COMMUNITY HEALTH CARE ASSOCIATION of New York State

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New York State Department of Health
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Submitted via email to *regsqna@health.ny.gov*

RE: Amendment of Sections 505.17 and 533.6 & Addition of Part 538 to Title 18 NYCRR (Telehealth Services)

The Community Health Care Association of NYS (CHCANYS) submits these comments on the proposed regulatory amendments to ensure continuity of care provided to Medicaid enrollees during the transition of telehealth services provided during the public health emergency and after the public health emergency ends. CHCANYS is the primary care association for the State's 70+ federally qualified health centers (FQHCs), also known as community health centers (CHCs), serving 2.1 million New Yorkers each year.

CHCANYS is supportive of the State's expansion of the definition of telehealth to include audio-only technologies, eConsults, virtual check-ins and virtual patient education. Additionally, we support the expanded definition of a telehealth provider to include **all** Medicaid providers who are authorized to provide in person services, so long as the services are within the provider's scope of practice. However, thoughtful reimbursement policy will ultimately ensure the success of the telehealth program, and the regulation provides little insight, stating only that "reimbursement shall be made in accordance with fees determined by the commissioner based on and benchmarked to in-person fees for equivalent or similar services." CHCANYS submits the following suggestions for reimbursement policy to be added to the regulation.

1. **Provide Full Reimbursement Parity, Regardless of Patient or Provider Location, for In Person, Audio-Only and Audio-Visual Telehealth**

In Medicaid, most FQHCs are reimbursed via their Prospective Payment System (PPS) through three fee-for-service rate codes: a threshold rate, a lower offsite rate, and a group psychotherapy rate. All three are bundled payment rates, and, as dictated by Federal statute, are cost-based in nature. The offsite rate is not equivalent to the threshold rate minus a traditional facility fee. The offsite rate was created for FQHCs to provide care outside of the walls of the clinic, however it does not account for the costs associated with providing a service remotely, even if the provider and patient are outside of the clinic. FQHCs continue to incur fixed personnel costs along with operation and maintenance of their physical sites and telehealth infrastructure regardless of provider and patient locations. As such, the offsite rate should not be deemed an appropriate reimbursement for any FQHC service delivered via telehealth, even when both a patient and provider are offsite. FQHCs should receive their threshold rate for audiovisual and audio-only telehealth, even when both the patient and provider are outside of the clinic.

Moreover, limiting payment when a patient and provider are both offsite will limit access to care, especially in behavioral health. Given the increased need for behavioral health services since the beginning of the pandemic, recruitment for behavioral health providers is extremely competitive. The ability to provide visits remotely has enhanced health centers' ability to attract behavioral health providers, most notably in areas that would otherwise go unserved. Some health centers have hired professionals living in urban areas to serve rural sites via telehealth. Others share providers with other organizations to ensure their patients have access to specialty care. During the pandemic, a surge in demand for behavioral health coupled with flexible work from home policies allowed FQHCs to significantly expand their behavioral health departments. If financial incentives do not align with flexible work policies, health centers will be forced to choose between cutting back on behavioral health staff or medical appointment availability, since in-person sites are stretched to their limits and requiring a behavioral health provider to return will necessitate removing a room used for physical health care.

A recent survey of CHCANYS members found that among all telehealth (audio only and audio visual) visits, about 17% occur with both the patient and the provider offsite. That same survey of CHCANYS members found that nearly 60% of behavioral health visits are occurring remotely, and 16% of those are occurring with both the patient and the provider located offsite. Full telehealth payment parity is needed regardless of provider and patient location to ensure that FQHCs have the most flexibility to recruit and retain providers and to meet the care needs of patients.

2. **Ensure Consistency in Payment Across Licensure Types & Payment Models**

More than a third of CHCANYS members are dually licensed, with many health centers obtaining Article 31 and/or 32 licenses through the Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) in addition to their Article 28. Some of these providers have opted into Ambulatory Patient Groups (APGs) across facilities; others bill health center PPS through one license and APGs through another; some only bill PPS across licenses. There should be no disparity between payment policy among Article 28, 31, or 32 licensed providers. Providers should receive their full APG or full threshold rate for all audiovisual and audio only telehealth visits just as they would for in person services, regardless of patient or provider location.

3. **Enable FQHCs to Bill for a Full Range of Telehealth Services**

As noted above, CHCANYS welcomes the expanded definition of telehealth to capture various synchronous and asynchronous modes of care. FQHCs have expanded work in areas like remote patient monitoring (RPM) to ensure the health and wellbeing of their patients while preventing more costly visits. Historically, FQHCs have not been able to bill for additional modes of telehealth outside of audio-visual telehealth and the telephone. We encourage the Department to add FQHC providers to the list of those who can bill for RPM and the services under the expanded definition of telehealth included in the regulation (i.e. eConsults). The Department should accomplish this by allowing FQHCs to bill separately for the new modes of telehealth **or** by recalculating the costs in the bundled PPS rates to account for costs not currently captured under PPS.

For follow up, please contact Marie Mongeon, Senior Director of Policy: mmongeon@chcanys.org.