ata ACTION
Telehealth Policy to Transform Healthcare

May 4, 2026

The Honorable Toby Ann Stavisky
Chair, Senate Higher Education Committee
New York State Senate
State Capitol Building
Albany, NY 12247

RE: ATA ACTION COMMENTS ON S. 8484

Dear Chair Stavisky and members of the Senate Higher Education Committee,

On behalf of ATA Action, I am writing to share our association's perspective on Senate Bill 8484, the Oversight of Technology in Mental Health Care Act. ATA Action appreciates the Legislature's focus on patient protection and the quality of mental health services, and we are broadly supportive of the intent of this legislation. However, we are concerned that, as written, this proposal could unintentionally prohibit physicians from providing therapy, cause confusion for providers due to overly broad definitions, restrict licensed clinicians from using beneficial AI tools consistent with their scope of practice, and fails to account for FDA-cleared products. We urge the Committee to consider the amendments described below before advancing S. 8484.

ATA Action is the affiliated policy and legislative advocacy arm of the American Telemedicine Association. ATA Action is the leading advocacy organization dedicated to advancing policy and accelerating the adoption of technology-enabled healthcare. Working collaboratively with federal and state legislators and policymakers, our organization drives industry momentum by influencing legislative and regulatory developments in telehealth, virtual care, remote patient monitoring, artificial intelligence in health, health data privacy, private sector healthcare investment, and more. We represent a diverse membership – including hospital systems, technology companies, professional associations, direct-to-consumer digital health providers, payers, pharmaceutical manufacturers, digital therapeutics developers, and remote monitoring organizations.

ATA Action has followed and engaged in the development of state policies regarding the use of AI in mental health care, including the recently enacted Illinois and Nevada AI mental health frameworks – which appear to have served as the inspiration for S. 8484. Both states enacted their laws with significant flaws in place, over our opposition, including an unintentional ban on physicians delivering therapy, a failure to consider FDA-cleared products, overly broad definitions, and restrictions that limit licensed clinicians from using AI tools consistent with their scope of practice and the standard of care. Unfortunately, S. 8484 appears to have imported many of these issues, and we believe the following amendments are necessary if this bill is to be advanced.

The Bill Unintentionally Prohibits Physicians from Providing Therapy

The definition of "licensed professional" in § 6517.1(d) explicitly excludes physicians. This exclusion creates a significant problem when read alongside Subdivision 3(a), which states that only licensed professionals may provide, advertise, or offer therapy or psychotherapy services. The combined effect is an unintentional prohibition on physicians providing therapy – a result that would upend established medical practice and create real confusion for patients and providers.

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Physicians regularly provide therapy and psychotherapy services within their scope of practice, and there is no policy rationale for excluding them here. We urge the Committee to strike the physician exclusion from the definition of "licensed professional."

The Definition of "Administrative Support" Uses an Overbroad Standard

The definition of "administrative support" in § 6517.1(a) limits the category to tasks that "do not involve communication." Read literally, this would prohibit AI from assisting with any communication at all – including the routine logistical emails and appointment reminders that the definition itself then goes on to include as examples. We recommend replacing "communication" with "therapeutic communication" to make the definition internally consistent and to ensure that AI-assisted drafting of routine, non-clinical communications is unambiguously permitted.

The Definition of "Therapeutic Communication" Is Overly Broad

The definition of "therapeutic communication" in § 6517.1(h) captures everyday, non-clinical speech that unlicensed persons, health coaches, community health workers, and peer supporters routinely use in communications with individuals about their mental or emotional health. The opening clause extends to any interaction "intended to … address an individual's mental, emotional, or behavioral health concerns" – a standard broad enough to encompass general wellness guidance and supportive conversation that have never been considered the exclusive domain of licensed clinicians. Several of the enumerated examples compound this problem: item (ii) ("providing guidance, therapeutic strategies, or interventions designed to achieve mental health outcomes") and item (v) ("offering behavioral feedback intended to promote psychological growth or address mental health conditions") are broad enough to sweep in coaching, wellness guidance, and other non-clinical services. Item (iii) ("offering emotional support … in response to psychological or emotional distress") captures everyday empathic conversation rather than the specific, clinically significant interactions it should target.

We recommend removing "or address" from the opening clause, revising item (i) to capture direct interactions that constitute the delivery of therapy or psychotherapy services rather than any exchange involving understanding or reflecting a client's thoughts, deleting items (ii) and (v), and narrowing item (iii) to "suicidal or self-harm ideation" rather than "psychological or emotional distress." We also recommend adding a negative definition clarifying that "therapeutic communication" does not include general wellness education, instruction, or guidance intended to promote overall health and well-being rather than to diagnose or treat a specific mental, emotional, or behavioral health concern.

The Definition of "Therapy or Psychotherapy Services" Should Be Narrowed

The definition of "therapy or psychotherapy services" in § 6517.1(i) includes services that "improve" an individual's mental health or behavioral health – a standard so broad it could capture a wide range of resources, products, or services not currently provided by licensed professionals. The relevant mental health professional associations do not define therapy or psychotherapy so expansively. Given that the bill's significant requirements and prohibitions flow from this definition, we believe it should be narrowed to services provided to diagnose or treat.

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The Requirement to Anonymize Patient Data for Progress Tracking Is Counterproductive

Section 6517.1(g)(ii) limits AI-assisted analysis of client data to "anonymized data" for the purpose of tracking client progress or identifying trends. Tracking an individual patient's progress over time necessarily requires that the data be linked to that patient – anonymizing it removes the very information that makes patient-level progress tracking clinically meaningful. Existing privacy and confidentiality frameworks are more than adequate to protect patient data without this additional restriction. We recommend removing the word "anonymized."

Consent Requirements Should Apply to All AI Uses, Not Just Supplementary Support

As currently drafted, Subdivision 2 limits the written informed consent requirement to situations where a licensed professional uses AI "to assist in providing supplementary support." ATA Action believes that all potential uses of AI in a therapeutic context should be subject to the same consent requirements, not just one category. We recommend removing the limiting language so that consent is required for any use of AI in therapy or psychotherapy services where a session is recorded or transcribed.

The Prohibition on AI-Assisted Detection of Emotions or Mental States Will Harm Patients

Subdivision 3(b)(iv) prohibits licensed professionals from using AI to detect emotions or mental states. ATA Action believes this prohibition goes further than patient safety requires and will in fact be a net loss for patients. AI tools capable of detecting shifts in a patient's emotional state or recognizing suicidal ideation between sessions can be critical to patient safety – several states are actively considering requiring AI tools in mental health contexts to have this precise functionality. New York should not inadvertently prohibit what other states are mandating. The language here could have the unintended effect of preventing an AI system from recognizing suicidal ideation and routing the patient to appropriate emergency resources. We recommend removing this prohibition.

We also recommend changing "generate" to "determine" in Subdivision 3(b)(iii), as "determine" more precisely captures the concern – that AI should not independently reach therapeutic conclusions – while preserving the ability of licensed professionals to use AI to assist in drafting treatment documentation that the professional then reviews and approves.

The Bill Fails to Account for FDA-Cleared Products

As currently drafted, S. 8484 does not distinguish between FDA-cleared AI products and unregulated consumer applications, treating all products the same. We believe this is potentially harmful to patient care and inconsistent with sound regulatory policy.

FDA-regulated digital therapeutics and AI tools are held to rigorous standards, including quality management systems, cybersecurity requirements, and mandatory adverse event reporting, ensuring both safety and efficacy. Our organization represents Digital Therapeutics – clinically validated, FDA-regulated Software as a Medical Device products that incorporate artificial intelligence and other technologies into treatments delivered to patients through phones, tablets, computers, and VR headsets. The FDA cleared its first prescription digital therapeutic in 2017 and has since approved more than 20 through this rigorous review process under both the Biden and Trump administrations.

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These products undergo clinical validation, are subject to pre- and post-market oversight, and involve regulated healthcare practitioners as gatekeepers, protecting patients throughout the care process. In contrast, unregulated mobile health apps operate without these safeguards, rely only on general consumer protections, and may compromise patient data while making unproven health claims. Maintaining the distinction between regulated and unregulated products is essential to protect patients while allowing safe, evidence-based digital interventions to thrive. Indeed, given the existing federal oversight, Colorado's AI Act – the country's first comprehensive AI law – exempts high-risk AI systems already approved, authorized, or certified by the FDA. We urge the Committee to add a similar exemption to Subdivision 6 of S. 8484.

Thank you for the opportunity to comment on S. 8484. We urge the Committee to consider our feedback before advancing this bill, with the goal of striking the best balance between patient safety, clinician flexibility, and regulatory clarity. If you have any questions or would like to discuss the telehealth industry's perspective further, please contact me at hyoung@ataaction.org.

Kind regards,

Hunter Young

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ATA Action