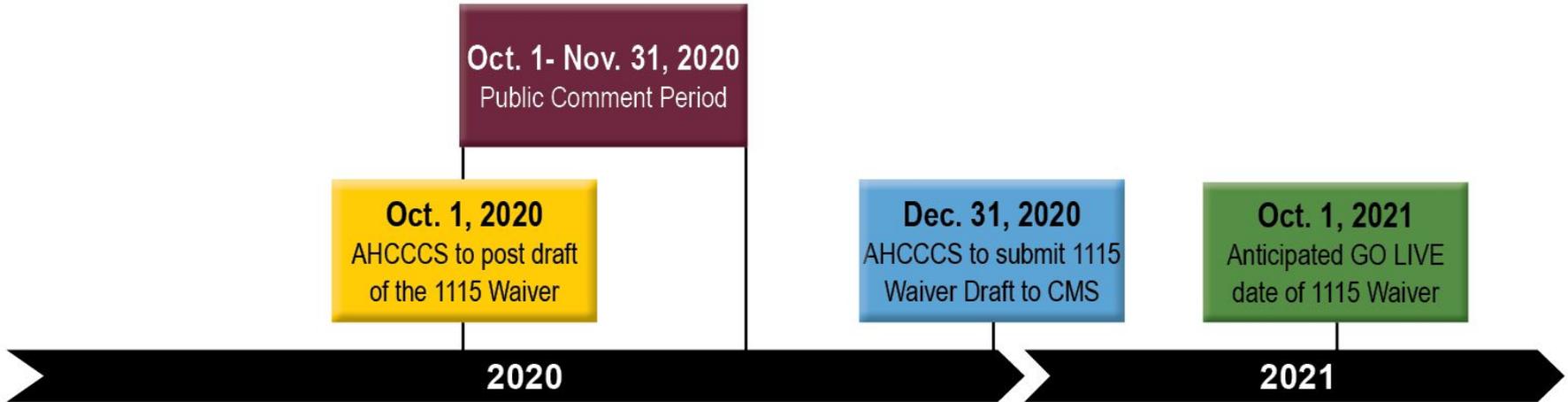
# AHCCCS Enrollment and Application Trends

Enrollment Growth 07/2019 - 6/2020

# Applications Submitted

| | WE 2/8 | WE 2/15 | WE 2/22 | WE 2/29 | WE 3/7 | WE 3/14 | WE 3/21 | WE 3/28 | WE 4/4 | WE 4/11 | WE 4/18 | WE 4/25 | WE 5/2 | WE 5/9 | WE 5/16 | WE 5/23 | WE 5/31 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Applications | 21,885 | 19,193 | 17,039 | 17,567 | 19,840 | 18,930 | 18,201 | 19,899 | 21,288 | 18,268 | 16,792 | 15,474 | 15,345 | 14,865 | 14,754 | 13,479 | 12,752 |

12,752

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# Legislative Update

# Session Summary

- Total Bills: 1607

- Bills Signed into Law: 58 (31 awaiting action as of 6/1)

- Adjourned Sine Die: 5/26/20

- General Effective Date: 8/25/20

- Biggest disparity in bills introduced to bills signed into law in state history

- Special Session likely to occur this summer

# AHCCCS Related Bills

- HB 2244- Requires AHCCCS to request CMS approval for the provision of dental services beyond current service limitations when provided at IHS/638 facilities which are eligible for 100% FMAP

- HB 2668- Establishes a new hospital assessment which can be used to create a hospital directed payment program, increase practitioner and dental rates, and pay for administrative expenses

- SB 1523-The Mental Health Omnibus bill requires commercial insurers to report on mental health parity, establishes funding to pay for BH services in schools for uninsured/underinsured children, and creates the suicide mortality review team at ADHS

# Budget

- AHCCCS was funded at the JLBC baseline (approx. $14B TF)
- $8 million was appropriated for BH in Schools funding for uninsured/underinsured children in the Mental Health Omnibus
- AHCCCS was provided flexibility to offer retainer payments to BH and DD providers from existing appropriation

# Resources

# AHCCCS COVID-19

- AHCCCS COVID-19 Information: https://azahcccs.gov/AHCCCS/AboutUs/covid19.html
- AHCCCS FAQs Regarding COVID-19: https://azahcccs.gov/AHCCCS/AboutUs/covid19FAQ.html
- AHCCCS Federal Authorities Request: https://www.azahcccs.gov/Resources/Federal/PendingWaivers/1135.html

# SMAC Subcommittee Presentation on Telehealth and Telephonic

## Subcommittee Members:

Peggy Stemmler

Tara Plese

Ginny Rountree

Daniel Haley

Arjie Gomez

John Hogeboom

Marcus Johnson - Spokesperson

All statements submitted by the subcommittee were combined in their entirety for this presentation.  While the presentation will not get to each point, the individual suggestions provided by each subcommittee member will be sent to AHCCCS Clinical Leadership for review.
AHCCCS will reach out to the subcommittee if any follow up or clarification is needed upon review.



Each category has a slide highlighting the main points with the full detail behind each highlight slide.

# Highlighted Points:

**Benefits of Utilizing Telephonic and Telehealth Services in the Community**

Increased Access to Care

Decreased Barriers to Care

Network Adequacy

Safety of Staff & Patient

Decreased Administrative Burden

# Benefits of Utilizing Telephonic and Telehealth Services in the Community

❖ Increased access to services, especially when transportation is a problem (including urban areas).

❖ Improved monitoring of chronic health conditions (e.g. CHF).

❖ Improved emphasis on the history part of exam, less on running tests.

❖ Reducing patients' barriers to care including:
Lack of transportation, work schedules that make it difficult to schedule an appointment, reducing long wait times to see a provider or more that one provider during a visit, reluctance to see a behavioral health provider during a primary care visit.  We believed correctly that clients would keep their appointments at a better rate.

❖ We also believed our families would better receive services when they could set the schedule with the staff member at evening or early morning times.

❖ Reducing providers' barriers to providing care:
Ability to provide services to a patient from distant locations, improving workflow between multiple providers (in an integrated system), reducing the chances of a patient not following through with a higher level of care, especially for behavioral health services, ability to rapidly follow up with the patient telephonically or through a telehealth visit, providing flexibility that can improve patient engagement in their healthcare treatment.

❖ Increased access to services resulting in increased utilization of medically necessary services.

❖ A strategy that may be employed by Managed Care Organizations to address specific network gaps.

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# Benefits of Utilizing Telephonic and Telehealth, CONT.

❖ Reinforces the use of existing codes and encourage patients who are medically vulnerable not to put themselves at risk in order not to miss an appointment.

❖ BH and Psychiatric assessments or appointments over the phone for those who do not have access to needed technology for telehealth widens availability of services to those who may not have had previous access.

❖ Widens opportunities for engagement of patients who are traditionally treatment resistant and provides an environment that may be less invasive to deliver treatment services.

❖ Presents opportunity for those who have no access to immediate transportation and limits administrative burden of arranging transport and transportation costs to AHCCCS.

❖ Creates true "No Wrong Door" by having availability of all services through the use of telehealth.

❖ Provides a less invasive approach to doing home visits and provides additional protections to staff.

❖ Maximization of resources that ultimately results in more services delivered to the patient rather than solely relying on traditional brick and mortar facilities.

❖ Our parent education program is in one hour increments and is being delivered at 6:00 am and 9:00 pm and are full.

# Highlighted Points:

## Realized Benefits to Date

Better Care Utilization

Fewer No-Shows

Patient-Provider Relations

More Patients Served

Private Conversations in Group Settings

# Realized Benefits to Date

❖ Increased utilization of services, with overall easier access to treatment (medical and behavioral) across the board.

❖ PT/OT report better home maintenance of therapy plan when using tele therapies for children.

❖ Home visitors report that parents are better ability to pay attention to the virtual visit when they don't have to also monitor the child (others can monitor the child).

❖ A significant decrease in no-show appointments (some health centers report 5-0% no-show since implementing telephonic and telehealth visits.

❖ Strengthening outreach to the patient and increased patient's outreach to the provider.

❖ Greater commitment to provider's recommendation for resolving a health problem or for ongoing BH visits.

❖ Overall, health centers report that their patients have had a very positive response to both telephonic and telehealth visits.

❖ For therapy services (within the DDD network), individual therapists/ staff can see more members as a result of no travel

❖ Therapy vendors report more parent involvement, more carry over in home programs

# Realized Benefits to Date, CONT.

❖ Follow up and/or routine appointments have increased due to ease of access of both the patient and the practitioner/clinician.

❖ No show rates for appointments has gone down significantly and follow up engagements have increased.

❖ Have maximized existing workforce to meet demand regardless of where the patient is at in the state.

❖ Increased access in rural and tribal areas to patients who would not have previously had treatment services available.

❖ In group setting has created an environment where patients can privately ask questions that may not have been previously asked if in a traditional group setting.  This has been most evident in adolescent groups.

❖ Has increased access to group, individual counseling, practitioner services and case management for those who have difficult works schedules, child care issues, and/or consistent transportation issues.

# Show Rate Data

| Service Type | Show Rate (Last Week) | Show Rate (Two Weeks Ago) |
|---|---|---|
| Psychiatric Appointments | 76% | 70% |
| Wellness Coaching | 84% | 86% |
| Intensive Outpatient SUD Program | 54% | 61% |
| Intake Appointments | 78% | 81% |

The data referenced above was provided by Argie Gomez.

# Highlighted Points:

## Current Contribution to Healthcare and the Community

Maintains Patient-Provider Relationships

Assures Safety

Improved Rural Outreach

Group Behavioral Health

Care Utilization and Follow-Up

Flexible After-Hours Options

# Current Contribution to Healthcare and the Community

- ❖ Ability to maintain some connection with healthcare providers during need for physical distancing and lack of ability to protect providers/patients (very limited PPE).

- ❖ Improves safety measures for everyone and allows access to care while social distancing.

- ❖ Ability to reach patients in rural areas.

- ❖ Ability to continue group BH meeting via telehealth platforms.

- ❖ More reliable, familiar (for the patient) connections to patients like text messages, virtual telehealth visits.

- ❖ Providers have had more frequent contact with patients for shorter periods of time during the COVID-19 crisis.

- ❖ Allowed for necessary social distancing and quarantine while still providing access to medically necessary services.

# Current Contribution to Healthcare and the Community, CONT.

❖ Has increased the use of therapeutic interventions and follow up rates due to the ease of access to both the patient and the clinician/practitioner.

❖ Have seen an increase in access of new and follow up services because of added availability and ease of access

❖ Allows more flexibility in after hours coverage.

❖ Has allowed us, and others, to provide services to individuals who would not have engaged in services due to transportation, distance, illness, work schedule, and child care issues.

❖ Allowed for the provision of critically important BH services especially during the pandemic.

❖ Effects are still emerging

# Highlighted Points:

**Future Contribution to Healthcare and the Community post Covid-19**

Efficiencies via "Light Touch" Appts

Improved Communications

Increased Access to Care

Improved Attendance

Decreased Wait Times

Fewer Geographic Limitations

Decreased Provider Shortages

Decreased ER Visits

Cost Savings – Safety

# Future Contribution to Healthcare and the Community post Covid-19

❖ Increased efficiency of 'light touch' appointments for both patients and providers.
❖ Some individuals interact more easily in virtual environment (personal communication, MH/BH providers, adolescent services.
❖ Improved access to specialty services when distance is limiting factor.
❖ May allow for a higher attendance rate if meeting attendees are allowed to telecommute for half of the annual meetings.
❖ Health Centers predict that telehealth and telephonic visits will continue to be a viable and vital tool in patient care. The advantage of telehealth visits includes timely care and improved continuity of care for the patient. Shorter wait times for an appointment. Continued care when the patient is out of town and needs to connect with their trusted provider.
❖ Telehealth and telephonic services help mitigate the provider shortage. There is still a need for more providers, especially behavioral health providers, but telehealth can help fill the gap even temporarily.
❖ Possible reduction in minor children NEMT concerns if the service is available via telehealth.Potential decrease in emergency room or urgent care use for behavioral health or medical crisis.

# Future Contribution to Healthcare and the Community post Covid-19, CONT.

❖ Long term cost savings specifically in transportation and missed appointments.

❖ Increased productivity and utilization of existing resources by having the ability to treat the person where they are at regardless of where they are at.

❖ Has the ability to increase staff safety specifically in-home visits.

❖ Increase ability to change the way we currently provide assistance in the self-administration of medication.

❖ Will change the way we currently deliver healthcare because services will be based on what the patient needs because the agency, theoretically, would have the ability to coordinate specialty care in live time.

❖ Creates a virtual workforce that would expand the availability of treatment services.

❖ Consultations would be less burdensome to patients and perhaps facilitated in a more timely manner.

❖ Prevention of potential spread of virus.

❖ Could reduce wait times and increase access of individuals to their PCP and BH Med Practitioner which could reduce more costly treatment later.

❖ Reaching clients who have been stressed with their own loss of work, family illness, has been bridged with telehealth. I believe we will have resistance from families if this does not remain an option.

# Highlighted Points:

## Current or Potential Barriers

Isn't a Panacea

Low Payments

Health Plan Variation

Provider Resistance

Connectivity and Access to Tech

Potential Lack of Active Engagement During Meetings

Cell Phone Data Limits

Physical Signature Requirements

Multi-site Licensure Requirements

Code Modifiers=Burdensome

Training and Set-Up Costs

# Current or Potential Barriers

❖ Access to connectivity and technology and navigation of the technology.

❖ Sometimes, you just have to touch.

❖ Low payments are a barrier to uptake.

❖ Variation in implementation among various insurers (commercial) impact provider willingness to navigate the challenges.

❖ Habits are hard to break - the ability and desire to offer and use such modalities will likely build over time.

❖ During telephonic meetings some meeting attendees may be less engaged in the actual meeting.

❖ The lack of broadband capacity in remote, rural areas. Spotty connectivity.

❖ Patients who have phone contracts with limited data and minutes may not want to use it for telephonic visits.

❖ Patients' not having a computer or IPad to enable them to participate in a telehealth visit.

❖ Ability to instruct patients on how to conduct a telehealth visit, especially older patients

❖ Reluctance of older patients to use telehealth (although providers report that they are seeing less of that they anticipated).

❖ Some members may not be appropriate for telehealth

# Current or Potential Barriers, CONT.

❖ Anything (treatment plans, releases of information, AHCCCS applications, etc.) requiring a signature provides a potential block.  Not all EMRs have remote signature capabilities and has the potential to be a barrier.  Would recommend reviewing all current documents and having a conversation about what could continue to have verbal consent and/or alternative signature options.

❖ Licensure requirements for scheduling when practitioners and/or clinicians are remote and being assigned cases across multiple sites.

❖ Health plans having different requirements and not having standards requirements across all health plans.

❖ The DEA and SAMHSA are potential barriers in the delivery of MAT services once/if they place previous restrictions back on inductions.  This practice has been a barrier to people getting services.

❖ Complex use of modifiers can quickly become an administrative burden.

❖ Members' lack of devices/internet

❖ Provider staff training, member training and set-up costs for providers.

# Highlighted Points:

Concerns about Negative Outcomes

Diminishing Returns post-Honeymoon Phase

Effectiveness vs In-Person

Inability to View Social Cues

Desirability of Some Communities

Unhappy NEMT Providers

Telephonic Fraud/Abuse Risks

Telephonic Lowers the Bar

Ensure In-Person Services are Available

Determine Frequency of Televisits Permitted

# Concerns about Negative Outcomes

❖ The positive impacts that are described by some (e.g. therapists) may tail off once the honeymoon period is over

❖ Personal relationships are a strong driver of behavior change - can they be firmly established in a virtual environment?

❖ Differential (lower) payments for a telehealth visit that may take as much, if not more, time could make on-going uptake of telehealth visits non-viable

❖ For child abuse and domestic violence identification, virtual visits will likely miss out on identification - lack of revealed visual cues

❖ The overreliance on telephonic means takes away from the quality of the meetings. This is what face-to-face meetings bring to the table.

❖ Not hearing anything from our providers about negative outcomes. Some of the older providers are more reluctant to use telehealth, but have become increasingly more amenable to using telehealth services.

❖ Risk that telehealth may be used when face to face service is indicated; must conduct full assessment of appropriate codes and services for telehealth & telephonic strategies

❖ Potential for concerns to be voiced by NEMT providers due to decrease in NEMT utilization

# Concerns about Negative Outcomes, CONT.

❖ There is a risk providing an episode of care without actually seeing the person face to face. There is a potential loss in the ability to establish a clinical relationship that is needed to provide quality care.

❖ More risk for fraud and abuse with telephonic than with telehealth. Most systems used for telehealth have reporting and history for all meetings whereas phone calls, other than text messaging, do not.

❖ There is the potential risk for misdiagnosis when you are unable to see the patient and only listening to answers rather than seeing their behavior. Telehealth doesn't have this same risk.

❖ Has the potential to become the "easier softer way" of delivering services. Not as expensive as telehealth and given the choice I am concerned that some would not make the best choice for the patient and quality of care needed. I do not have the same concern of telehealth.

❖ This isn't for everyone and there needs to be choice. Very difficult to regulate how this would be done and should be done through agency policy. For example, if in an urban setting, there could be an in person appointment per quarter for those who have chosen telehealth. Frequency would be determined by need defined by the patient and attending clinician/practitioner. For the person who isn't comfortable receiving services this way the agency should either have in person services available or have a referral source.

❖ Not having this telehealth option for at least for another year will bring chaos to families who will be striving to bring some normality to their homes.

# Summarized Highlights from Presentation

**Benefits:**
- Increased Access to Care – Decreased Barriers to Care – Network Adequacy – Safety of Staff & Patient – Decreased Administrative Burden

**Realized Benefits to Date:**
- Better Care Utilization – Fewer No-Shows – Patient-Provider Relations – More Patients Served – Private Conversations in Group Settings

**Current Contributions:**
- Maintains Patient-Provider Relationships – Assures Safety – Improved Rural Outreach – Group Behavioral Health – Care Utilization and Follow-Up – Flexible After-Hours Options

**Future Contributions:**

● Efficiencies via "Light Touch" Appts – Improved Communications – Increased Access to Care – Improved Attendance – Decreased Wait Times – Fewer Geographic Limitations – Decreased Provider Shortages – Decreased ER Visits – Cost Savings – Safety

**Barriers:**

● Connectivity and Access to Tech – Isn't a Panacea – Low Payments – Health Plan Variation – Provider Resistance – Potential Lack of Active Engagement During Meetings – Cell Phone Data Limits – Physical Signature Requirements – Multi-site Licensure Requirements – Code Modifiers=Burdensome – Training and Set-Up Costs

**Concerns**

● Diminishing Returns post-Honeymoon Phase – Effectiveness vs In-Person – Inability to View Social Cues – Desirability of Some Communities – Unhappy NEMT Providers – Telephonic Fraud/Abuse Risks – Telephonic Lowers the Bar – Ensure In-Person Services are Available – Determine Frequency of Televisits Permitted

# Committee Discussion

**Please take the survey.** Surveys help us better tailor meetings to your needs.