NYACP is pleased to share a telehealth update with you written by Audrey Liu, MD, PGY-2 Internal Medicine, NSUH/LIJ. Dr. Liu is completing her Steven Walerstein, MD, MACP Advocacy Internship with us this week. Thank you for all of your hard work and help these past few weeks Dr. Liu. It has been a pleasure to work with you!

An Introduction to Telehealth Regulation, with Focus on New York

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By Audrey Liu, MD

Objectives

1. Describe the government groups involved in regulation of telehealth.
2. Describe the purpose of a business associate agreement in telehealth.
3. Identify the changes made during the COVID-19 pandemic surrounding regulation and reimbursement of telehealth.
4. Describe the role of the medical licensure compact in telehealth.
5. Describe current legislative items in New York that would impact telehealth.

Background

Telehealth is defined in New York State Public Health Law Section 2999-CC as follows: “Telehealth’ means 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.”

Different types of telehealth include live video (real-time, face-to-face interaction), store-and-forward (remote evaluation of stored video/images submitted by a patient), e-visits (communication via patient portal), remote patient monitoring (e.g., blood sugar and blood pressure monitoring), audio-only visits (i.e. telephone), mobile health (communicating via mobile devices/cell phones/computers), and case-based teleconferencing (e.g., interdisciplinary discussion).

Telehealth Reimbursement

Telehealth reimbursement is determined at several different levels, reflecting the “patchwork” health care system in the United States. The largest branchpoint begins at the federal level versus the state level. At the federal level, Centers for Medicare & Medicaid Services (CMS) sets reimbursement for Medicare services, which is the largest payer in the United States. At the state level, state governments largely dictate policies of their individual state Medicaid programs and also the private payer insurance market, though the federal government has a
role as well. These three major groups – Medicare, Medicaid, and private insurance dictate physician reimbursement for services. Among the New York population in 2019, 55.6% were insured by employer and non-group insurance (private insurance), 25.7% by Medicaid, 13.0% by Medicare, and 5.3% were uninsured, according to the Kaiser Family Foundation.

Protection of HIPAA in Telehealth
Another aspect of delivery of telehealth is the protection of Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically in telehealth, physicians typically would use a service provider, for example the technology or software company providing the audiovisual technology. Since the service provider therefore would handle HIPAA information, service providers and physicians had to enter a Business Associates Agreement (BAA). The function of this agreement is to detail the handling of HIPAA information, creating a “chain of responsibility”. As this relates to HIPAA, this falls under the jurisdiction of the Department of Health. U.S. Department of Health & Human Services.

Pre-Pandemic Landscape
Prior to the COVID-19 pandemic, telehealth was available, but only reimbursed in specific situations, and overall had low utilization by patients and providers. Telehealth in the pre-pandemic era accounted for a negligible share of services. Meanwhile, rapidly improving technology, including smartphones, seemed to demonstrate the theoretical ability of a large swath of patients to access telehealth from a technological standpoint. According to the Pew Research Center, in Feb 2019, 81% of U.S. adults owned a smartphone and 96% owned a cellphone. However, government regulations had not kept up with changing technology. For example, Medicare only reimbursed in situations where the patient lived in a rural area, or if the patient was in specific healthcare settings, such as qualified satellite clinical sites which fulfilled HIPAA and audiovisual technologic requirements set by CMS.

Telehealth changes with COVID-19
In early 2020, the COVID-19 pandemic upturned the country and the healthcare system. In response, the President Trump administration declared a state of emergency and the Coronavirus Preparedness and Response Supplemental Appropriations Act was passed. With this act and the 1135 Waiver, CMS expanded the telehealth benefits on a temporary basis concurrent with the declaration of the public health emergency.

This allowed for an expansion of telehealth utilization. For example, for patients with respiratory symptoms who could not come into the office due to potential for infecting others, we were now able to evaluate with telehealth visits. For patients with COVID-19, we were able to track their symptoms regularly and evaluate for needs such as monoclonal antibodies or
hospitalization. With telehealth, we cared for patients who feared coming into the clinic due to infection risk, busy parents or caregivers who could not leave their charges unsupervised at home, and working individuals who used a brief break at work to check in with their doctor.

Several major changes facilitated this. One was patients no longer had to live in a rural area, and patients could now be at home when accessing telehealth (before they had to be in specific healthcare centers). Physicians were also allowed to practice across state lines. In New York, Governor Cuomo’s Executive Order 202.5 allowed for physicians licensed in the United States, but not registered in New York to still practice without penalty related to licensure. Subsequently, Governor Hochul signed executive orders to extend these changes, and they are now set to expire March 31, 2022.

Audio-only telehealth visits also now qualified, whereas previously, visits had to be audiovisual. HIPAA regulations also were loosened and potential penalties for HIPAA violations waived as long as physicians acted in good faith. This allowed for usage of more accessible platforms that were not necessarily HIPAA compliant, such as Zoom, Skype, and FaceTime.

Regarding payment, starting in March 2020, CMS broadened reimbursement for Medicare telehealth services to include patient location/geographic location, additional CPT code services, telehealth modalities, and provider types. At the end of 2021, CMS made Medicare reimbursement for audio-only visits for mental illness/substance abuse permanent. However, currently for healthcare not under that specialty, face-to-face audiovisual connection must be used to be eligible for reimbursement.

For Medicaid, CMS issued guidance which gave states leeway to determine Medicaid reimbursement for telehealth. In New York, the Rosenthal L Bill (A10404a), signed into law in June 2020, expanded telehealth reimbursement such that audio-only or video-only communication was now eligible for reimbursement. This helped broaden access to the elderly who were comfortable using telephones and also to those with insufficient internet access to support audiovisual communication.

Throughout this discussion of reimbursement, is a concept called pay-parity. This means services provided by telehealth are reimbursed at the same rate as in-person services. The Woerner Bill (A9667) contains language for pay-parity. If pay-parity is not achieved, it is likely that physicians and other providers will not be able to continue offering telehealth service to their patients as easily.

**Interstate Medical Licensure Compact**

Expansion of telehealth included allowing physicians to practice across state lines. Prior to the pandemic, some states had banded together to create a streamlined licensing process, called the Interstate Medical Licensure Compact, allowing physicians to more easily practice in
multiple states. The compact began operations in 2017 and there are currently 34 states participating in the compact. In January, Governor Hochul’s budget proposal included the NY opt-in for participation in the Interstate Medical Licensure Compact. Final budget negotiations are currently ongoing.

**Current Legislative Items**

There are several bills in New York State legislation pertinent to this discussion:

- **Woerner Bill (A.9667)** is in Assembly Committee and would require insurances to have payment parity for certain services delivered by telehealth.
- In New York, the telehealth pay parity aspect is in Governor Hochul’s proposed budget at time of writing. If it stays in the budget, it will be able to circumvent getting through the State Senate and Assembly.
- **Palmesono Bill (A.5540)** is in legislation for NY to join the Interstate Medical Licensure Compact.

**Conclusion**

In a way, the COVID-19 pandemic was the catalyst that was able to push through the challenging and slow pace of routine legislation. As a result of these temporary regulatory changes, the usage of telehealth increased dramatically. Using claims data, the COVID-19 Healthcare Coalition Telehealth Impact Study Work Group tracked telehealth usage. In New York, just prior to the pandemic in February 2020, there were approximately 49,000 claims, which then peaked in April 2020 at 1.9 million and decreased to 1.2 million in Dec 2020, their last reported data point. In the United States, according to Kaiser Family Foundation, telehealth use increased from less than 1% of outpatient visits to a high of 13% during the first 6 months of the COVID-19 pandemic. Telehealth has become an essential part in delivery of healthcare, a valuable complement to in-person visits.

Without addressing these regulatory issues discussed, patients who are now accustomed to using telehealth may be left in a lurch when temporary measures that helped expand telehealth access expire. The outcomes of legislation for pay-parity, the Interstate Medical Licensure Compact will play an important role in the future of telehealth in New York.

**References**


8. Rosenthal L Bill (Bill Number A10404a); [https://assembly.state.ny.us/leg/?bn=A10404&term=2019&Summary=Y&Actions=Y&Memo=Y&Text=Y](https://assembly.state.ny.us/leg/?bn=A10404&term=2019&Summary=Y&Actions=Y&Memo=Y&Text=Y)


