Telehealth Advisory Committee Meeting

May 21, 2026

Facilitator:
Dr. Roger Willcox (AHCCCS)

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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Agenda

- Welcome, Reminder of Committee Purpose, & Introductions
- CMS Telehealth Updates
- AHCCCS Telehealth Updates
- AHCCCS Telehealth Utilization Trends
- CPT Code 92609
- Open Forum

Purpose of the TAC

- Created by House Bill 2454 in 2021 to:
  - Identify best practices for the provision of telehealth services
  - Monitor the number and type of out-of-state health care providers who have applied for interstate telehealth registration and the number and type whose registration has been approved
- As of 1/1/2022, the TAC shall identify which audio-only telehealth services must be covered by commercial insurers in the state
  - Have maintained alignment with AHCCCS' telehealth codeset
- Expected to meet at least annually with quorum
- TAC to be terminated on 7/1/2029

Unfilled Roles on the TAC

- Four unfilled positions:
  - Naturopathic Physician
  - Licensed Healthcare Professional Specializing in Treating Industrial Injuries
  - Licensed Healthcare Professional Specializing in Treating Those With Developmental Disabilities
  - Psychologist
- For interested individuals: reach out to the Office of Executive Appointments that makes these appointments at bc@az.gov

Introductions

- Name, organization, where you are located

CMS Telehealth Updates
Key Federal Telehealth Events Since November 2025

- Expiration of Medicare Telehealth Flexibilities
  - On October 1, 2025, many Medicare telehealth flexibilities expired amid a 43-day federal government shutdown causing nationwide coverage disruption.
- Temporary Reinstatement in November 2025
  - Congress passed a continuing appropriations measure reinstating telehealth flexibilities temporarily through January 30, 2026, restoring access briefly.
- Longer Extension in February 2026
  - The Consolidated Appropriations Act extended telehealth flexibilities through December 31, 2027, shifting from short-term fixes to longer-term stability.
- Policy Volatility and Planning
  - Frequent legislative changes create policy volatility, requiring providers and states to plan based on legislative deadlines, not permanence.

Medicare Telehealth Changes Do Not Impact Medicaid

- Even when, on October 1, 2025, many COVID-era telehealth flexibilities for Medicare expired. These changes did not impact Medicaid. We recognized that telehealth is an important option for accessing care, and AHCCCS coverage of telehealth services did not change.

- Members who were dually enrolled in Medicare and AHCCCS remained eligible for telehealth services reimbursed by AHCCCS (even when services were no longer covered by Medicare), as long as services comply with AHCCCS telehealth coverage policies

Medicare Telehealth Flexibilities Extended Through 2027

- Extension of Telehealth Policies
  - Medicare telehealth flexibilities extended through December 2027, preserving expanded access from the pandemic period.
- Access Without Geographic Limits
  - Patients can receive telehealth services from home with no geographic restrictions, benefiting rural and urban populations alike.
- Audio-Only Telehealth Services
  - Audio-only telehealth remains allowed, helping patients lacking video-capable devices or reliable broadband access.
- Expanded Provider Types
  - Multiple provider types including therapists and audiologists remain eligible

Federal Telehealth “Cliffs”

The Consolidated Appropriations Act extended telehealth flexibilities through December 31, 2027, shifting from short-term fixes to longer-term stability.

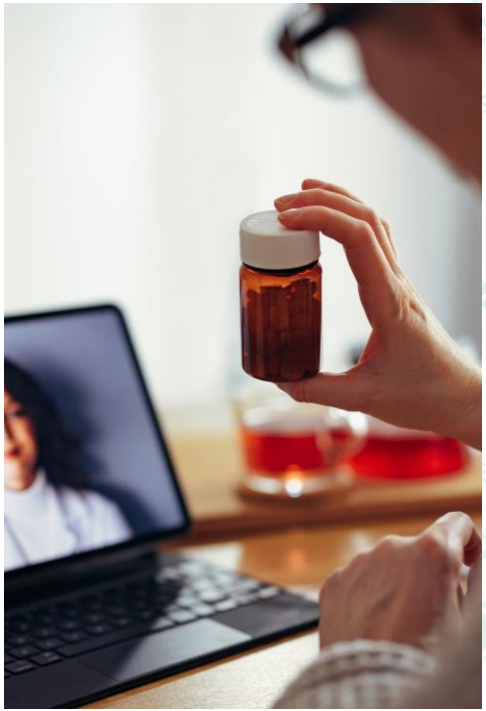
Impact on Medicare Telehealth. Expiration reinstates geographic limits, removes home-based telehealth, restricts audio-only services, and narrows eligible providers.

Consequences for Patients and Providers. Telehealth expirations disrupt care continuity, cause administrative confusion, and force sudden workflow changes for providers and patients.

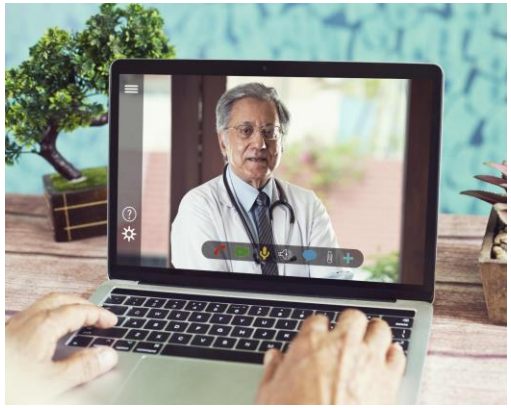
DEA issued a temporary extension allowing telehealth prescribing of Schedule II–V controlled substances through 2026.

Controlled-Substance Prescribing via Telehealth

- DEA Telehealth Prescribing Extension
  - DEA issued a temporary extension allowing telehealth prescribing of Schedule II–V controlled substances through 2026.
- Telehealth Modalities Permitted
  - Audio-video encounters are broadly allowed, with audio-only options for opioid use disorder treatments like buprenorphine.
- Policy Impact and Expiration
  - DEA telehealth prescribing flexibility ends in 2026, earlier than Medicare's 2027 extension, requiring careful planning.
- Future Regulatory Framework
  - DEA aims to establish permanent regulations, including special registrations, but no final rules yet exist.



Signals from 2026 Federal Telehealth Policy



- Normalization of Telehealth
  - Federal policies in 2026 indicate telehealth is becoming a standard part of healthcare delivery.
- Expansion of Remote Monitoring
  - Remote patient and therapeutic monitoring continue to expand with improved billing codes reflecting real care.
- Behavioral Health Support
  - Sustained federal support focuses on telehealth for behavioral health due to improved access benefits.
- Policy Caution and Oversight
  - Federal policies favor time-limited telehealth flexibilities allowing oversight, balancing innovation with cost control

AHCCCS Telehealth Updates

Financial Impact, Utilization Trends, and Policy Tradeoffs

- Telehealth Expenditure Overview
  - Annual telehealth spending ranges between $45 million and $50 million, representing a significant manageable cost.
- Utilization and Coding Shift
  - Post-January 2025, telehealth visits shifted from legacy codes to new telehealth-specific codes, showing provider compliance.
- Savings and Consequences
  - Proposed rate reductions could save $8-$9.5 million annually but may impact provider participation and patient access.
- Policy Tradeoffs and Future Monitoring
  - AHCCCS prioritizes care continuity and member access over immediate savings while monitoring future reimbursement adjustments.

Telehealth Policy Financial Overview

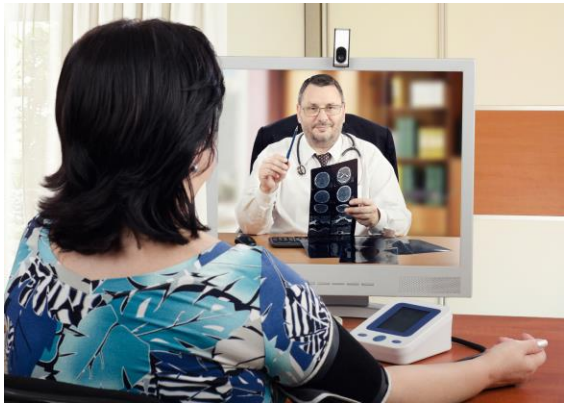
Telehealth Policy Overview

- **Recommendation:** Continue **payment parity** for telehealth A/V (98000–98007) and in-person E/M (992xx) codes for **CYE 2027**.
- **Fiscal Impact: Budget neutral**
- **Context:**
  - CMS introduced new telehealth codes in 2025 with **lower RVUs → lower reimbursement**
  - AHCCCS initially attempted reduced rates, but **providers strongly opposed**
- **Current Policy:**
  - **A/V telehealth = same rate as in-person**
  - **Audio-only codes remain lower-paid**
- **Rationale:** Maintain **access, provider stability, and continuity of care**

Financial & Utilization Considerations

- **Utilization Trend:** Majority of telehealth volume shifted to **new 980xx A/V codes**
- **Annual Spend:** ~**$45M–$50M** total telehealth expenditures.docx&action=default&mobileredirect=true)
- **If CMS-aligned rate cuts applied:**
  - Avg. reduction: **~19%**.
  - Estimated savings: **$8M–$9.5M total funds annually**
- **Tradeoff:**
  - **Cost savings vs. access/provider impact**
- **AHCCCS Position:**
  - Defer savings to **avoid disruption**
  - Continue monitoring for **future policy changes**

Medicare vs AHCCCS: Understanding POS 02, POS 10, and Originating Site Rules



- Medicare POS Codes
  - Medicare uses POS 02 and POS 10 to identify telehealth services at non-home and home locations respectively, signaling telehealth usage.
- AHCCCS Originating Site Rules
  - AHCCCS requires POS codes to reflect the patient's actual physical location, not telehealth delivery, using modifiers for service type.
- Billing Best Practices
  - Providers should determine patient's physical location first, then apply service delivery modifiers to ensure compliance and reduce denials.

Recommended Telehealth Best Practice Guidelines

- General Guidelines
- Behavioral Health
- Maternal Health Services
- Burn and Intensive Care
- Dermatology
- Neurology
- Nursing
- Ophthalmology
- Pediatrics
- Rehabilitation

Please send any questions to telehealth@azahcccs.gov

Best Practices - Asynchronous Communication

- Definition of Asynchronous Care
  - Asynchronous care transmits recorded clinical data for later review without real-time patient-clinician interaction.
- Strategic Benefits
  - Improves healthcare access and efficiency by enabling flexible review times and extending specialty expertise.
- Clinical Best Practices
  - Effective asynchronous care requires clear clinical purpose, documentation, and meaningful contribution to care planning.
- Future Positioning
  - In 2026, asynchronous telehealth should be a formal care pathway aligned with policy and proper workflows.

Key Asynchronous Use Cases in 2026: RPM, RTM, and Specialty Consults

Remote Patient Monitoring (RPM)

RPM collects and reviews physiologic data like blood pressure and heart rate for chronic disease management.

Remote Therapeutic Monitoring (RTM)

RTM tracks non-physiologic data such as therapy response, medication adherence, and functional status.

Store-and-Forward Specialty Consults

Specialty consults use store-and-forward methods for expert review of dermatology images or behavioral health records.

Billing, Documentation, and Compliance Best Practices for AHCCCS Asynchronous Care

- Accurate Billing Practices
  - Use appropriate modifiers like GQ and list services on approved telehealth code sets. Ensure correct Place of Service is recorded.
- Thorough Documentation
  - Document informed consent, data reviewed, clinical interpretation, and impact on diagnosis and treatment decisions.
- Compliance Risk Prevention
  - Avoid billing for administrative tasks. Only bill asynchronous codes with documented clinical review directly informing patient care.
- Embedding Best Practices
  - Implement provider education, standardized templates, and internal audits to maintain compliance and sustainability in asynchronous care.

Audio-Only Telehealth Coverage

Billing, Documentation, and Compliance Best Practices

Billing

Use appropriate E/M or audio-only CPT codes
Align coding with service and payer requirements

Documentation

Document why audio-only was necessary
Include clinical decision-making, not just conversation
Document informed consent

Best Practice

Audio-only is an access safety net, not a default care model
Every service must show clear clinical value

Audio Only Definition

Clinical services delivered via telephone without video
No visual interaction; relies on verbal clinical assessment

Strategic Role

Expands access when technology barriers exist
Supports continuity of care when video is not feasible

Best Practice

Use audio-only only when clinically appropriate and other modalities are not feasible

AHCCCS Telehealth Policy Stability and Refinement

- Policy Stability Since 2025
  - Arizona's telehealth policies under AHCCCS have remained stable with no major coverage reversals since late 2025.
- Comprehensive Telehealth Coverage
  - AHCCCS covers various telehealth modalities including video visits, audio-only calls, remote monitoring, and teledentistry.
- Coding and Billing Refinements
  - Recent updates introduced new CPT and ICD-10 codes to improve accuracy and compliance without restricting access.
- Focus on Best Practices
  - Policy stability allows focus on best practices, utilization trends, and quality oversight rather than emergency responses.

Review of AHCCCS Telehealth Utilization Trends

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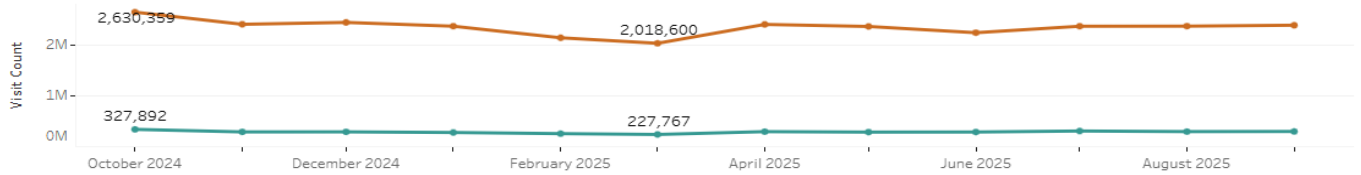
AHCCCS Telehealth | Utilization

Services provided through October 2025 and data updated on the 15th of each month.

Visits		Amount Paid		Average Cost Per Visit	
from Oct 2024 - Sep 2025 (*for selected population*)		from Oct 2024 - Sep 2025 (*for selected population*)		from Oct 2024 - Sep 2025 (*for selected population*)	
Telehealth	In-Person	Telehealth	In-Person	Telehealth	In-Person
3,324,126	27,998,147	$344M	$3,903M	$104	$139

Metric: Visits | Reporting Start Date: October 2024 | Reporting End Date: September 2025 | Select a Filter: Line of Business | Line of Business: All

Telehealth vs In-Person Visits Over Time



Percent of Telehealth vs In-Person Visits by Month

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AHCCCS Telehealth | Demographic Comparison

Services provided through October 2025 and data updated on the 15th of each month.

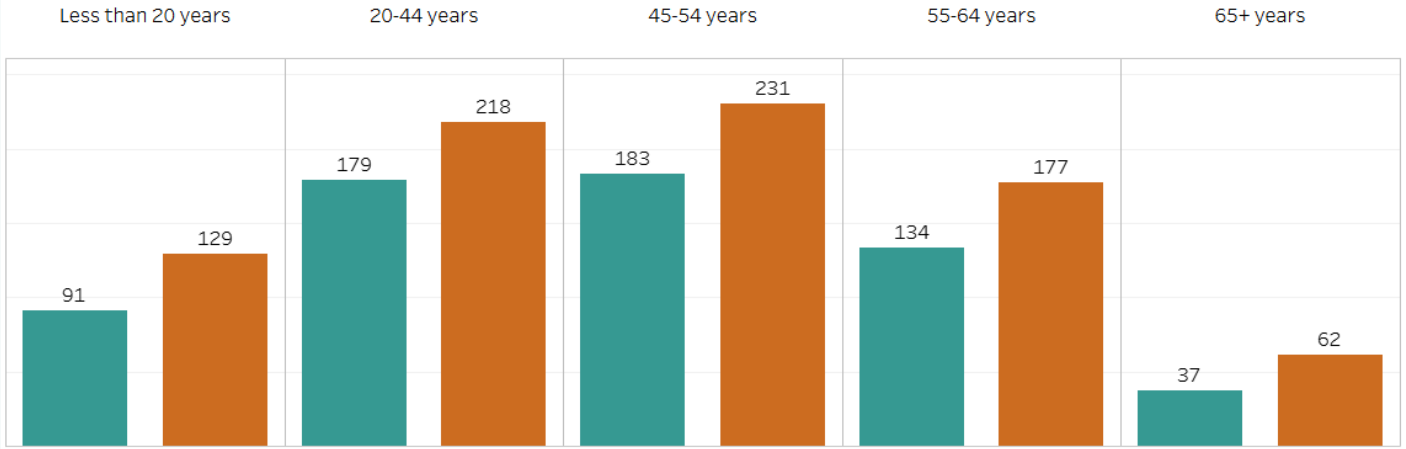
ACC
Telehealth Visits per 1,000 Member Months
from September 2025 - September 2025
124

AHCCCS Total
Telehealth Visits per 1,000 Member Months
from September 2025 - September 2025
163

Metric	Demographic Category	Line of Business	Reporting Start Date	Reporting End Date
Telehealth Visits per 1,000 Member Months	ADHS Age Group	ACC	October 2024	September 2025

Line of Business - ACC & AHCCCS Total Telehealth Visits per 1,000 Member Months by ADHS Age Group

Select a Metric, Demographic Category, and Line of Business to switch visualization display.



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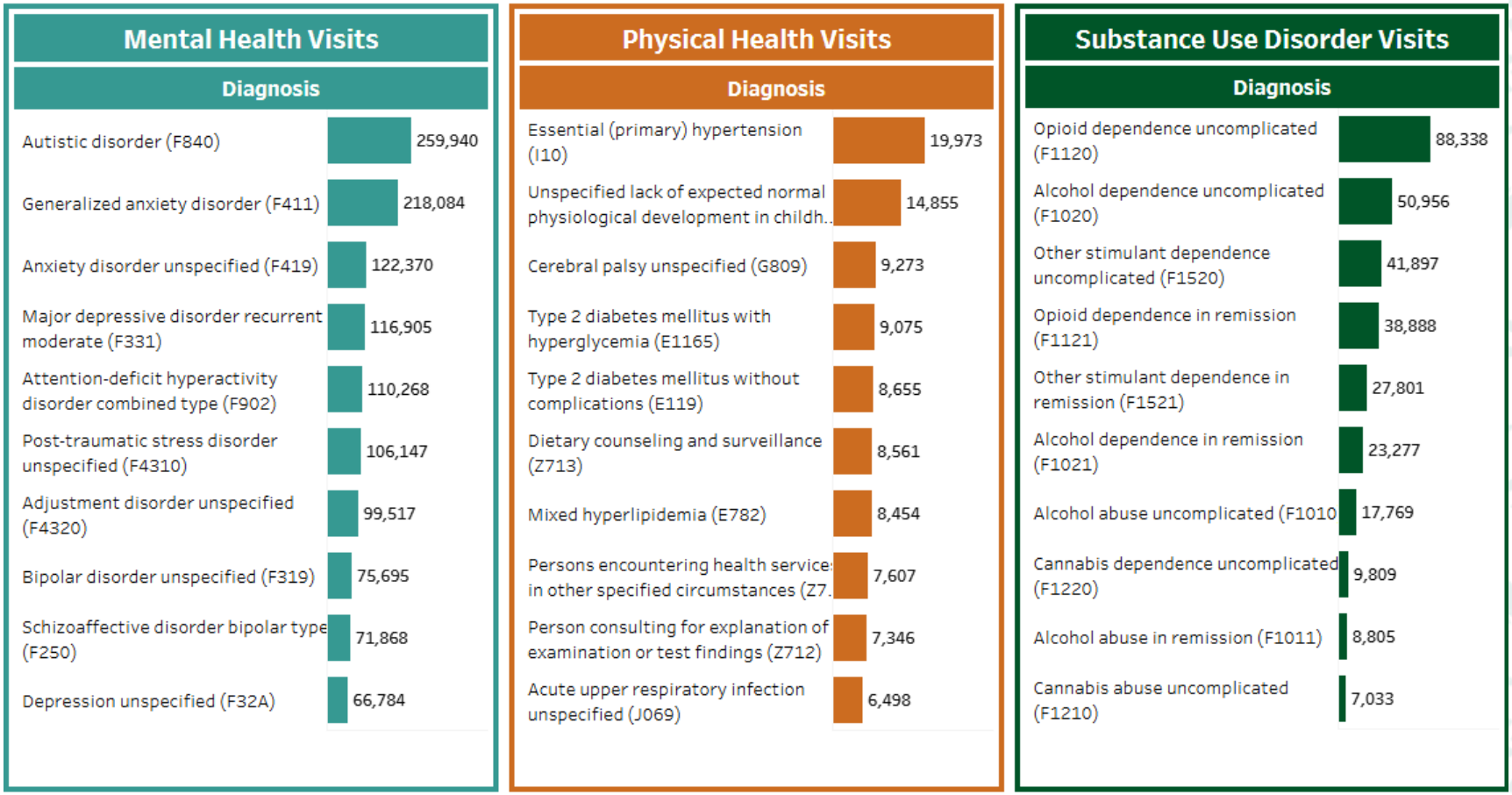
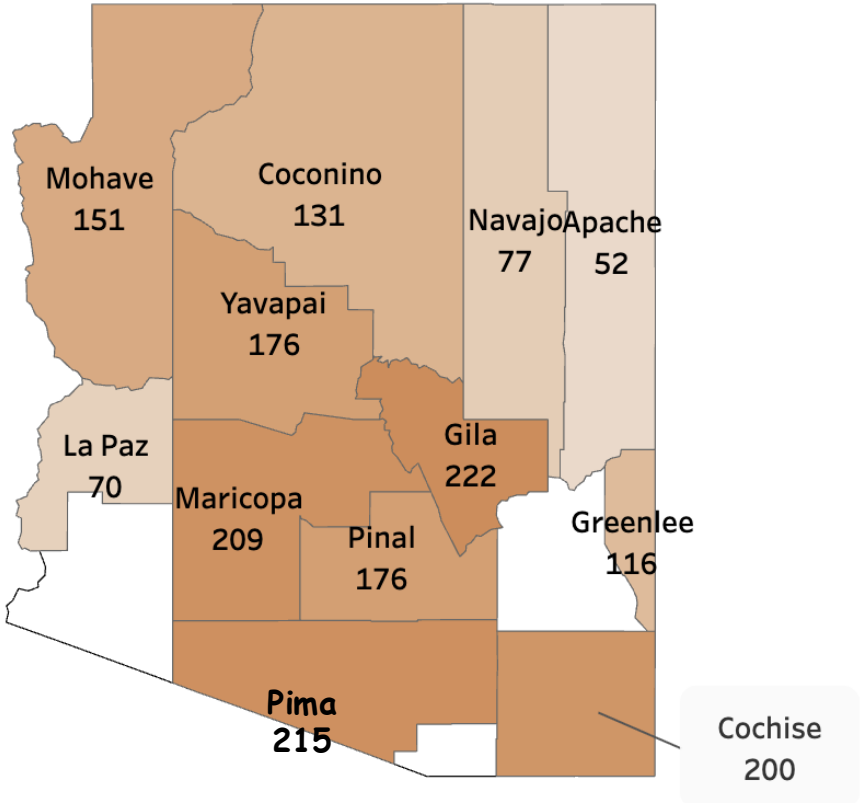
Top 10 Primary Diagnoses for Telehealth Visits

from October 2024 - September 2025



AHCCCS Total Telehealth Visits per 1,000 Member Months by **Member County**

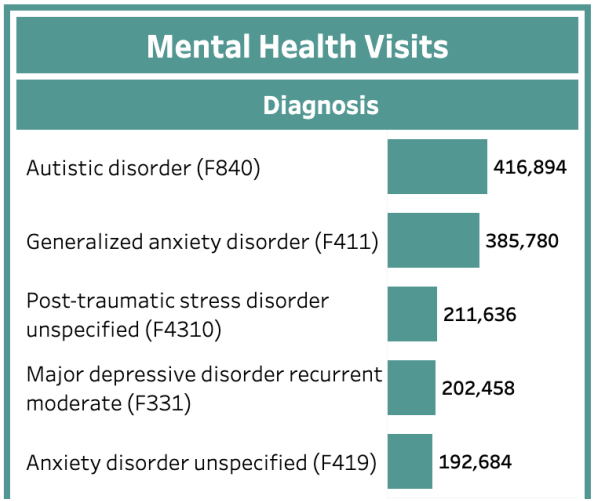
Select a Metric, Demographic Category, and Line of Business to switch visualization display.

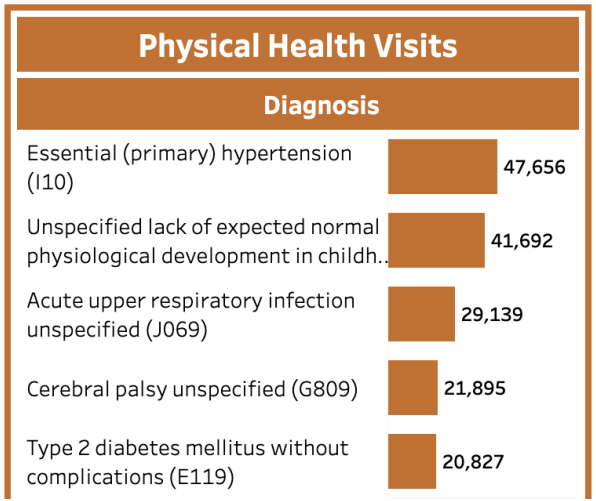


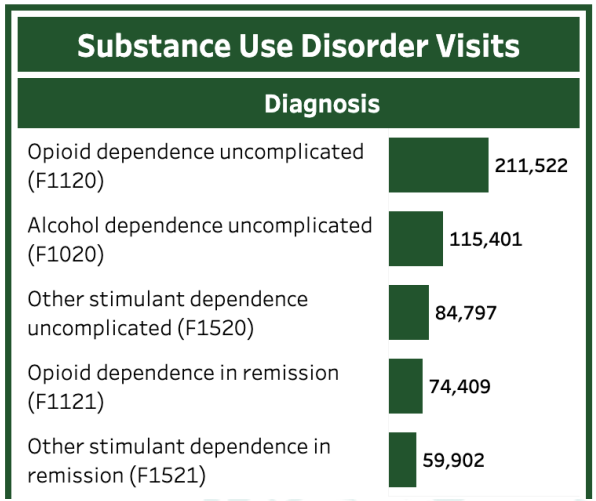
Notes: Numbers too small in Yuma, Santa Cruz, and Graham counties to display.

Data from Oct 2022-Sept 2024

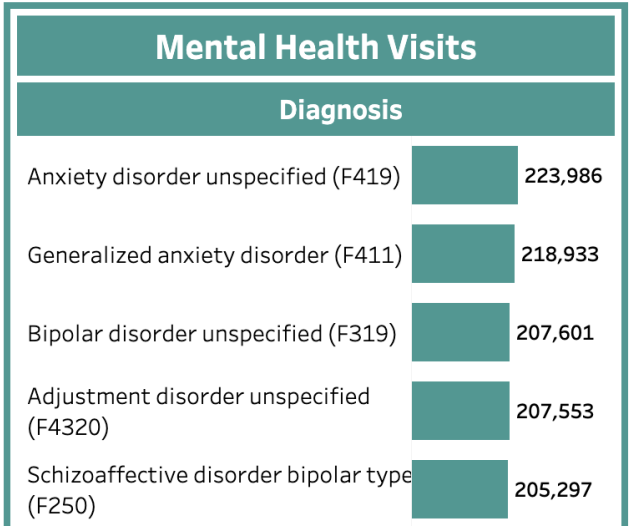
Top 5 Primary Diagnoses for Audiovisual Telehealth Visits (Oct 2022-Feb 2025)

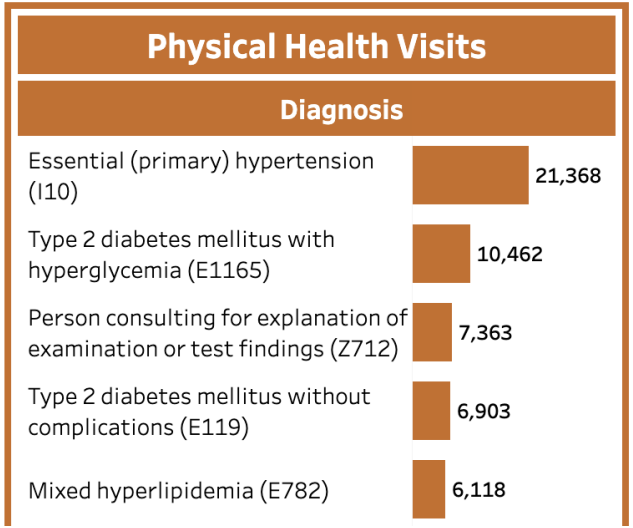


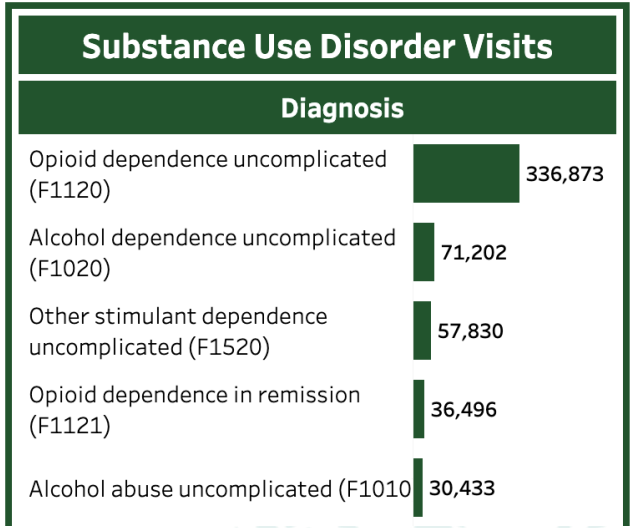




Top 5 Primary Diagnoses for Audio-Only Telehealth Visits (Oct 2022-Feb 2025)







CPT Code 92609

- CPT code 92609 is used for therapeutic services involving speech-generating devices, including programming, modification, and patient training.
- Code had been closed because of non-use
- TAC member, Amy Enriquez, has asked that we consider advising re-instatement. emphasizing that the code includes caregiver and patient training, not just device programming. She argues that these training components are effectively delivered via telehealth, especially for rural families, and are clinically important for successful AAC outcomes.

CPT 92609 explanation context)

CPT 92609 (in this context):
CPT 92609 refers to **speech-language pathology services for the therapeutic use of a speech-generating (AAC) device**, including **programming, modification, and training of the patient and caregivers**.
In this scenario, it's specifically being used not just for **initial device setup**, but also for **ongoing training and coaching sessions**, which can often be delivered effectively via **video telehealth**, especially for follow-up support and caregiver education.

Proposed TAC Recommendation

- • Reconsider CPT 92609
- • Limit to caregiver training and follow-up coaching
- • Keep in-person for programming

Open Forum for Discussion

Thank You