Reimagine NY Commission

Telehealth Working Group – Background Research

I. Executive summary

The COVID-19 crisis has underscored the importance of New Yorkers having access to high-quality healthcare, while at the same time making it harder for them to obtain in-person care. As a result, New Yorkers are today more aware of telehealth. To realize the potential of telehealth to improve patient care both during and after the COVID-19 crisis, Governor Cuomo has charged the Reimagine New York Commission with 'reimagining' the future of telehealth in the state.

Prior to COVID-19, telehealth played only a small role in patient care. This has changed over the course of 2020. Telehealth usage has surged, driven by both an increase in patient and provider demand, as well as temporary policy actions taken by the federal government, New York State, and health plans to expand when, where, and how telehealth may be used. New Yorkers stand to benefit from this expansion of telehealth, as evidence suggests telehealth can improve access to care and patient outcomes, increase patient satisfaction, and reduce healthcare costs.

In order to inform the Commission's work, this memo provides background information on the current state of telehealth usage in New York, existing evidence on telehealth's effectiveness, and the impact policy guidelines have on telehealth's usage. Appendices detail telehealth terminology, the anatomy of a telehealth episode, and a recap of the Commission's work to date.

II. Telehealth usage today

Note: This and the subsequent section rely primarily on commercial claims data (requests for reimbursement submitted to private health insurance companies) to assess usage of telehealth in New York State. This data has several limitations[i] but nevertheless provides a starting point to understand the extent of current telehealth usage.

Since the outbreak of COVID-19, telehealth has evolved from a niche area of medical practice to a mainstream form of patient care. While this growth has helped soften the blow of COVID-19 to our medical system, it also has exacerbated preexisting disparities in access to healthcare — underscoring the importance of deliberate actions to ensure broader access to telehealth in the future.

Telehealth adoption

Prior to COVID-19, telehealth usage was low as a share of overall medical care across the United States. A McKinsey survey found that roughly 1 in 10 Americans (~11 percent) used telehealth at least once in 2019[ii], yet telehealth represented approximately only 1 in 500 commercial insurance claims (~0.22 percent) in January 2020, suggesting that even those Americans who could take advantage of telehealth did so for a small percentage of their care.

In New York State, telehealth also represented a small percentage of medical claims. One in 700 commercial claims filed in January 2020 were for telehealth (~0.13 percent), ranking New York slightly below the national average (~0.22 percent), and 18th of the 50 states in that metric. Texas ranked first with telehealth representing ~1.1 percent of all claims; Alaska, South Dakota, California, and Florida ranked 2nd through 5th, with telehealth representing between ~0.39 and ~0.32 percent of claims.[iii]

During the COVID-19 crisis, telehealth usage increased dramatically both in New York and nationwide due primarily to increased demand from patients and providers as well as temporary policy flexibilities that made access to such services easier (discussed further in Section IV). A number of statistics illustrate telehealth's rapid growth during this time:

- **New York State:**
  - New York had a ~130x increase in telehealth, from ~0.13 percent to ~16.8 percent of all commercial insurance medical claims from January to April of 2020.[iv]
  - New York City Health + Hospitals, the nation's largest safety net provider, saw an increase from 500 to 83,000 billable telehealth visits from February to April of 2020 (~165x).[v]
- **Nationally:**
  - McKinsey reported a 50–175x increase in telehealth visits across a range of health systems, independent practices, and behavioral health providers after the COVID-19 crisis began.[vi]
  - McKinsey also found that 76 percent of Americans are at least moderately likely to use telehealth in the future (as compared with the ~11 percent who used in 2019).[vii]
  - A separate survey found that only 18 percent of providers nationwide used telehealth in 2018, whereas 48 percent did so in April of 2020.[viii]

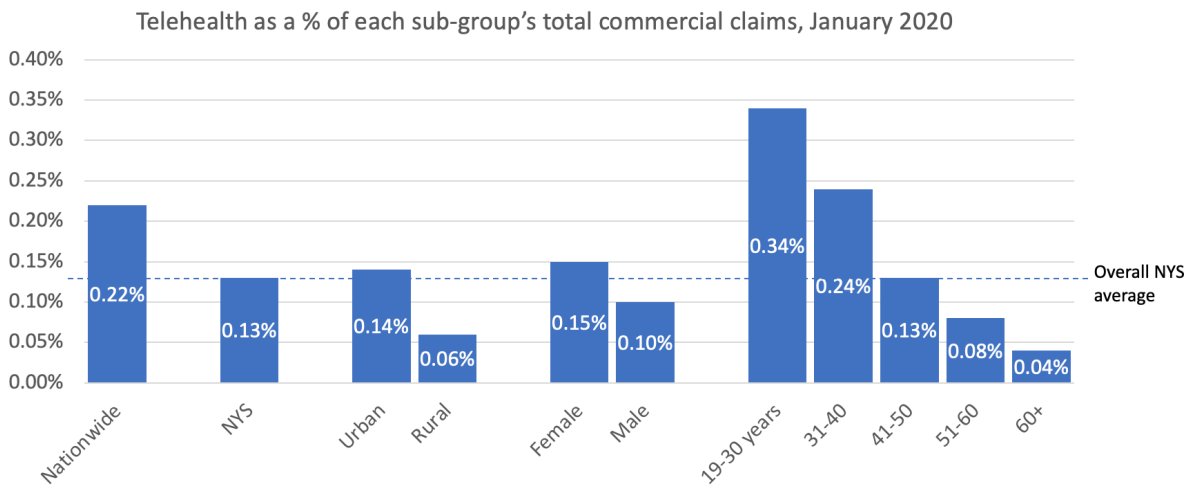
Disparities in telehealth adoption

Telehealth usage was spread unevenly throughout New York before the COVID-19 crisis, and preliminary evidence suggests usage disparities may have grown even more pronounced as a result of the crisis. These disparities reinforce the need for health plans, providers, New York State, and others to take action to ensure broader access to telehealth in the future.

Commercial claims data showed that, in January of 2020, urban residents, women, and younger New Yorkers were more likely to use telehealth than were their peers (Figure 1),[ix]

- Urban residents used telehealth at more than twice the rate of rural residents.
- Women used telehealth ~1.5x more frequently than men did.
- Younger New Yorkers (19–30 years old) used telehealth more frequently than did any other age group.

Figure 1. Telehealth usage by sub-group
(Commercial insurance, January 2020)



Source: FAIR Health

Additional research confirms that, pre-pandemic, various underserved communities were less likely to be able to take advantage of telehealth. Separate studies have found that, in addition to rural and older populations, lower-income communities, racial and ethnic minorities, and groups with limited English proficiency are less likely to

have access to telehealth because they lack internet connectivity, audiovisual devices, technical and general health literacy, and health insurance, among other barriers.[xi, xii, xiii, xiv, xv]

Evidence suggests many of these disparities persist. Commercial claims data reveals that, in April of 2020, rural and older New Yorkers remained significantly less likely to access telehealth than were their peers.[xvi] Early data suggests increases in telehealth usage have been smaller among community providers serving lower-income populations. These ongoing disparities are likely due to a similar set of reasons as the pre-existing disparities noted above, including lack of internet connectivity, devices, technical literacy, and translation tools. These barriers may impede telehealth access entirely or limit underserved populations to audio-only telehealth visits, which in some situations may result in lower-quality care.[xvii, xviii]

III. Evidence of telehealth's efficacy

Telehealth's efficacy

Telehealth can benefit patients—through broader access to care, and improved outcomes and satisfaction—while reducing healthcare costs. Although telehealth has historically been used most frequently for behavioral health, evidence suggests promise across primary care and a range of practice specialties.

- **Broader access:** Telehealth can offer access to care that patients would otherwise delay or forego entirely. Telehealth can (1) minimize costs and risks associated with traveling to access care, including having to miss school or work; (2) make it easier for patients to set appointments, including during nights and weekends; (3) increase access to scarce specialty care; and (4) avoid in-person exposure to both COVID-19 and other secondary infections that can be picked up in clinical settings.[xix, xx]
- **Improved outcomes:** Evidence suggests quality of care delivered via telehealth is comparable to in-person care, while also being logistically easier for patients and providers alike. The ease by which appointments are set up online lets providers rapidly see and triage patients with urgent needs, ultimately resulting in better patient outcomes.[xxi]
- **Improved satisfaction:** A number of studies suggest patients value the convenience of telehealth. Telehealth can save patients' time and money in travel expenses, reduce wait times, and provide scheduling flexibility. In addition to increasing access to care, these factors also improve patients' satisfaction with their care.[xxii, xxiii, xxiv, xxv]
- **Reduced costs:** Preliminary evidence suggests telehealth can also substantially decrease healthcare costs by ensuring patients get both the preventative and regular care they need to avoid more expensive forms of care (e.g., emergency care, inpatient). Telehealth has been associated with reduced hospitalizations and days of inpatient care for patients with a wide range of conditions, including mental health, heart failure, hypertension, and diabetes. One study by the Veterans Health Administration associated effective telehealth with a ~$6,500 decrease in annual costs per patient.[xxvi] A study in California found that telehealth utilization is skewed toward nights and weekends, raising the possibility that telehealth can serve as a much less expensive substitute for emergency department visits during times when physicians' offices tend to be closed.[xxvii] A third study highlighted the role that remote monitoring can play in helping the elderly to age in place, avoiding the need to relocate to more expensive care sites.[xxviii]
- **Other benefits:** A 2017 meta-analysis reviewed 44 studies on telehealth and found that additional benefits may include improved communication between patients and providers, improved patient self-awareness and ability to self-manage, and fewer missed appointments. Many of these findings held across a variety of modalities (e.g., synchronous versus asynchronous care) and patient conditions (e.g., physical versus behavioral health).[xxix]

While telehealth can lead to the benefits previously mentioned, its efficacy can vary depending on the context

in which it is utilized. Provider-to-patient telehealth (see Appendix 1 for definitions) is more likely to be effective for services that allow for remote diagnosis and care (e.g., management of chronic conditions, some behavioral health needs, some virtual urgent care).[xxx] Provider-to-provider telehealth can be particularly useful in time-sensitive situations when patients lack immediate in-person access to a specialist, for example when used for tele-stroke services.[xxxi]

There are situations in which providers may choose to avoid telehealth. These may include, for example, situations that require physical contact (e.g., physical exams, diagnostic testing, lab or imaging work, surgical procedures), complex or uncertain diagnoses, or scenarios in which human-to-human contact may have therapeutic benefit. Some providers may also prefer to avoid telehealth when delicate conversations are required (e.g., severe diagnoses), although evidence suggests telehealth can also be effective in these scenarios.[xxxii, xxxiii, xxxiv]

Further research into utilization and efficacy of specific telehealth tools and use cases is critical to continually improve clinical practice. For instance, additional research is needed to understand how different modalities of telehealth (e.g., audio-only versus audiovisual) perform in various clinical contexts. Yet evidence to date suggests telehealth has an important role to play as one tool in the arsenal of healthcare providers.

Telehealth usage by type

While evidence suggests telehealth can be successful in multiple contexts, historical usage in New York State has been more narrowly focused.

Generally speaking, telehealth can create two types of connections: provider-to-patient, to directly provide care, and provider-to-provider, to enable consultation between medical professionals (see Appendix 1 for definitions). As referenced in the previous section, both of these types of care can deliver significant benefits. That said, New York-based providers use telehealth primarily for provider-to-patient purposes, which represented over 98 percent of commercial telehealth claims in January of this year.[xxxv]

Within provider-to-patient interactions, telehealth is not used equally across specialties. Usage for behavioral health services, for example, significantly exceeds that for other specialties. In State fiscal year 2019, more than 50 percent of all New York Medicaid telehealth encounters were for behavioral health.[xxxvi] Among commercial insurance claims, ~40 percent of January 2020 telehealth encounters were coded as “mental health conditions” (a subset of behavioral health).[xxxvii]

After behavioral health, the next most common diagnosis categories in New York State commercial insurance claims were for acute respiratory diseases and conditions (~12 percent), skin infections or issues (4 percent), urinary tract infections (3 percent), and contraception (2 percent).[xxxviii]

While telehealth use has been concentrated so far in behavioral health, the technology has the potential to play a larger role across a range of additional specialties and primary care.[xxxix]

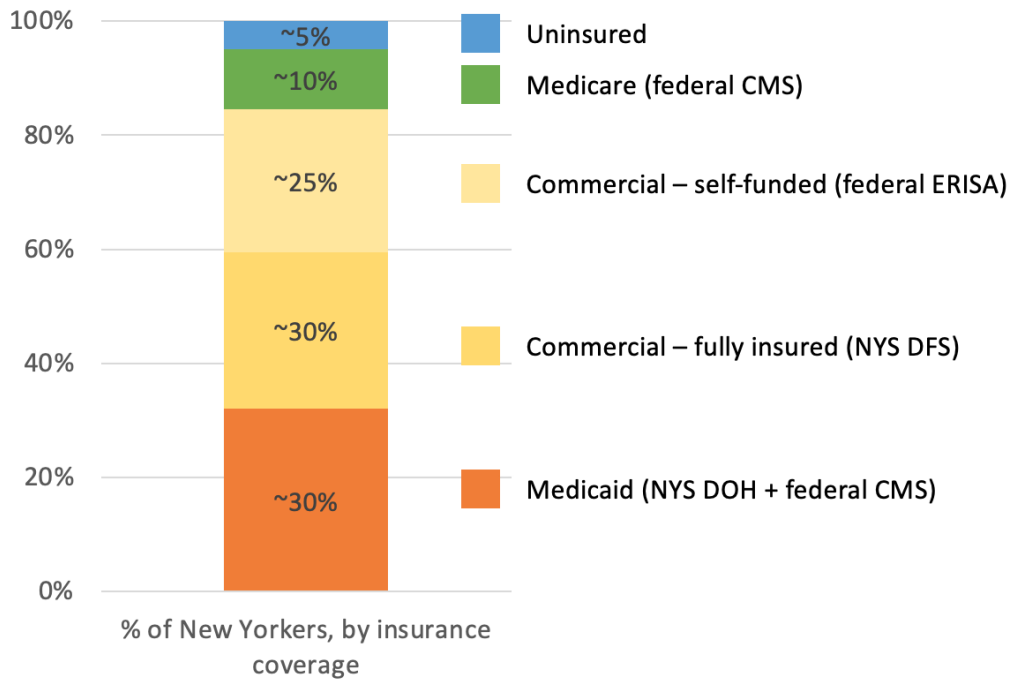
IV. Telehealth policy in New York State

A combination of federal, New York State, and private health plan policies dictate which telehealth services are covered and at what rate they are reimbursed. Prior to COVID-19, many of these policies erred on the more restrictive side, placing limits on telehealth’s usage. Since the crisis, these institutions have implemented flexibilities that have been critical to the expansion of telehealth discussed in Section II.

Telehealth policy prior to the COVID-19 crisis

Most New Yorkers receive insurance coverage through one of three programs: Medicaid, commercial insurance, or Medicare (Figure 2).[xl, xli] New York State's ability to set policies that influence telehealth's treatment varies across each of these three programs. The State has direct responsibility for overseeing Medicaid; commercial insurance falls under the regulatory authority of the State but is operated primarily by private health plans; and Medicare is a federally managed program over which the State has minimal control. While all three programs have traditionally included limitations on telehealth's usage, Medicare has in many ways been the most restrictive.

Figure 2. New Yorkers by insurance coverage
(and primary oversight authority)



The below section outlines telehealth policy pre-COVID-19 in New York State across these three programs.

Source: NYS Dept. of Health, Kaiser Family Foundation, Centers for Medicare & Medicaid Services, Reimagine NYS Analysis

Medicaid

Medicaid covers almost one-third of the State's population, and generally serves low-income New Yorkers. Enrollees generally have the choice to access care via telehealth if they prefer, with most common provider and service types available. However, Medicaid does not cover audio-only telehealth or guarantee equal reimbursement for telehealth (relative to in-person care), and has additional restrictions limiting behavioral health services.

Enrollment. As of August 2020, there were 6.6 million New Yorkers enrolled in Medicaid.[xlii] Within New York's Medicaid population, ~72 percent of enrollees are covered by Medicaid Managed Care (MMC), an arrangement in which the State pays managed care organizations a set per-member/per-month payment to deliver benefits.[xliii] Most remaining enrollees are covered through fee-for-service (FFS) arrangements. Medicaid policy is set by the

State Department of Health, the federal Centers for Medicaid and Medicare services (CMS), and individual MMC plans (see Appendix 1 for an overview and definitions of key policy terminology).

Coverage. Medicaid MMC offers patients a number of telehealth options. MMC covers most major provider types via telehealth,[xliv] while also allowing patients to access telehealth from a broad range of locations, formally termed "originating sites" (e.g., their homes, schools, clinical settings).[xlv] New York State's Medicaid program covers asynchronous telehealth modalities such as store-and-forward and remote patient monitoring, with some limitations.[xlvi] Under MMC policy, any services covered in-person are also covered via telehealth ("coverage parity"). Several of these telehealth options are the result of actions New York State has taken since 2006 to expand coverage of telehealth.[xlvii]

For physical health services (non-behavioral health), the State and federal governments maintain some restrictions on telehealth in order to minimize fraud, waste, and abuse, protect patient privacy, and manage overall healthcare quality and cost. The State only allows reimbursement for visits in which the provider's physical location (i.e., distant site) is a subset of clinical locations.[xlviii] Neither CMS nor the State reimburses for audio-only telehealth.[xlix] The State does not require that plans reimburse in-person and telehealth services at the same rate ("reimbursement parity"). The federal government also limits which services can be offered via telehealth, excluding for example a variety of home and community-based services including day habilitation, community habilitation, and respite.

For behavioral health, several additional federal and State restrictions apply. Federal and State laws require that certain types of behavioral health visits, in particular those that involve the prescription of controlled substances, only occur between a provider and a patient who has had a prior in-person encounter. Federal and State policies also require written consent from a patient in advance of certain behavioral telehealth encounters. State policy requires providers to have prior written authorization before offering certain behavioral telehealth services.[l, li]

For those patients under Medicaid fee-for-service arrangements, Medicaid typically covers and reimburses for physical health services provided via telehealth in the same manner as for those provided in-person.

Licensing. Licensure laws limit out-of-state practitioners from serving patients in New York. New York State requires providers wishing to serve New York State patients (i.e., patients with an originating site in New York State) to be licensed in New York through the New York State Education Department's Office of the Professions, even if such providers do not physically reside in the State. Twenty-nine other states participate in the Interstate Medical Licensure Compact, which streamlines reciprocal licensing, but New York State has not joined this compact.[lii] This licensure requirement holds across providers and insurance types.

Commercial insurance

More than half of New Yorkers are enrolled in commercial insurance plans. Commercial insurance encompasses a wide range of insurers and plans that vary significantly in terms of their telehealth coverage policies.

Enrollment: In 2018, there were more than 10.5 million New Yorkers enrolled in commercial insurance plans (~55 percent of the state population).[liii] Approximately half of these New Yorkers were in fully insured plans (~5-6 million) and half in self-funded plans (~5 million) (see Appendix 2 for definitions of fully insured versus self-funded plans).[liv, lv] Fully insured plans are regulated primarily by the State Department of Financial Services (DFS). The federal government, under the Employee Retirement Income Security Act (ERISA), regulates self-funded plans.

Coverage: DFS mandates coverage parity between in-person and telehealth, but commercial insurers have flexibility to set their own policies with regard to issues such as reimbursement levels and coverage for originating sites, distant sites, and asynchronous telehealth modalities.[lvi] ERISA does not require self-insured plans to offer coverage parity for telehealth, leaving telehealth coverage to the discretion of plan operators.[lvii]

Medicare
Approximately one in ten New Yorkers are enrolled in Medicare, which covers telehealth in a limited range of settings.

Enrollment: As of May 2020, there were more than 2.1 million New Yorkers enrolled in Medicare[lviii, lix] (~10 percent of the state population). Medicare generally serves patients who are older than 65 years or who have complex medical needs, and the federal government (CMS) sets Medicare policies.

Coverage: Prior to the COVID-19 crisis and associated policy changes, Medicare was relatively more restrictive of telehealth coverage (outside of emerging alternative payment arrangements or Medicare Advantage). Medicare only reimbursed for telemedicine (synchronous, audiovisual telehealth), not store-and-forward or remote patient monitoring. Medicare also only covered a limited set of services, with restrictions on originating sites (clinical settings only) and patient geography (rural areas only).[lx]

Uninsured
Enrollment: In 2018, there were ~1 million uninsured New Yorkers (about five percent of the population).[lxi]

Coverage: While some institutions across New York have sought to provide telehealth services to uninsured populations, access is generally limited for these individuals, who rely instead on safety net, urgent, and emergency care facilities for healthcare services.

Telehealth policy flexibilities since COVID-19

Since the beginning of the crisis, New York State and the federal government have implemented a number of policy flexibilities in order to expand access to and usage of telehealth. These changes have been far-reaching, influencing Medicaid, commercial insurance, and Medicare alike. Such flexibilities have helped drive the growth in telehealth discussed in Section II; and if made permanent, these changes would place New York among the most progressive states in telehealth.

In this section, we review how select New York State policies compare to other states, and how they have been modified by temporary flexibilities granted by New York State during COVID-19.

The rows in the following table constitute a non-exhaustive list of policies in support of telehealth. For each policy, the table indicates how many states had implemented the relevant policy prior to the crisis, whether New York was one such state, and whether New York has changed its policy during the crisis. Green shading indicates that New York implemented the policy during the corresponding period; red means it did not. See Appendix 1 for more detail on each policy discussed in this table.

(See next page for table)

Summary of key telehealth policies and emergency flexibilities in New York State

		Number of states meeting criteria (pre-crisis)[lxii, lxiii]	New York State (pre-crisis)[lxiv, lxv]	New York State's temporary flexibilities[lxvi, lxvii, lxviii]
Medicaid	**Covers at least 1 asynchronous modality**	34	Yes	Incremental changes to expand coverage
	Covers audio-only telemedicine	4+	No	Yes
	Allows home as originating site	41	Yes	Incremental changes to add additional covered sites
	Reimburses home as a distant site	NA	Limited to certain provider types	Yes
	Allows all provider types	26	No (although most provider types covered)	Yes
	Has coverage parity	21	Yes	No change
	Has reimbursement parity	28	No	Parity informally recommended
Commercial (fully insured)	**Requires coverage of audio only telemedicine**	NA	No	Yes
	Requires coverage parity	36	Yes	No change
	Requires reimbursement parity	16	No	No change
All insurance types	**Offers interstate licensure reciprocity**[lxix]	29	No	Yes
	Prohibits co-pays / cost-sharing for telehealth	NA	No	Yes
	Allows digital consent	NA	No	Yes

The federal government—including CMS, the Drug Enforcement Agency (DEA), and the Department of Health and Human Services (HHS)—has also made several temporary changes to expand utilization of telehealth in response to the COVID-19 crisis. CMS substantially reduced limitations on telehealth delivery, including taking steps to waive Medicare's restrictions on originating and distant sites as well as patient geography, to waive a variety of Medicare and Medicaid restrictions on providers and services covered via telehealth, and to allow coverage for audio-only telehealth. The DEA similarly created flexibility by waiving the requirement that patients and providers have an established in-person relationship prior to prescription of certain controlled substances. HHS made it easier for providers to quickly launch and expand telehealth programs that were convenient for their patients by announcing that the federal government would not impose penalties on providers inadvertently violating the Health Insurance Portability and Accountability Act (HIPAA), provided those violations were part of good-faith efforts to provide telehealth while protecting patient privacy.[lxx]

The impact of these State and federal flexibilities has been to catalyze expansion of telehealth. While they largely remain in place as the COVID-19 crisis continues, both New York State and the federal government must assess which of these or other new policies warrant permanence beyond the crisis. Those decisions will have significant implications for telehealth usage in New York State.

V. Conclusion

Telehealth's recent expansion has been catalyzed by short-term need and temporary policy flexibilities. Achieving telehealth's long-term potential, however, will require deliberate action by the State, federal government, and organizations throughout the health system. These organizations should preserve and build on policies that most effectively enable telehealth. They should also find ways to empower patients with the tools they need to access telehealth, and equip providers with the resources to deliver high quality care to all patients. These actions should include steps to specifically address persistent inequities in access to care and ensure underserved communities can take full advantage of telehealth.

In the coming months, the Reimagine New York Commission will identify opportunities to ensure that New York State can leverage telehealth to create a more accessible, equitable, effective, and efficient healthcare system.

Appendix 1. Terminology

Definitions

The Center for Connected Health Policy describes telehealth as "a collection of means or methods for enhancing health care, public health and health education delivery and support using telecommunications technologies."[lxxi] Telehealth can include several modalities:

- **Telemedicine:** real-time audiovisual consultation, examination, diagnosis, and treatment (depending on regulations/statutes, audio or video only communication may or may not be included)
- **Store-and-forward:** asynchronous transmission of an electronic recording (e.g., photo, video) to a provider for examination (patient-to-provider, or provider-to-provider)
- **Remote patient monitoring (RPM):** collection and transmission of patient data to a remote provider via wearable devices or other medical technologies
- **Mobile health:** ("mHealth", sometimes considered a subset of RPM) use of mobile devices to access health information (e.g., health applications, portal messaging, push notifications on disease outbreaks)

Telehealth may also include other remote communication technologies, including some remote activities that have no in-person equivalent.

Within "telemedicine," there are several further subdivisions:

- **Provider-to-patient,** which includes:
  - Established provider-to-patient: patient sees established provider via telehealth
  - Outsourced provider-to-patient: established provider outsources telehealth to a partner, who sees patient
  - Telehealth direct to patient: patient consults telehealth provider with no connection/relationship to established/in-person provider(s)
- **Provider-to-provider:** provider-to-provider consultation (e.g., a specialist in a "hub" hospital consults with a provider based in a "spoke" facility, or an "e-consult")

Policy terminology

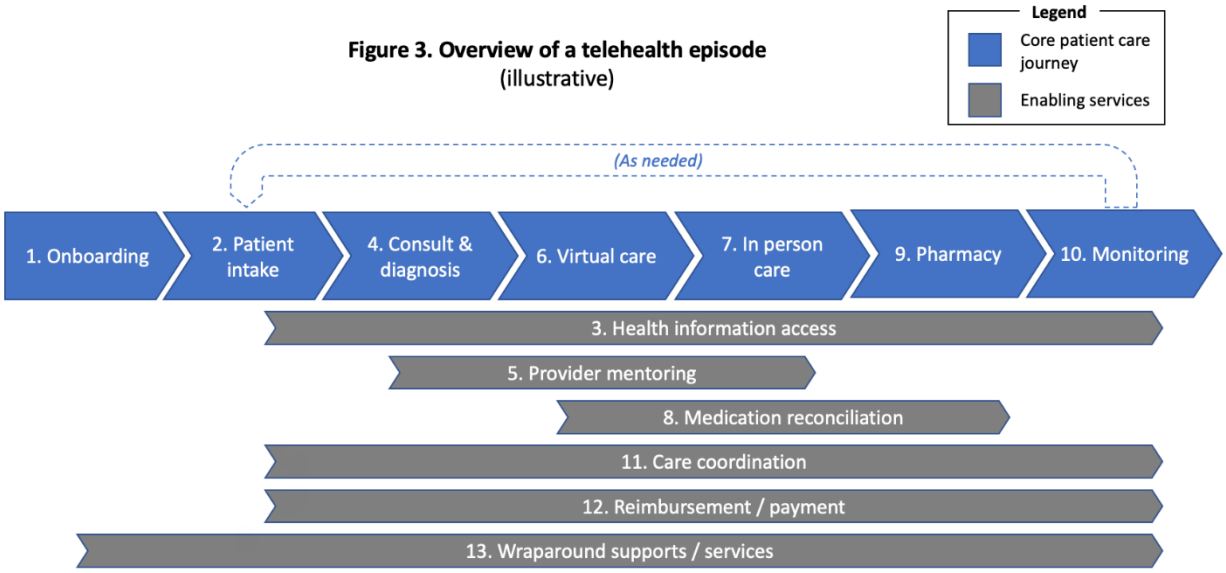
Telehealth policy may cover a variety of areas, including:

- **Modality:** the format of a telehealth encounter (e.g., audiovisual, audio only, store and forward, remote patient monitoring)
- **Originating site:** where the patient is located (e.g., clinical versus non-clinical setting), with relevant factors including
  - State: for provider licensure purposes
  - Patient geography: urban, rural, suburban
- **Distant site:** where the provider is located
- **Covered providers:** the types of providers that are allowed to use telehealth
- **Covered services:** the types of services providers can offer
- **Physician-patient relationship:** whether the patient has an existing or new relationship with the provider (e.g., prior visits)
- **Coverage requirements:** e.g., requirements for same coverage for telehealth as in-person visits ("coverage parity")

- **Reimbursement requirements,** e.g., requirements for same reimbursement levels for telehealth as in-person visits (“reimbursement parity”)
- **Data and privacy:** HIPAA as well as other federal/state data privacy laws ensuring data is handled in a secure way
- **Informed consent:** requirements on how patient must provide consent (e.g., prior, written)
- **Licensure:** state-granted permission for a provider to serve patients at the originating site
- **Device regulations:** e.g., federal Food and Drug Administration regulations on remote monitoring devices

Appendix 2. The anatomy of a telehealth episode

Figure 3. Overview of a telehealth episode
(illustrative)



A telehealth clinical encounter may involve several components. While a single patient encounter is unlikely to entail all of the following steps via telehealth, this continuum represents the range of possible components of a telehealth encounter (Figure 3):

1. **Provider and patient onboarding:** provider sets up infrastructure and tools to offer telehealth services (prior to first use of telehealth); patient sets up infrastructure prior to first telehealth use
2. **Patient intake:** provider gathers necessary personal and clinical background information, consents, insurance information, etc. prior to seeing a patient
3. **Health information access:** provider accesses pre-existing patient health records (e.g., via a Health Information Exchange) to streamline and inform care
4. **Consultation and diagnosis:** provider evaluates and diagnoses patient
5. **Provider mentoring:** provider-to-provider support; one provider may consult another to aid in diagnosis or care provision (e.g., remote doctor guides a local doctor through a surgery)
6. **Virtual care:** either emergency care (urgent triage of patient symptoms) or non-emergency care (e.g., prescription, behavioral health visit)
7. **In-person care:** face-to-face care including to more effectively diagnose or treat a patient (e.g., when physical exam required)
8. **Medication reconciliation:** provider reviews patient's complete medication history and protocol to prevent adverse interactions/changes
9. **Pharmacy:** patient accesses medications needed through pharmacy services
10. **Monitoring:** post-visit, provider monitors patient's health (e.g., blood pressure, oxygen saturation) to evaluate response to treatment and potential need for further care
11. **Care coordination:** provider facilitates coordination across ongoing care services for a patient to maximize efficacy and efficiency of treatment
12. **Reimbursement/payment:** provider bills and receives payment from appropriate payor, which may include use of a claim "modifier" to inform when services are furnished via telehealth
13. **Wraparound supports/services:** wide variety of services that patient may require/receive to increase efficacy of care received (e.g., transportation, nutrition supports)

The above activities can involve the following:

- **Patients:** recipients of care
- **Providers**
  - **Traditional providers:** (e.g., hospitals, independent primary care physicians, specialists) historically provided care primarily in person, may offer some of the above services via telehealth
  - **Telehealth providers:** "pure play" providers without an in-person presence who often specialize in particular in consultation and diagnostic services via telehealth
- **Payors**
  - **Commercial insurance:** including both private insurers who offer fully insured plans and self-funded insurance plans.
    - In a fully insured plan, an employer or individual pays fixed premiums to an insurance company, which then pays out health claims as needed. In this scenario, the insurance company bears the risks associated with claims payouts. In a self-funded plan, an employer pays out health claims directly, thus bearing the risk associated with claims payouts itself.
  - **Government insurance:** primarily Medicare and Medicaid
  - *Note: Other payors may also include patients or employers who pay directly for care*
- **Facilitators:** companies (e.g., management service organizations) that specialize in providing the systems and supports for telehealth delivery, often to providers

Appendix 3. The Reimagine New York Commission's work to-date

In the course of its work, the Commission has identified a number of groups that have traditionally been underserved by the healthcare system. Some of these groups include low-income individuals; Black, Indigenous, and people of color; rural communities; older adults; individuals for whom English is a second language; individuals with complex health needs; individuals without sufficient health coverage; and individuals experiencing housing insecurity.

These groups are at the center of the Commission's mission to build New York back better. Accordingly, the Commission has sought input from these groups through a series of direct conversations. Input from these conversations has been critical to shaping the Commission's understanding of the opportunities and challenges facing telehealth. These conversations have been supplemented through engagement with advocates representing a diverse range of New Yorkers.

In parallel, the Commission has spoken with a variety of experts on telehealth. These have included representatives from hospital systems, community and individual providers, academics focused on public health and equity, technologists innovating on applications of telehealth, leaders from non-profit and for-profit health insurers, policy experts from New York and other states, as well as a variety of additional public and private organizations across New York State working to improve telehealth and the healthcare system.

References

[i] First, claims data is an incomplete measure, as it does not include telehealth interactions that may occur wherein no claim is filed (e.g., as part of a CMS bundled service, managed care per-member/per-month arrangement, or telehealth visit with a clinician who is not permitted to bill). Second, claims data may not capture claims that do not have a correct modifier, place of service, or procedure code signaling telehealth. Third, the majority of the data is based on commercial claims, limiting insight into telehealth usage among Medicaid and Medicare populations.

[ii] Bestsennyy, O., Gilbert, G., Harris, A., & Rost, J. (2020, June 01). Telehealth: A quarter-trillion-dollar post-COVID-19 reality? https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality

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[iv] Ibid.

[v] Lau, J., Knudsen, J., Jackson, H., Wallach, A. B., Bouton, M., Natsui, S., . . . Chokshi, D. A. (2020). Staying Connected In The COVID-19 Pandemic: Telehealth At The Largest Safety-Net System In The United States. Health Affairs, 39(8), 1437-1442. doi:10.1377/hlthaff.2020.00903.

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[vii] Ibid.

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