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Fact Sheet: Policy Opportunities to Expand Equitable Access to Telehealth across New York State

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Background

Telehealth utilization spiked during the COVID-19 pandemic, facilitated by state and federal policy change through the COVID-19 public health emergency (PHE) declaration. Use has tapered off from the height of the pandemic, but telehealth is still used more widely than pre-pandemic and has become an integral component of care delivery, particularly for behavioral health. The PHE illuminated the benefits of telehealth in expanding access to care. For many, 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. However, barriers remain that limit the potential of telehealth for patients, such as lack of affordable broadband service and digital literacy gaps, and for the providers that serve them, such as disparate payment rates and licensure challenges.

New York State (NYS) has been a national leader in expanding access to telehealth.[i] Before and throughout the PHE, NYS removed restrictions to telehealth delivery and broadened its telehealth policies for Medicaid and commercial plans to enable providers to deliver a comprehensive set of virtual health care services in a variety of settings. NYS has largely maintained PHE-era telehealth policies and kept pace with the majority of states, but opportunities remain for NYS to strengthen and enshrine these policies.

State policymakers are now revisiting whether to sunset or memorialize in statute policies temporarily enacted during the PHE. They are also considering additional policy changes to preserve and expand equitable access to telehealth services for all New Yorkers.

The purpose of this document is to highlight key issues policymakers are considering aimed at expanding equitable access to telehealth, including:

- ***Coverage and Payment Parity:*** *Will temporary telehealth coverage and reimbursement parity across payors be extended or codified in statute?*
- ***Payment Rates for NYS' Community Health Centers (CHCs):*** *Will different types of providers have different payment rates and flexibilities to provide telehealth?*
- ***Cross-State Provider Licensure:*** *Will telehealth be leveraged to allow providers in other states to provide patient care in NYS and relieve workforce shortage and strain?*

Telehealth Policy Issues and Opportunities

Coverage and Payment Parity

Coverage and payment parity laws[ii] ensure equal coverage and reimbursement for services delivered in-person and virtually, thereby providing the foundation for patients' access to telehealth. In response to the PHE, which enacted coverage and payment parity in NYS, providers rapidly expanded their telehealth offerings, adjusting their workflows and allocating significant capital and staff resources to make virtual modalities an option for patients.

While most states have made coverage and payment parity permanent, NYS' policies remain temporary.[iii] Payment parity, or reimbursement for telehealth services on par with in-person care, will sunset on April 1, 2024 for Medicaid and state-regulated commercial health plans under current statute.[iv] Similarly, coverage parity will sunset on April 1, 2024 for state-regulated commercial payors and December 31, 2024 for Medicaid.[v]

To date, NYS policymakers have not yet settled on a policy approach to telehealth coverage and payment parity. **Governor Hochul's Executive Budget and the Assembly's One-House Budget for State Fiscal Year 2024-2025 propose to extend telehealth payment parity for Medicaid and state-regulated commercial payors through April 1, 2025. The Senate's One-House Budget proposes to codify telehealth payment parity in state statute with no sunset date.** Without the codification of payment and coverage parity protections in statute, providers may be reluctant to pursue further investment in telehealth and virtual care delivery.

Payment Rates for NYS' CHCs

One of the benefits of telehealth is the flexibility and convenience virtual visits offer both patients and providers. However, the NYS Department of Health currently requires Article 28-licensed CHCs to have either the provider *or* their patient on-site at the clinic to receive the normal, bundled prospective payment service (PPS) rate**. If neither the provider nor the patient is on-site, Article 28-licensed CHCs may only bill their "off-site" rate for a telehealth visit, which effectively reduces payment by two-thirds of the PPS rate**. In contrast, behavioral health clinics licensed by the Office of Mental Health (Article 31 clinics) and substance use disorder outpatient clinics licensed by the Office of Addiction Services and Supports (Article 32 clinics) receive full payment of their bundled rates for all telehealth visits, regardless of where the patient and provider are located.[vi] NYS differs from most other states in these licensure distinctions and telehealth regulations.

This reimbursement difference significantly impacts the ability of CHCs to sustain delivery of services via telehealth, meet patients' needs and preferences, and recruit and retain providers,

particularly behavioral health clinicians, who are seeking flexibility to work remotely through other clinics.

Both the Senate and Assembly One-House Budgets address this discrepancy, allowing Article 28-licensed CHCs to receive their full reimbursement rate for telehealth service delivery regardless of provider or patient location.

Cross-State Provider Licensure: Flexibility to Deliver Telehealth Services

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. The onset of the PHE prompted many states, including NYS, to adopt temporary licensure flexibilities that enabled physicians and other health professionals to work across state lines and provide telehealth care without having to apply for a license in those states. Other states are memorializing such changes through a spectrum of licensure policies, 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, which offers different pathways to practice across state lines by provider type.
- Telehealth Registries or Special Licenses: 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.
- Licensure Reciprocity: A state may issue extraterritorial licenses to providers who reside or practice in adjoining states.
- Exceptions to 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).

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. **Governor Hochul's Executive Budget proposes to expand the ability of select provider types to deliver telehealth services across state lines through participation in licensure compacts:**

- **The Interstate Medical Licensure Compact, which provides 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 Nurse Licensure Compact, which allows nurses to have one multistate license that enables them to practice in all member states, including NYS.**

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However, the Senate and Assembly have removed these provisions from their One-House Budgets.

Conclusion

Policymakers are at an inflection point as they consider the future of telehealth in NYS. Now is an important window of opportunity following the COVID PHE to memorialize lasting telehealth policy and enable all New Yorkers to have continued and enhanced access to telehealth. This is an active area of policy change that will be closely monitored in the coming months.

Beyond structural changes to telehealth reimbursement and regulation, city and state policymakers are also considering support for telehealth programs to address pressing health needs. For instance, the Senate One-House budget proposes to expand statewide a New York City program for teenagers to receive up to five no-cost telehealth sessions annually with licensed therapists for acute crisis response and mental health assessment.

Shoring up telehealth policies in NYS, scaling promising programs across the state, and replicating effective policy changes from other states are all needed to ensure that New Yorkers have equitable access to care.

NOTES

[i] Definitions of telehealth in NYS:

- Medicaid: The use of electronic information and communication technologies by telehealth providers to deliver health care services, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient (Public Health Law, Article 29-G, Section 2999-CC).
- Commercial: The use of electronic information and communication technologies, including the telephone, by a health care provider to deliver health care services to an insured while such insured is located at a site that is different from the site where the health care provider is located (NY Code of Rules and Regs. Title 14, Sec. 596.5 and 596.7).

[ii] Definitions:

- 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.
- Payment parity requires payors to reimburse for telehealth at the same rate as the equivalent in-person service.

[iii] As of December 2023, 40 states provide coverage parity and 25 provide payment parity (4 states only for specific services). For more information, please see: https://www.ama-assn.org/system/files/ama-state-telehealth-policy-trends-2023.pdf

[iv] Medicaid:

- Public Health Law, Article 29-G, Section 2999-DD

Commercial:

- NY Insurance Law Article 32 Section 3217-h & NY Insurance Law Article 43 Section 4306-g, as amended by A 9007 (2022 Session)

[v] Medicaid:

- Department of Health Announcement, July 2023, available here: https://www.health.ny.gov/press/releases/2023/2023-07-31_medicaid_telehealth_coverage.htm

Commercial:

- Insurance Chapter 28, Article 32, Section 3217-H
- Insurance Law, Article 43 Section 4306-g

[vi] There are no separate professional fee schedules or facility fees that Article 28 clinics may bill that differ from Article 31 and 32 clinics.

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