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Ensuring Long-Term Equitable Access to Telehealth in New York State

Opportunities and Challenges

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Executive Summary

Telehealth utilization spiked during the COVID-19 pandemic, facilitated by state and federal policy change implemented in response to the COVID-19 public health emergency (PHE) declaration. Utilization has tapered off from the height of the pandemic but is still higher than pre-pandemic levels. Telehealth is now an accepted modality of care delivery embraced by providers and patients, particularly for behavioral health care.

The PHE highlighted telehealth's value in ensuring continuity of care during a crisis, but also its potential to address longstanding challenges such as provider shortages and accessibility, particularly for individuals with disabilities, chronic or complex health conditions, and those who face transportation barriers. However, disparities in access continue to hinder telehealth's full potential. Ensuring equitable telehealth access and use requires concerted effort from policymakers, health care providers, health plans, telehealth companies, and others to ensure that telehealth solutions are accessible, affordable, and culturally competent for all patients. This is especially important in New York State (NYS), which is demographically, culturally, economically, and geographically diverse.

PHE-driven telehealth policy changes reshaped the landscape for reimbursement and regulation of telehealth. There is momentum among federal, state, and commercial payors to continue to cover and reimburse for services delivered via telehealth at parity with the equivalent in-person service, though debate over the longevity of these policies is ongoing. The PHE also spurred new, permanent policy options to facilitate cross-state licensure due to demand by providers and patients for the flexibility provided by telehealth modalities. Going forward, many states, including NYS, are expected to continue adapting and refining their telehealth laws and regulations as care models evolve to incorporate hybrid in-person and telehealth elements.[1]

NYS has been a national leader in expanding access to telehealth. Before and throughout the PHE, NYS removed restrictions to telehealth delivery and broadened its telehealth policies for Medicaid and state-regulated commercial plans to enable providers to deliver a comprehensive set of virtual health care services in a variety of settings. Recent telehealth policy shifts also facilitated the launch or expansion of innovative telehealth programs in NYS, including Finger Lakes Community Health's pediatric teledentistry program, the University of Rochester Medical Center's pilot program to provide telehealth consultations in non-traditional settings, and New York Health and Hospitals' Virtual ExpressCare service platform that offers patients rapid, accessible medical and behavioral health care. Though NYS has largely maintained PHE-era telehealth policies and kept pace with the majority of states, opportunities remain for NYS to enshrine and strengthen these policies.

The objectives of this report are twofold: (1) provide a comprehensive assessment of the post-PHE telehealth policy landscape in NYS; and (2) propose policy recommendations for NYS, informed by best practices, aimed at enhancing equitable access to telehealth. The report's insights are drawn from available literature, NYS legislation, regulation and policy guidance, and interviews with a variety of NYS stakeholders (see Appendix A).

The key policy opportunities identified include:

Policy Opportunity	Recommendation	Rationale
Payment Parity for Video Visits	Implement permanent payment parity across all payors for video visits.[2]	Promotes provider adoption, investment in telehealth and continued accessibility for patients.
Permanent Payment Parity for Audio-Only Visits, Under Certain Circumstances	Implement payment parity for audio-only visits across all payors, adopting Medicaid-specific requirements governing use of the modality.	Ensures access to care for low-income populations that may not have access to video capabilities or available providers in their area.
Equitable Reimbursement Parity for Federally-Qualified Health Centers (FQHCs)	Reimburse FQHCs licensed under Article 28 of the Public Health Law at the full Prospective Payment System (PPS) rate for video and audio-only visits when both the provider and patient are located offsite.	Ensures accessibility for patients, promotes recruitment and retention of behavioral health providers, and sustainable financing for FQHCs.
Cross-State Licensure	Adopt a NYS-specific approach to cross-state licensure such as licensure compacts, special licensure pathway, or exceptions.	Promotes continuity of care across state lines and addresses provider shortages.

Key Definitions

A subset of key definitions listed below are drawn directly or adapted from NYS statute or regulations, unless otherwise noted. A comprehensive list of terminology and definitions relevant to this report can be found in Appendix B.

- Virtual Care: Health care delivered remotely—synonymous with "telehealth." [American Medical Association (AMA)]
- Telehealth: The use of electronic information and communication technologies by providers to deliver health care services, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient. [Adapted to include a range of synchronous and asynchronous modalities, such as video visits, audio-only visits, and remote patient monitoring] (Public Health Law, Article 29-G, Section 2999-CC)
- Video Visits: Use of synchronous, two-way electronic audio-visual communications to deliver clinical health care services, which shall include the assessment, diagnosis, and treatment of a patient, while such patient is at the originating site and a telehealth provider is at a distant site. (Adapted from Public Health Law, Article 29-G, Section 2999-CC; referred to as "telemedicine")
- Audio-only Visits: The use of telephone and other audio-only technologies to deliver services. (NY Code of Rules and Regs. Title 18, Sec. 538.1)
- Payment Parity: Requires payors to reimburse for telehealth at the same rate as the equivalent in-person service. [Adapted from Insurance Chapter 28, Article 32, Section 3217-H]
- Coverage Parity: Requires payors to cover a service via telehealth if it is also covered in-person and can be delivered remotely while meeting the standard of care. [Adapted from Insurance Chapter 28, Article 32, Section 3217-H]
- Originating Site: A site at which a patient is located at the time health care services are delivered to him or her by means of telehealth. (Public Health Law, Article 29-G, Section 2999-CC)
- Distant Site: A site at which a provider is located while delivering health care services by means of telehealth. (Public Health Law, Article 29-G, Section 2999-CC)

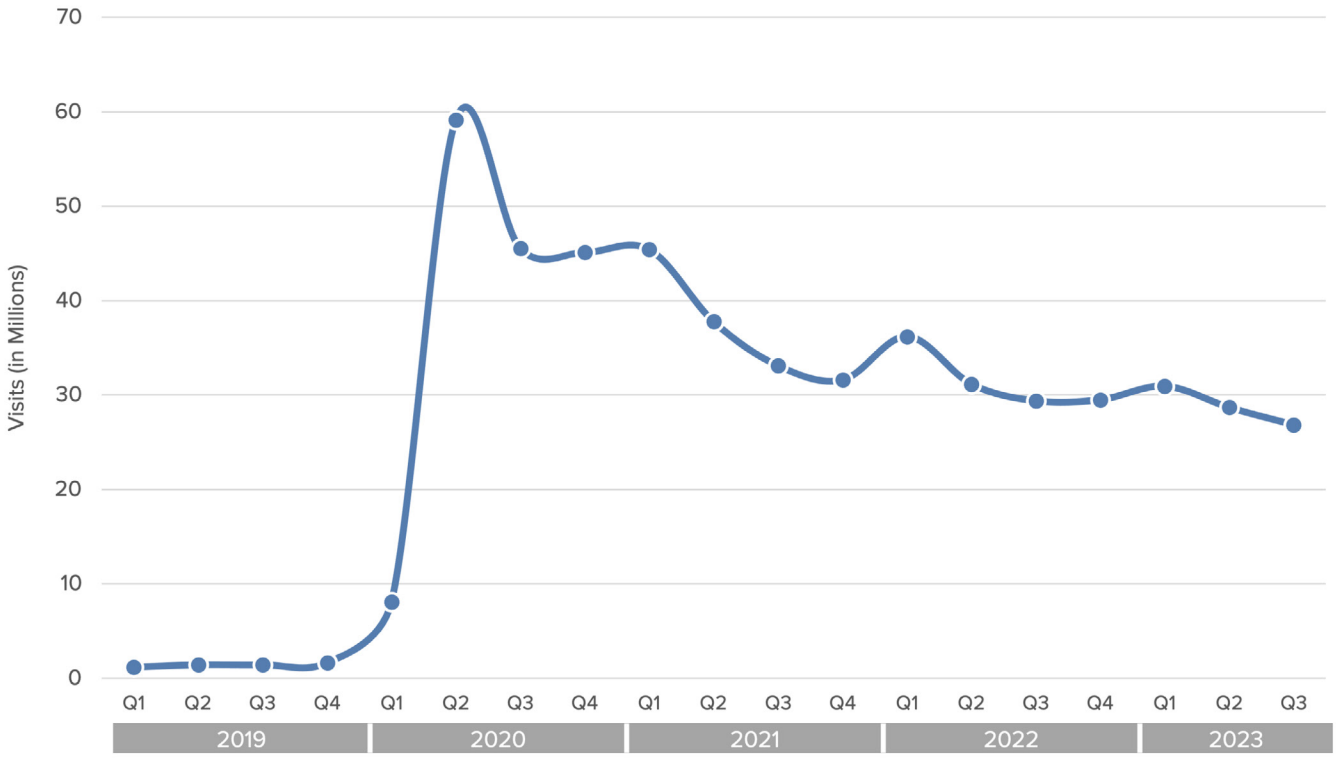
Background

Utilization Trends

National

Prior to the PHE, telehealth utilization accounted for less than 1% of all health care-related visits. An analysis of the national all-payer claims database (Figure 1) shows that telehealth peaked in the first half of 2020. Since then, telehealth visit volumes declined or plateaued quarter-over-quarter, except for an increase from late 2021 through early 2022. While utilization remains above pre-pandemic levels, telehealth utilization volumes in the third quarter of 2023 were 55% below the peak in early 2020.

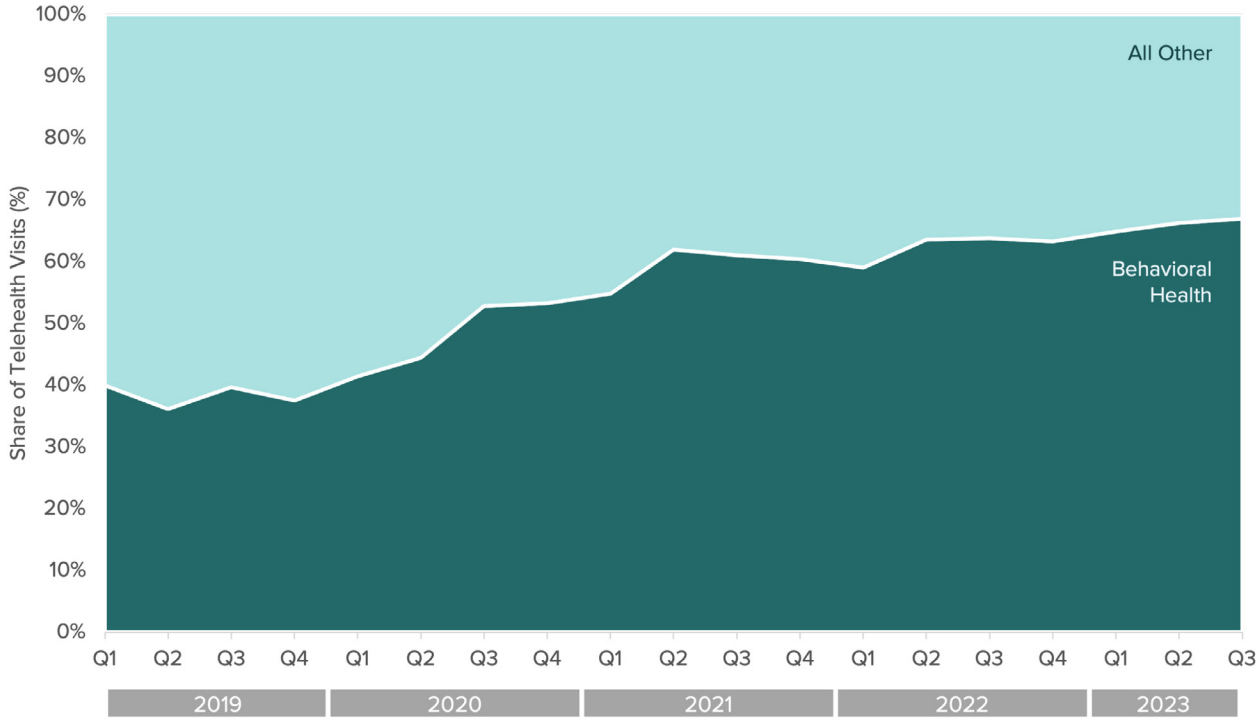
Figure 1. All-Payor Telehealth Visit Volumes, 2019–2022



Source: Trilliant Health.

Telehealth is most commonly used to deliver behavioral health services. Since 2019, behavioral health-related telehealth visits have represented a consistently increasing share of total telehealth utilization, up from 41% in the first quarter of 2020 to 67% in the third quarter of 2023 (Figure 2). Beyond behavioral health, providers use telehealth to deliver primary care and specialty care directly to patients or through interprofessional consultations (between primary care providers and specialists).

Figure 2. All-Payor Telehealth Utilization, Behavioral Health vs. All Other Services, 2019–2022



Source: Trilliant Health.

Continued interest in and use of telehealth is attributable to a number of factors. Telehealth offers a convenient, high-quality, and accessible alternative to traditional care, especially for patients who have childcare or work obligations, live in communities that lack transportation options or require accessible care due to disability. Telehealth also plays a critical role in care delivery for medically complex children and their families and/or caregivers. Telehealth is a critical option to enable frequent connection with a child's care team and specialists, and it mitigates logistical challenges related to attending in-person visits (i.e., transportation of medical equipment).

Providers benefit from incorporating telehealth into their workflows, to include: enhanced patient engagement, lower no-show rates and expanded flexibility to deliver care from non-traditional settings, such as the provider's home. Physicians across different specialties, geographic locations, practice locations, and care situations report satisfaction with delivering services directly to the patient via telehealth and using telehealth to consult with other physicians. The majority of physicians plan to continue using telehealth in their practice.

Notably, available telehealth utilization data shows variances in utilization by demographic groups. An all-payor utilization study found that patients who were older, Black or Asian and did not speak English as a primary language at home were less likely to use telehealth. Telehealth use was also lower among individuals living in rural areas. A similar all-payor utilization study found that individuals who were Hispanic or Latino, Black, and Asian were more likely to use audio-only telehealth than individuals who were White (and less likely to use video telehealth services than individuals who are White).

Widespread adoption of telehealth has prompted discussion regarding patient choice and barriers to accessing care. Certain individuals or populations, such as older adults, prefer in-person care due to discomfort using technology. Thus, patients have stressed the importance of maintaining patient flexibility to determine how their care is delivered and legislators are embedding this consideration in policy.[3] In addition, individuals experiencing homelessness, individuals without access to devices or affordable broadband, and people with limited language skills may be further marginalized due to barriers related to digital literacy and access to affordable broadband and devices.

NYS

According to Medicare telehealth utilization data, NYS was one of three states that experienced the largest growth in telehealth encounters in 2019 and 2020. According to a study on NYS Medicaid telehealth utilization during the PHE, nearly 15 million telehealth services were delivered to 1.7 million enrollees in 2020, with similar utilization rates in 2021. Individuals between ages 21–64, women, and residents of NYC utilized telehealth at higher rates relative to other demographic groups. The most common telehealth services were psychological/psychiatric evaluation and therapy, diagnostic procedures (interview, evaluation and consultation), and alcohol and drug rehabilitation/detoxification. Broader state-level consumer survey results and State reporting demonstrate these findings are trending beyond the PHE, as most NYS residents who continue to use telehealth live in the New York City/mid-Hudson areas, and leverage telehealth to address mental health and urgent care needs. Further, Medicaid was the most frequent payer of telehealth services.

The increase in telehealth utilization since the onset of the PHE spurred provider innovation and the integration of telehealth into care delivery models across NYS. More information is available in the Innovative Telehealth Programs Across NYS section of this report below.

National and NYS Policy Landscape

National

The sharp increase in telehealth utilization nationwide during the PHE is attributable to implementation of a multitude of federal flexibilities aimed at ensuring continuity of care while reducing the risk of COVID-19 exposure in health care environments. Before the PHE, Medicare coverage of telehealth services was generally limited to rural areas,[4] with restrictions on originating and distant sites, covered telehealth services, allowable modalities, and eligible providers.

Congress and the Centers for Medicare and Medicaid Services (CMS) rapidly issued flexibilities in early 2020 within the Medicare program to expand access to virtual care.[5] The Consolidated Appropriations Act of 2023 extended many telehealth flexibilities through the end of 2024, implemented through the Medicare Physician Fee Schedule (MPFS).[6,7] While many of these flexibilities remain temporary, several are now memorialized, particularly for behavioral and mental telehealth services. The table below provides a summary of these changes:

Table 1. Post-PHE Evolution of Medicare Telehealth Policy

PHE Flexibility	Current Status
Payment Parity: Reimbursement for telehealth services at the same rate as the equivalent in-person service.	**Temporary** through December 2024.
Covered Services: Significantly increased the number of covered services, including the following behavioral health services: group psychotherapy, licensed clinical social work, clinical psychology, and psychology/neurological testing.	**Permanently Adopted:** Several telehealth services first covered temporarily during the PHE have been permanently added to the Medicare Telehealth Services List (e.g., emergency department visits, physical and occupational therapy, and certain other services). **Continued Flexibility Through the End of 2024:** Some PHE-era telehealth services remain temporarily covered in Medicare (i.e., outpatient therapy, diabetes self-management training).
Audio-Only: Coverage and reimbursement for audio-only services.	**Permanently Adopted:** Behavioral/mental telehealth services can be delivered using audio-only communication platforms. **Continued Flexibility Through the End of 2024:** Some non-behavioral/mental telehealth services can be delivered using audio-only communication platforms.
Other Modalities: Expanded coverage of asynchronous and other modalities, such as virtual check-ins and remote patient monitoring (RPM).	**Permanently Adopted.**
Eligible Providers: Expanded the list of eligible telehealth practitioners (e.g., clinical social workers, certified nurse midwives, nutrition professionals).	**Continued Flexibility Through the End of 2024:** • Telehealth services can be provided by all eligible Medicare providers. • An in-person visit within six months of an initial behavioral/mental telehealth service, and annually thereafter, is not required.
Sites of Care: Lifted geographic and site of service requirements, which allowed all beneficiaries, regardless of whether they are in a rural or non-rural community, to access telehealth from any location, including their home.	**Permanently Adopted:** • There are no geographic restrictions on originating sites (where the patient located at the time of a telehealth encounter) for behavioral/mental telehealth services. • Rural Emergency Hospitals are eligible originating sites for telehealth. • FQHCs (and rural health centers) can serve as a distant site (where the provider is located at the time of a telehealth encounter) provider for behavioral/mental telehealth services. Continued Flexibility Through the End of 2024: • There are no geographic restrictions for originating sites for non-behavioral/mental telehealth services. • FQHCs can serve as a distant site provider for non-behavioral/mental telehealth services.

Source: U.S. Department of Health and Human Services, Telehealth Policy Changes After the COVID-19 PHE.

NYS

In addition to federal telehealth laws and policies, state laws govern telehealth coverage and reimbursement requirements for state-regulated payors, impacting how telehealth can be delivered to patients located in-state (e.g., licensure, privacy, scope of practice, etc.). State-regulated commercial payors must comply with state-mandated telehealth coverage requirements. In regards to Medicaid, states have had long-standing flexibility to determine their Medicaid telehealth coverage and reimbursement policies, including which services can be delivered using telehealth modalities, what types of practitioners or providers may deliver services via telehealth, which specific Medicaid populations and geographic areas can be served, and what payment rates to providers will be.[8] Since 2021, many states have evaluated which PHE-era flexibilities should be implemented permanently, and ultimately revised their existing laws and policies to support ongoing access to telehealth.

NYS is considered by stakeholders across the health care continuum as an early adopter and leader in expanding access to telehealth services. The future of telehealth use is bright in NYS: the state's latest telehealth surveys indicate that a majority of both Medicaid and non-Medicaid patients are comfortable with telehealth (e.g., only 14% of respondents indicated telehealth was not suitable for their health needs) and nearly one-third of providers plan to offer telehealth options at the same frequency as during the PHE.

NYS' pre-PHE Medicaid telehealth policy, as in many states, was limited to live video only at certain facilities by a limited set of providers. However, NYS began removing telehealth policy restrictions in 2019, including a series of foundational changes to Medicaid coverage (e.g., additional originating and distant sites, modalities and provider types). NYS Medicaid has largely kept pace with telehealth policies adopted in the majority of states following the end of the PHE. In early 2023 (later updated in August 2023), the New York State Department of Health (NYSDOH) issued new telehealth guidance memorializing a number of flexibilities adopted during the PHE. See Table 2 below for a summary of NYS Medicaid's current telehealth policy.

Table 2. NYS Medicaid Telehealth Policy Snapshot

Please see the New York State Medicaid Provider Policy Manual (linked below) for detailed information.

Policy	Status
Payment Parity	Temporarily extended through April 1, 2026 (described further below). **Exception:** Article 28 FQHCs do not receive the full PPS rate when both the provider and the patient are located off-site during a telehealth visit.
Eligible Modalities	• Video visits are covered. • Audio-only visits are covered, with conditions (described further below). • Teledentistry is covered. • RPM may be used to treat chronic conditions[9] and monitor patients during pregnancy and up to 84 days postpartum. • Store and forward is covered (at 75% of the Medicaid fee for the service). • Virtual patient education, virtual check-ins, and e-visits are covered under certain conditions. • E-consults are covered.
Eligible Providers	Eligible Medicaid-enrolled providers include: physicians, physician assistants, dentists, nurse practitioners, registered professional nurses, psychologists, social workers, optometrists, speech language pathologists, audiologists, physical and occupational therapists, among others listed in Public Health Law 2999-CC.[10,11]
Geographic Restrictions	Originating sites are anywhere the member is located, to include NYS provider sites, the member's place of residence within NYS, temporary locations within or outside NYS, and other locations listed on NYS Medicaid's Telehealth homepage. Distant sites are any secure site within the United States. Providers located outside of NYS may provide telehealth services to New York Medicaid members if: • The services are allowable, • The provider is enrolled in NYS Medicaid, and • The provider possesses NYS licensure.
Licensure	If the out-of-state provider is NYS licensed, enrolled in the Medicaid program, and appropriately privileged and credentialled by the originating site, then they can provide services via telehealth to a Medicaid-enrolled individual in NYS. Out of state licensing is under the authority of the NYS Education Department.
Confidentiality	Services provided via telehealth must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and all other relevant laws and regulations governing confidentiality, privacy, and consent.[12]
Patient Rights and Consent	The practitioner shall confirm the identity of the NYS Medicaid member and provide the NYS Medicaid member with basic information about the services that they will be receiving via telehealth. Written consent by the NYS Medicaid member is not required, but the provider must document informed consent in the chart of the patient before or during the first visit in which telehealth services are provided.[13]

Source: NYS Medicaid Telehealth Guidance. See Appendix C for relevant laws governing NYS Medicaid telehealth policy.

The Office of Mental Health (OMH) regulates Article 31-licensed providers (i.e., behavioral health clinics), and the Office of Addiction Services and Supports (OASAS) regulates Article 32-licensed providers (i.e., outpatient substance use disorder clinics). Both agencies have distinct telehealth guidance documents that align closely with requirements for telehealth use in the Medicaid program but include additional rules and regulations related to unique services like group-based therapy classes and administration of buprenorphine treatment via telehealth.[14] In concert with the Medicaid program, both agencies have significantly changed their policies to expand the spectrum of eligible providers and programs capable of offering telehealth services (e.g., allowing audio-only delivery with guardrails and removing previous geographic restrictions) though neither agency has expanded telehealth coverage to additional modalities like store and forward or e-consults. OMH and OASAS have also taken steps to simplify the approval process for adding telehealth to a licensed provider's operating certificate.

State-regulated commercial plans in NYS must, at a minimum, adhere to the coverage and reimbursement requirements set forth in state insurance law but may otherwise define their own telehealth coverage policies. See Appendix C for relevant laws governing telehealth requirements for state-regulated commercial plans.

Innovative Activity to Expand Access to Telehealth Care to Adolescents

In recognition of rising levels of anxiety and depression among youth and young adults, there is growing interest in and support for innovation in virtual mental health care. Recently, Mayor Adams and the New York City Department of Health and Mental Hygiene launched a free telehealth health service to city residents between ages 13 and 17. Through this service, teenagers can engage with a clinical professional through video, phone, and unlimited texting through a secure platform. The service also enables referrals to extended services, if needed.

In February 2024, Governor Hochul announced the state's commitment of $10 million to expand mental health services at all State University of New York campuses (secured through the Governor and NYS Legislature's $163 million increase in the direct operating budget for state-operated campuses in 2024). Significant components of this historic investment include building on NYS' Statewide Tele-Psychiatry Network and offering a new tele-counseling option for community colleges.

Key Policy Recommendations to Expand Equitable Access to Telehealth in NYS

Based on an assessment of NYS' telehealth policies, best practices in other states, and interview findings, the following are key policy recommendations for NYS to enable all residents equitable access to telehealth.

Policy Recommendation: Implement payment parity across all payors for video visits.

Coverage and payment parity ensure equal coverage and reimbursement for services delivered in-person and virtually, thereby providing the foundation for patients' access to telehealth.

When temporary parity was enacted during the PHE, providers rapidly expanded their telehealth offerings, adjusted their workflows and allocated significant capital and staff resources to make telehealth modalities available for patients. Given continued demand for telehealth as an option for patients and providers alike, sustainable reimbursement is important to many providers, particularly health systems and independent providers that now offer both in-person and telehealth services, and thus incur both physical facility and technology infrastructure costs. Without ongoing certainty regarding the long-term future of payment parity, providers will be reluctant to continue investing in maintaining their telehealth offerings, limiting patients' access to virtual care and stifling innovation that could improve patient experience and clinical outcomes.

Most states have permanently implemented telehealth coverage and payment parity.[15] As of June 2024, 22 states implemented permanent payment parity. In contrast with the majority of other states, NYS policymakers have not yet settled on a long-term policy approach to telehealth payment parity. The NYS State Fiscal Year (SFY) 2024–25 (FY25) enacted budget extends payment parity for state-regulated commercial and Medicaid services through April 1, 2026. The extension supports ongoing provision of telehealth services in NYS and allows the state to continue to study the impact of telehealth service delivery, but providers may require further clarity from the state to make additional investments in care models that feature telehealth.

Raising Medicaid Rates to Support Telehealth

NYSDOH's 2023 telehealth report identified significant differences in Medicaid and state-regulated commercial payment rates for primary care and behavioral telehealth services between April 1, 2022 to April 1, 2023. For example, the commercial allowed amount for institutional services was significantly higher than the Medicaid paid amount for behavioral health and primary care claims (71% and 105%, respectively). Similarly, for professional claims, commercial payors paid 47% more for behavioral health services and 88% more for primary care services. Rate differences held steady across different regions of NYS, though Downstate showed the starkest differences between commercial and Medicaid rates.

In future funding cycles, NYS may consider making a requisite rate adjustment(s) to reduce or eliminate the gap between Medicaid and commercial reimbursement for primary and behavioral health care services delivered via telehealth.

Note: Professional claims are generally used for services provided by a physician, multiple physicians, or qualified health care professionals in practice or outpatient department settings. Institutional claims generally cover reimbursements provided to facilities for a patient's stay in a hospital, or care provided in a clinic or emergency department.

Policy Recommendation: Implement payment parity for audio-only visits across all payors, adopting Medicaid-specific requirements governing use of the modality.

Another major lesson learned during the PHE was that audio-only visits are an important pathway to care for patients who do not have access to home internet, digital devices, or data plans to support video visits. As noted previously, all payor telehealth utilization data indicate disparities in access to video visits by race and ethnicity. Another study found that small practices from communities with high social vulnerability were almost twice as likely as providers in communities with low social vulnerability to use telephones as their primary telehealth modality.

Since the end of the PHE, the vast majority of states have continued to cover audio-only telehealth services. Forty-three states and the District of Columbia (D.C.) reimburse for audio-only telephone in some capacity in their Medicaid program. Many of these states have narrowed their audio-only coverage and payment policies by imposing limitations (e.g., by service type, geography, existing relationship with provider) to consider the types of services most appropriate for audio-only according to the standard of care and appropriate payment level (given cost differences with video or in-person services).[16] For example:

- Hawaii passed legislation authorizing the following audio-only policy through December 31, 2025:
  - Reimbursable telehealth services must be conducted through an "interactive telecommunications system" (i.e., two-way video) except for behavioral health services, which may be covered and reimbursed if conducted via audio-only;
  - Audio-only services "for the purposes of diagnosis, evaluation, or treatment of a mental health disorder" is reimbursed at 80% of comparable in-person rates; and,
  - To receive reimbursement for audio-only services, "the health care provider shall first conduct an in-person visit or a telehealth visit that is not audio-only, within six months prior to the initial audio-only visit, or within twelve months prior to any subsequent audio-only visit."
- Washington requires that patients receiving audio-only telehealth services to have had one in-person or real-time audio-video appointment with the provider, or a provider employed by the same group, clinic or integrated delivery system, in the previous three years.
- Connecticut allows coverage for audio-only services when (1) clinically appropriate, as determined by the commissioner; (2) it is not possible to provide comparable covered audiovisual telehealth services; and (3) it is provided to individuals who are unable to use or access comparable, covered audiovisual telehealth services.

NYS' current Medicaid policy is more expansive than many states to give providers decision-making autonomy, but it includes guardrails. Audio-only visits are covered when all the following conditions are met:

- Audio-visual telehealth is not available to the patient due to lack of patient equipment or connectivity, or audio-only is the preference of the patient;
- The provider must make either audio-visual or in-person appointments available at the request of the patient;
- The service can be effectively delivered without a visual or in-person component, unless otherwise stated in guidance issued by the NYSDOH (this is a clinical decision made by the provider); and
- The service provided via audio-only visits contains all elements of the billable procedures or rate codes and meets all documentation requirements as if provided in-person or via an audio-visual visit.

Expanding Broadband Accessibility in NYS

To improve participation rates in video visits, NYS can continue to expand broadband access and opportunities to support members in obtaining affordable devices and service plans. In 2015, NYS made an initial $500 million investment through the New NY Broadband program—the largest state broadband investment in the nation at the time. Working through public-private partnerships, the New NY Broadband program deployed more than 21,000 miles of fiber, providing access to 256,000 homes, businesses, and community institutions. However, gaps still exist in high-speed internet coverage upstate. Governor Hochul's $1 billion ConnectAll initiative builds upon previous efforts to close the state's digital divide.

NYS added audio-only telehealth to their definition of telehealth in 2020 but should the temporary payment parity provision sunset in April 2026, providers will not be able to offer patients a synchronous alternative to video visits. The field is seeking more information and research on the effectiveness and appropriateness of audio-only telehealth for certain types of services but, for the purpose of promoting health equity, adopting NYS Medicaid's current audio-only policy permanently for all payors would strike a balance in ensuring continued access to care for certain patients without compromising clinical standards of care.

Policy Recommendation: Reimburse Article 28 FQHCs at the full PPS rate for video and audio-only visits when both the provider and patient are located offsite.

One of the benefits of telehealth is the flexibility and convenience virtual visits offer both patients and providers. However, NYSDOH currently requires all Article 28-licensed facilities, many of which are FQHCs, to have either the provider **or** patient on-site at the clinic to receive the full payment for a service delivered via telehealth. In particular, Article 28-licensed FQHCs that have not opted into Ambulatory Patient Groups (APGs) may only bill their "off-site" rate for a telehealth visit when both the provider and patient are off-site, rather than the full PPS rate.[17,18,19] This billing structure effectively reduces payment in these circumstances from the PPS rate by an average of one-third ($75 compared with $215 dollars in 2023; rates vary by FQHC and geographic location). In contrast, behavioral health clinics licensed by OMH (Article 31 clinics), and substance use disorder outpatient clinics licensed by OASAS (Article 32 clinics) receive nearly full payment of their bundled rates for all telehealth visits, regardless of where the patient and provider are located (see Table 3).

Table 3. Telehealth Reimbursement Policy for FQHCs

Type of FQHC	Either the Provider OR Member are On-Site	Both the Provider AND the Member are Off-Site
FQHC Operated Article 28 that has not opted into APGs	Bill PPS Rate (rate code: 4013).	**Bill Off-Site Rate (rate code: 4012).** **Examples with 2023 Rates:** **Downstate** 121st Street Family Health Center PPS Rate: $234.41 Offsite Rate: $77.50 **Upstate** Community Health Center of Buffalo PPS Rate: $144.03 Offsite Rate: $69.23
FQHC Operated Article 28 that has opted into APGs	Bill APG claim.	Bill the Professional Component only.
FQHC Operated Article 31 (OMH) or Article 32 (OASAS) that has not opted into APGs	Bill Article 31 or Article 32 rate coded claim for PPS rate.	

Source: NYS Medicaid Telehealth Guidance.

Among the twenty-seven states that explicitly mention that FQHCs may bill the PPS rate for telehealth services, NYS is unique in reducing Article 28 FQHCs' reimbursement depending on the location of the patient and provider. For example:

- Colorado requires that reimbursement for services delivered via telehealth by an FQHC must be set at parity with an in-person visit.
- California requires that video, audio-only visits and store and forward modalities must be reimbursed at the applicable FQHC's per-visit PPS rate to the extent the Department of Health Care Services determines that the FQHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter and when services delivered through that modality meet the applicable standard of care.

At the center of this policy difference is a debate around differential overhead costs for care provided by the clinician outside the four walls of the clinic and limitations inherent in the PPS rate to account for non-traditional care delivery models. FQHCs incur additional infrastructure costs to adopt and maintain telehealth technologies on top of existing physical infrastructure expenses. There is a lack of evidence to support the claim that it costs less for hybrid care providers to conduct a telehealth visit (no matter where the visit occurs) and telehealth requires the same clinical effort as in-person care. NYSDOH's telehealth reimbursement

approach for Article 28 facilities (relative to Article 31 or 32 clinics, and Medicaid broadly) likely results in missed revenue, which limits the ability of these facilities to fully operationalize the provision of telehealth services for all populations across NYS.

In practice, a lower reimbursement rate may force FQHCs to discontinue telehealth service delivery or maintain it with significant revenue loss in an already strained system. If telehealth is discontinued, this exacerbates workforce shortages, particularly for behavioral health clinicians, who are increasingly seeking flexible work options at other clinics, given that these services can effectively be delivered remotely. If telehealth is maintained, lower reimbursement rates for telehealth services may trigger significant revenue loss and costs that outpace revenue. The NYS Medicaid Provider Survey indicates that nearly one-third of providers/patients are **never** at the facility during telehealth visits, therefore these revenues are not accounted for in future years' PPS rates.[20] Either scenario poses risks to access to care for FQHC patients, who are primarily low-income patients and patients of color.

Both the Senate and Assembly One-House Budgets, proposed in early 2024, sought to address this issue by including a provision that would allow Article 28-licensed clinics to receive their full PPS rate for telehealth visits regardless of provider or patient location.[21] However, the provision was not included in the FY25 enacted budget.

Additional Opportunities to Expand Equitable FQHC Reimbursement

There are opportunities in NYS to expand FQHC coverage and reimbursement parity for modalities beyond video and audio-only visits. For example, FQHCs are not yet able to bill Medicaid for e-consult services; and FQHCs that have opted out of APGs cannot bill for RPM services.

Policy Recommendation: Adopt a NYS-specific approach to cross-state licensure such as licensure compacts, special licensure pathway or exceptions.

Telehealth holds potential not just to expand patient access to care, but also to extend the reach of providers contending with workforce shortages and strains. NYS, like many states, adopted temporary licensure flexibilities during the PHE to allow physicians and other health professionals to practice across state lines and deliver telehealth to New York residents without having to apply for a license. These flexibilities have expired, but many states have since recognized the benefits of cross-state licensure flexibilities in addressing workforce shortages and enabling continuity of care for established patients while clinicians are traveling. States have subsequently implemented ongoing policies through a spectrum of approaches, including:

- **Licensure Compacts:** Through licensure compacts, states establish uniform standards to lower barriers to multi-state practice while preserving an individual state's authority to regulate the practice of medicine. A majority of states are participating in at least one licensure compact. For example, 39 states/D.C. participate in the Interstate Medical Licensure Compact (IMLC) and 41 participate in the Nurse Licensure Compact (NLC). Each of these compacts varies in the licensure flexibilities it provides.[22] The IMLC provides an

expedited pathway for physician licensure in member states but does not enable reciprocity for physicians to practice across member states. Physicians are still required to apply for and obtain licensure in order to practice in other member states. The NLC enables true licensure reciprocity: professionals licensed and residing in a member state are able to practice in other compact member states without obtaining multiple licenses.

- **Special Purpose Telehealth Registry:** Several states have established out-of-state telehealth registries that enable providers licensed and in good standing in other states to register and deliver care via telehealth to state residents. These registrations or limited licenses are typically faster and cheaper to obtain than a full license.
  - Utah allows for the issuance of temporary licenses to individuals who (1) have a "nonresident health care license" (i.e., a medical license issued by another state, district, or territory) and (2) have completed an application for a license by endorsement in Utah, but (3) the license application will not be able to be processed within 15 days of being submitted. Individuals with a temporary license are eligible to provide telehealth services if the telehealth service is a service the physician is eligible to provide under their current "nonresident health care license," the patient is located in Utah, and performing the telehealth service would not otherwise violate state law.
  - Vermont allows physicians (and other health care professionals) who are appropriately licensed and in good standing in another state to obtain a temporary telehealth registration to provide telehealth services to patients located in Vermont until the telehealth licensure and registration system authorized through legislation is operational.
  - Florida authorizes out-of-state health care practitioners to perform telehealth services for patients in Florida following registration online with the Florida Department of Health. Registered providers are prohibited from having an in-state physical address or providing in-person services in the state, and they must also maintain liability coverage for telehealth services provided to patients located in Florida.
- **Exceptions to In-State Licensure:** Certain states allow out-of-state providers in good standing to deliver services via telehealth under certain circumstance (e.g., emergencies, follow-up care with existing patients traveling out of state).
  - Idaho allows a provider that is licensed and in good standing in another state—but not licensed in Idaho—to provide services when the provider (1) has established a patient-provider relationship with a patient who is in Idaho temporarily; (2) has established a patient-provider relationship with a patient and provides temporary or short-term follow-up services to ensure continuity of care; (3) is employed by, or contracted with, an Idaho facility or hospital for which the provider has been privileged and credentialed; (4) provides emergency care in a time of disaster and follow-up services to ensure continuity of care; or (5) consults with or refers a patient to an Idaho-licensed provider.
  - Idaho also allows mental and behavioral health providers not licensed in Idaho to provide telehealth services to Idaho residents (or persons located in Idaho), provided that they (1) hold a current, valid, and unrestricted license from a state, district, or territory with substantially similar licensing requirements; (2) are not subject to any past or pending disciplinary proceedings; (3) act in full compliance with

applicable Idaho laws; (4) act in compliance with requirements regarding the maintenance of liability insurance; or (5) consent to Idaho jurisdiction; (6) biennially register in Idaho to provide telehealth services.

- Oregon allows out-of-state physicians that are not licensed in Oregon, but have an established physician-patient relationship, to provide temporary or intermittent follow-up care.
- Virginia allows physicians who are licensed in another state or the District of Columbia to provide telehealth services when (1) the purpose of services is to ensure continuity of care; (2) there is a preexisting physician-patient relationship; and (3) the physician has performed an in-person examination in the past 12 months. New legislation expands these provisions to allow another practitioner of the same subspecialty, at the same group practice, and with access to the patient's treatment history to provide telehealth services if the patient's primary provider is unavailable.

NYS has not yet adopted any of the above strategies. Under current law, providers delivering telehealth services to patients located in NYS must be licensed to practice in the state. NYS' current regulatory structure poses a significant barrier for providers who wish to deliver care in NYS.

The enacted FY25 budget removed provisions from Governor Hochul's 2025 Executive Budget to expand the ability of select provider types to deliver telehealth services across state lines through participation in the following licensure compacts:

- The IMLC, which would provide an expedited pathway for physicians licensed in a member state to obtain a full and unrestricted license to practice medicine in NYS and other member states; and,
- The NLC, which would allow nurses to have one multistate license that enables them to practice in all member states, including NYS.[23]

There are some challenges involved in adopting a strategy of pursuing registry into multiple interstate licensure compacts to enable cross-state practice of telehealth. Specifically, each compact only applies to one type of licensed professional (i.e., NYS would have to enter several compacts to achieve meaningful impact) and true reciprocity is only enabled by certain compacts (e.g., NLC).

Alternatively, NYS could follow the approach of several states that have established a state-specific, special purpose telehealth registry to enable a broad group of providers the ability to obtain a license to delivery telehealth services to in-state residents.

NYS Non-Complete Policies and Telehealth

In the health care context, non-compete clauses prevent both current and terminated providers from performing the same (or specific) activities for a competing employer in a certain geographic location for a set period of time. Telehealth poses a challenge for the geographic restriction component of a non-compete agreement because providers may practice telehealth across a large geographic area and, should they switch employers, are at high risk of violating the agreement and facing sanctions that prevent them from seeing their patients. Removing noncompete clauses enables continuity of care for established patients and allows providers to continue to provide care via telehealth across a broad region and/or for multiple providers.

At the federal level, the Federal Trade Commission (FTC) voted in April 2024 to finalize a new rule to prohibit employers from enforcing non-competes against workers. However, the new rule may not be enforceable in nonprofit organizations, which are prevalent throughout the health care sector, as the FTC does not have jurisdiction over most nonprofits.

New York allows non-compete agreements. In December 2023, Governor Hochul vetoed a bill (S3100A) that sought to prohibit them. By contrast, some states, such as California, Massachusetts, and Colorado, have eliminated non-compete clauses in physician-provider agreements to facilitate providers' ability to continue to deliver telehealth or in-person services upon switching employers. NYS may explore future policy opportunities to pass narrow scope legislation similar to other states that either prohibits non-compete clauses for all providers or only certain types of health care providers.

Innovative Telehealth Programs Across NYS

The case studies below describe NYS providers' efforts to adopt hybrid care delivery models to meet the evolving needs of their patients.

Finger Lakes Community Health

Finger Lakes Community Health (FLCH) is a leading FQHC of medical, dental and behavioral health care in the Finger Lakes region in upstate NYS (Wayne, Ontario, Yates and Seneca counties). In 2023, FLCH provided care to 28,481 members, nearly a third of whom were agricultural workers and family members. Telehealth has been a cornerstone of FLCH's organizational strategy for over a decade and has driven the adoption of an array of innovative telehealth programs.

A key example of FLCH's embrace of telehealth is its pediatric teledentistry program. FLCH does not have pediatric dentists on staff and therefore previously referred pediatric patients with significant dental disease to the Eastman Institute of Oral Health in Rochester, New York. Though the Eastman Institute has a comprehensive pediatric dental program with sedation and access to an operating room, many parents did not schedule appointments there, leading to worsened oral health diagnoses that FLCH's providers were not equipped to address. The Institute's distant location (one to two hours away) posed a significant barrier, requiring multiple trips by the patient for consultation and treatment. Language barriers further complicated appointment scheduling, and patients faced a six to eight-month waitlist for treatment at the Institute.

FLCH established a partnership with the Eastman Institute to implement virtual pediatric dental consultations, which allows for evaluation and preparation for treatment at the Institute without the need for an in-person visit. During the appointment, a pediatric dentist from the Institute connects remotely to the FLCH provider, who then introduces the child and parent and collaborates to review the patient's health history. Using an intraoral camera, the FLCH provider then shows the patient's mouth to the pediatric dentist on their monitor at the Eastman Institute to complete the consultation.

FLCH employs care coordinators to support this program, who serve as patient navigators, prepare documentation, schedule appointments, arrange transportation, and provide interpretation and translation services, if needed. Care coordinators continue to work with the patient following the teledentistry consultation to ensure that they return to FLCH for regular three-month follow-ups.

FLCH's teledentistry program serves approximately 150 pediatric patients a year and has served over 1,000 patients since the program began. The percent of children with completed treatment plans is now over 90%, and wait times have decreased to three weeks to obtain an appointment at the Eastman Institute.

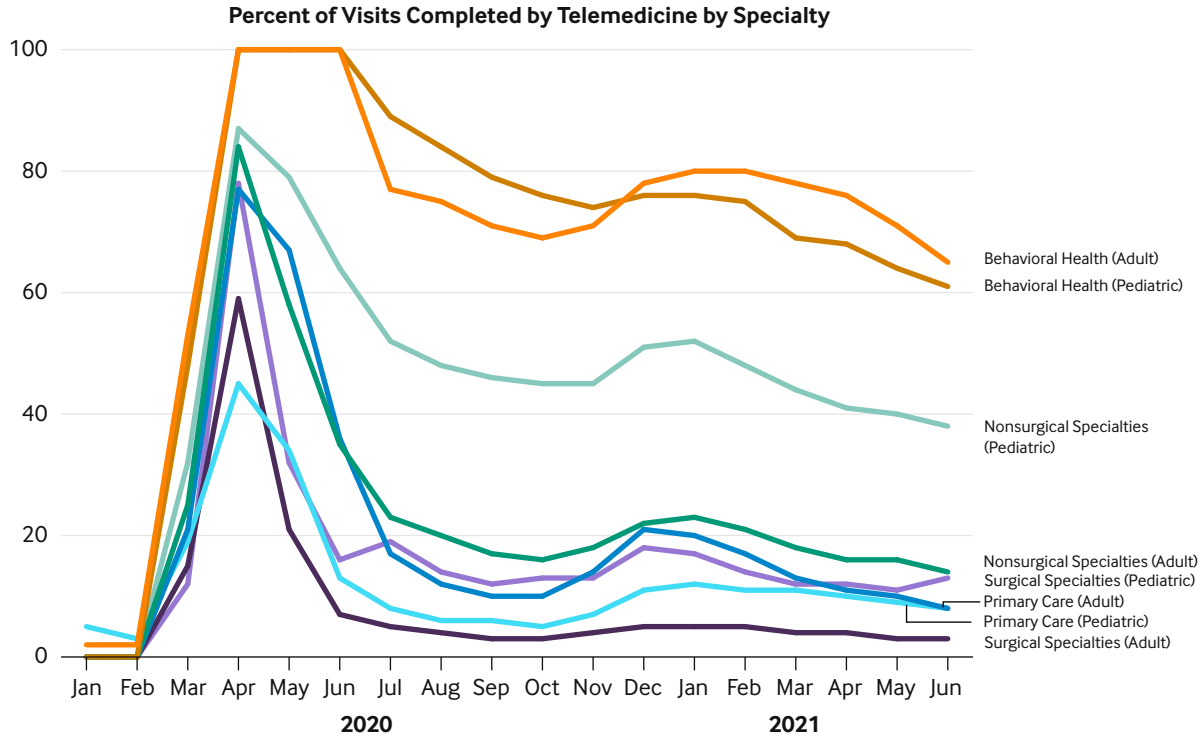
University of Rochester Medical Center

The University of Rochester Medical Center (URMC) is a large academic medical center with approximately 1,400 full-time faculty situated in Rochester, a city with high poverty rates. URMC's clinical enterprise, UR Medicine, serves a large, rural geographic region throughout the Finger Lakes and Southern Tier regions

of New York State through six hospitals, the Golisano Children's Hospital, James P. Wilmot Cancer Center, Eastman Institute for Oral Health, UR Medicine Home Care, the Highlands at Pittsford and Highlands at Brighton, nine urgent care centers, and an extensive primary care network. URMC's diverse population represents the patients who can substantially benefit from access to telehealth due to barriers related to transportation, access to devices/broadband and digital literacy.

In early 2020, URMC transitioned from conducting almost exclusively in-person visits to completing more than 75% of visits via phone and video. Uptake was highest among behavioral health and primary care, but surgical and nonsurgical specialties successfully shifted to telehealth for more than 55% of nonprocedural appointments as well (see Figure 3). Since the PHE, URMC has continued to conduct visits via telehealth as well as in person; an estimated 10% of all ambulatory visits are telehealth.

Figure 3. Proportion of URMC Visits Completed via Telehealth by Specialty, January 2020–June 2021

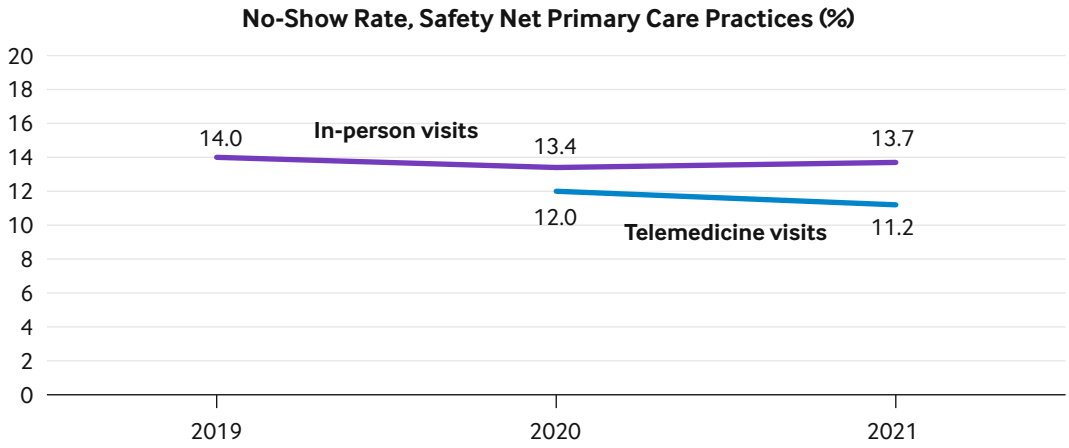


Source: NEJM Catalyst, Busting Three Myths About the Impact of Telemedicine Parity.

A study using URMC's data in 2020 debunked several myths about the reasons for not adopting telehealth payment parity, namely that: (1) telehealth would reduce access for the most vulnerable patients; (2) payment parity encourages overuse of telehealth; and (3) telehealth is an ineffective way to care for patients (leading to additional downstream care). The study found that Medicaid patients had the highest uptake of telehealth across patients of various insurance types during the PHE. In addition, Medicaid patients appeared to benefit from the convenience of telehealth, as safety-net primary care practices—which serve a large proportion of Medicaid patients—had lower no-show and cancellation rates for telehealth visits relative to in-person

visits (see Figure 4). Providers also did not order excessive amounts of additional testing to make up for the limitations of virtual visits. Lastly, telehealth patients did not have higher rates of acute care utilization or require additional in-person follow-up visits to supplement their telehealth visit.

Figure 4. No-Show Rate of Telehealth vs. In-Person Visits at URMC Safety-Net Primary Care Practices, 2019–2021



Source: NEJM Catalyst, Busting Three Myths About the Impact of Telemedicine Parity.

Building on lessons learned during the PHE, URMC invested in an innovative telehealth model beyond its clinic settings. URMC launched a pilot program in February 2024, in partnership with Five Star Bank, to provide access to telehealth and remote monitoring services at rural bank branches. URMC leveraged data collected during the PHE to identify pilot site locations in communities with health care providers shortages and where many residents lack broadband home internet. The pilot's telehealth-enabled stations—which measure key health indicators, including risk for high blood pressure, obesity, Type 2 diabetes, heart attack and stroke—are installed in private, enclosed spaces in each banking location to enable patients to meet with URMC providers through virtual appointments. URMC does not have data on the pilot program yet but is monitoring the impact on community health and access to care.

NYC Health + Hospitals

NYC Health + Hospitals (H+H) is an integrated network of hospitals, community-based health centers/providers, and a health plan serving New York City. H+H is the largest safety net hospital system in the country. H+H launched the Virtual ExpressCare service in 2020 with the goal of providing convenient health care services to all New Yorkers during the PHE and has since built out the platform as an essential service within H+H's delivery system.

Understanding the need for flexibility in health care, H+H made Virtual ExpressCare available 24/7, including overnight, weekends, and holidays. This continuous access ensures that patients can receive timely medical attention regardless of their schedule. Patients can request on-demand appointments through the organization's website, myChart app or call directly via telephone. Recognizing the varied needs of New Yorkers, Virtual ExpressCare offers both video and audio-only consultation options. This flexibility

accommodates patients with different technological capabilities and preferences. Additionally, interpretation support in over 200 languages, including American Sign Language, ensures that language barriers do not hinder access to care.

Virtual ExpressCare has three services lines, (1) medical urgent care for both adult and pediatric populations, (2) behavioral telehealth care for adults, children and adolescents, and (3) reproductive health care. H+H also offers all of these services to individuals experiencing homelessness through tailored services across NYC shelters.

Once connected via video or audio, patients are greeted by an H+H support person who assists with registration and prepares them for the appointment. The support person provides a warm handoff to the clinician to conduct the clinical evaluation, coordinate further care, and prescribe necessary medications. Following the clinical visit, H+H support personnel help patients engage in continuous primary care or behavioral health services, including health insurance enrollment. All visit details and follow-up care plans are accessible through the patient's electronic health record. Virtual ExpressCare efficiently handles a variety of common, non-emergency health issues, including: cold and flu symptoms, sinus infections, upper respiratory issues, allergies, asthma, minor pains, sexual health services including assessments for STDs and reproductive health or urgent mental, emotional, and behavioral health needs, including substance use care services.

Virtual ExpressCare swiftly filled a critical health care gap for vulnerable residents during the PHE and has continued to be a high-value service. It played a key role in the City's and State's response to the COVID-19 pandemic, mitigating the need for 1,300 unnecessary ambulance trips in New York City during the height of the PHE.

In Fall 2020, H+H and the New York City Department of Social Services launched an initiative to provide homeless shelter residents access to Virtual ExpressCare. The initiative has grown significantly over time, with more than 5,000 shelter residents using the platform from January 2023 to April 2024 (70% of residents are Black/Latino). The shelters use telephones, tablets, and computers to connect residents with H+H Virtual ExpressCare physicians. Technology is provided by the Department of Social Services and other agencies, which are responsible for all technical needs, including ensuring WiFi access and equipment cleaning. The health system is responsible for all health care needs, including enrolling uninsured patients in health plans and referring them to other social services as needed.

In 2022, Virtual ExpressCare partnered with the New York State Department of Health to offer COVID-19 therapeutics through the State's COVID-19 hotline, 888-TREAT-NY. This service provided same or next-day life-saving COVID-19 therapeutic treatment to over 60,000 people, with nearly 43% of these patients living in the hardest-hit communities focused on by the New York City Taskforce on Racial Inclusion & Equity.

Today, Virtual ExpressCare offers approximately 90,000 virtual visits annually, maintaining a +78 net promoter score and +95% patient satisfaction scores for service and clinicians. This platform stands as a testament to H+H's commitment to innovation and patient-centered care, ensuring that quality health care is always within reach for all New Yorkers. As Virtual ExpressCare evolves, it sets a blueprint for integrating virtual health care services into traditional health care systems, paving the way for the future of public health in the 21st century.

Conclusion

As demonstrated by widespread adoption in recent years, telehealth offers a convenient, efficient, and safe means of accessing health care services. By continuing to support and expand telehealth infrastructure through the recommendations offered in this report, policymakers can address the needs of individuals who face barriers to care, address workforce shortages, and promote health care accessibility for all New Yorkers. Embracing telehealth as a permanent fixture in the state's health care landscape not only enhances flexibility for patients but strengthens the overall resilience of the health care system in the face of future challenges.

Appendix A. Acknowledgements

Manatt would like to thank the following stakeholders for their contributions to this report:

- Adirondack Health Institute
- Brownsville Multi-Service Family Health Center
- Community Health Center of Buffalo
- Community Health Advocates (Community Service Society of New York)
- Community Health Care Association of New York State
- East Hill Health
- Elevance Health
- Evergreen Health
- Finger Lakes Community Health
- Forward Leading Independent Practice Association
- Greater New York Hospital Association
- Healthcare Association of New York State
- Jordan Health
- New York Assemblymember Amy Paulin
- North Country Family Health
- NYC Health + Hospitals
- NYS Office of Addiction Services and Supports
- Oak Orchard Health
- Patient and Family Advocates from Montefiore Medical Center, New York-Presbyterian, and the University of Rochester Medical Center
- Rocket Doctor
- Safety Net Association of Primary Care Affiliate Providers
- Settlement House
- South Asian Council for Social Services
- Teladoc
- The Chautauqua Center
- Trillium Health
- Universal Primary Care
- University of Rochester Medical Center
- Upstate Family Health
- Westchester Community Health Center

Appendix B. Definitions

All definitions below are drawn directly or adapted from NYS statute or regulations, unless otherwise noted.

- Virtual Care: Health care delivered remotely—synonymous with "telehealth." [American Medical Association (AMA)]
- Telehealth: The use of electronic information and communication technologies by providers to deliver health care services, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient. [Adapted to include a range of synchronous and asynchronous modalities, such as video visits, audio-only visits, and remote patient monitoring] (Public Health Law, Article 29-G, Section 2999-CC)
- Video Visits: Use of synchronous, two-way electronic audio-visual communications to deliver clinical health care services, which shall include the assessment, diagnosis, and treatment of a patient, while such patient is at the originating site and a telehealth provider is at a distant site. (Adapted from Public Health Law, Article 29-G, Section 2999-CC; referred to as "telemedicine")
- Audio-only Visits: The use of telephone and other audio-only technologies to deliver services. (NY Code of Rules and Regs. Title 18, Sec. 538.1)
- Payment Parity: Requires payors to reimburse for telehealth at the same rate as the equivalent in-person service. [Adapted from Insurance Chapter 28, Article 32, Section 3217-H]
- Coverage Parity: Requires payors to cover a service via telehealth if it is also covered in-person and can be delivered remotely while meeting the standard of care. [Adapted from Insurance Chapter 28, Article 32, Section 3217-H]
- Originating Site: A site at which a patient is located at the time health care services are delivered to him or her by means of telehealth. (Public Health Law, Article 29-G, Section 2999-CC)
- Distant Site: A site at which a provider is located while delivering health care services by means of telehealth. (Public Health Law, Article 29-G, Section 2999-CC)
- E-Visits: Patient-initiated communications with a medical provider through a text-based and HIPAA-compliant digital platform, such as a patient portal. (Public Health Law, Article 29-G, Section 2999-CC)
- Interprofessional Consultations (E-Consults): Asynchronous or synchronous, consultative, provider-to-provider assessment and management services conducted through telephone, internet, or electronic health records. (NY Code of Rules and Regs. Title 18, Sec. 538.1)
- Remote Patient Monitoring (RPM): The use of synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an originating site that is transmitted to a telehealth provider at a distant site for use in the treatment and management of medical conditions that require frequent monitoring. (Public Health Law, Article 29-G, Section 2999-CC)
- Store and Forward: Asynchronous, electronic transmission of a patient's health information in the form of patient-specific digital images and/or pre-recorded videos from a provider at an originating site to a telehealth provider at a distant site. (Public Health Law, Article 29-G, Section 2999-CC)
- Virtual Check-Ins: Brief communication via a secure, technology-based service initiated by the patient or patient's guardian/caregiver, e.g., virtual check-in by a physician or other qualified health care professional. (Public Health Law, Article 29-G, Section 2999-CC)

Appendix C. Current Regulations Establishing Telehealth Coverage and Reimbursement Rules in NYS

Medicaid	
Public Health Law, Article 29-G, Section 2999-DD	• **Temporary** payment parity for services provided via telehealth under the Medicaid program (administered by NYSDOH) through April 1, 2026. • Sets standards for dental telehealth services.
Public Health Law, Article 29-G, Section 2999-CC	• Defines telehealth delivery. • Defines eligible telehealth providers and modalities (store and forward, RPM).
NY Code of Rules and Regulations. Title 18, Sec. 538.1	• Stipulates that all Medicaid providers and providers can deliver services via telehealth if they are appropriate to meet a patient's needs and are within a provider's scope of practice. • Provides definitions for additional modalities (i.e., e-consults, virtual check-in).
NY Code of Rules and Regulations. Title 14, Sec. 596.5 **and** 596.7	• Authorizes telehealth services delivered by OMH providers. • Specifies coverage requirements (e.g., originating, distant site, documentation, provider license and scope of practice).
14 NYCRR Part 596	• Establishes telehealth policy regulations and requirements for services provided by practitioners employed by OMH; establishes a formal set of standards for telepsychiatry.
14 NYCRR 830	• Establishes telehealth policy regulations and requirements for services provided by practitioners employed by OASAS.

State-Regulated Commercial Payors	
• Insurance Chapter 28, Article 32, Section 3217-H • Insurance Law, Article 43 Section 4306-g • NY Codes, Rules, & Regulations. Title 11, Sec. 52.16 (q)(3)	• Telehealth definition. • **Temporary** payment parity through April 1, 2026. • Permanent coverage parity up through and beyond April 1, 2026. • Network adequacy must meet the telehealth needs of insured individuals.

1. PHE flexibilities also provided opportunities for fully virtual providers who do not have brick-and-mortar locations to deliver telehealth services. Investment in these providers is growing.

2. See Appendix C, state statute indicates that that coverage parity is in place in NYS up through and beyond April 1, 2026.

3. For example, Massachusetts Medicaid members have the choice to decline to receive services via telehealth in favor of in-person.

4. As defined by the Section 1834(m) of the Social Security Act. Telehealth services authorized before the PHE covered a limited set of services, to include stroke care, home dialysis, substance use disorder, and mental health treatment.

5. In the early 2000s, CMS established a regulatory process to evaluate telehealth benefits and determine coverage of telehealth services for Medicare beneficiaries. CMS provides the public with the opportunity to submit requests to add or delete telehealth services and coverage, and payment decisions are communicated annually through the Physician Fee Schedule rule. Services can be added to the coverage list if they resemble a service already on the permanent telehealth services list (Category 1), or if there is sufficient evidence to show that the service can be safely and effectively provided via telehealth (Category 2). CMS added a third category (Category 3) in 2020 as a temporary holding place for some of the telehealth services that were added during the PHE.

6. Medicare has also expanded coverage over time of virtual check-in services and remote patient monitoring to established patients.

7. On July 10, 2024, CMS released the 2025 MPFS proposed rule. More information is available here.

8. A separate state plan amendment is only required if Medicaid telehealth services are paid differently than the equivalent in-person service.

9. Congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems, and technology-dependent care.

10. Certain providers have temporary eligibility to provide telehealth coverage through April 1, 2026 (e.g., certified peer advocates, mental health practitioners licensed under Article 163 of the Education Law).

11. Per Title 18 of the New York Codes, Rules and Regulations (NYCRR) Part 538, recent additions to the "telehealth provider" definition include: 1. Licensed and certified voluntary foster care agencies, as well as providers employed by those agencies. 2. Providers licensed or certified by the New York State Education Department (NYSED) to provide Applied Behavioral Analysis therapy. 3. Radiologists licensed pursuant to Article 131 of the Education Law and credentialed by the site from which the radiologist practices. 4. All NYS Medicaid providers and providers employed by NYS Medicaid facilities, or provider agencies who are authorized to provide in-person services, are authorized to provide such services via telehealth if such telehealth services are appropriate to meet the needs of the patient and are within the scope of practice of the provider.

12. Including, but not limited to 45 Code of Federal Regulations (CFR) Parts 160 and 164 [HIPAA Security Rules]; 42 CFR, Part 2; Public Health Law Article 27-F; and Mental Hygiene Law §33.13.

13. Informed consent includes: 1. The telehealth provider must confirm that the NYS Medicaid member is aware of the potential advantages and disadvantages of telehealth, be given the option of not participating in telehealth services and information regarding their right to request a change in service delivery mode at any time. 2. The telehealth provider must inform NYS Medicaid members that they will not be denied services if they do not consent to telehealth devices or request to receive services in-person. 3. Where the NYS Medicaid member is a minor and the service requires parent/guardian consent, consent shall also be provided by the parent/guardian or other person who has legal authority to consent to health care on behalf of the minor.

14. OMH's guidance is available here; and OASAS' is here. See Appendix C for relevant state statutes related to OMH and OASAS telehealth policy.

15. There is broad acceptance of coverage parity. As of March 2024, at least 40 states have implemented coverage parity. NYS has implemented coverage parity permanently.

16. As noted above, audio-only services may be used to deliver behavioral health services in the Medicare program as stipulated in the MPFS.

17. Under PPS, FQHCs are paid a predetermined rate that encompasses reimbursement for all services provided during a single visit, and it is adjusted annually for inflation. States have some flexibility in the scope of services considered in the PPS rate development calculation and must have a process to adjust PPS rates to reflect changes to the scope of services provided by the FQHC, such as when a new covered benefit is added to the Medicaid program.

18. APGs are NY's outpatient payment system, which groups similar procedures based on patient clinical characteristics and expected resources.

19. Other Article 28 facilities, such as hospital outpatient departments, emergency departments hospital diagnostic and treatment centers, and FQHCs opting into APGs, may only bill the Professional Component of the APG claim when the provider and patient are offsite. Similar to FQHCs that have not opted into APGs, this results in lower total reimbursement.

20. The PPS rate is determined using data available from a specific base year. The rate is often based on the costs of each provider, which are then trended forward year-by-year to take into account inflation. NYS has an ambulatory care cost-based, prospective payment system in regulation, which uses a rolling base year (i.e., changes each year to a base of two-years prior). Because it has been frozen since 1995, however, it has effectively become a flat, fixed rate of payment.

21. The Senate and Assembly One-House Budgets modeled their proposal based on legislation introduced by Assemblymember Paulin and Senator Rivera (A.7316 /S.6733).

22. Some compacts are relatively new and not yet active, such as the Audiology and Speech-Language Pathology Interstate Compact.

23. NYS lawmakers have previously introduced legislation (A7947/A7948; SB6883/5872) for the state to join the following licensure compacts in addition to the IMLC and NLC: Psychology, Emergency Medical Services, Counseling, Physical Therapy, Occupational Therapy, Audiology, Speech-Language Pathology.

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