Exploring the Virtual Care Policy Landscape One Year Post-PHE

Background

May 11, 2024, marked one year since the end of the COVID-19 public health emergency (PHE), and not much has changed in Medicare telehealth policy. We are still operating under temporary waivers and flexibilities and, as a result, many pandemic-era virtual care policies are facing a cliff on December 31, 2024. This looms large during a contentious election year in which legislating has grown increasingly difficult.

In March 2024, Congress signed a small healthcare package into law alongside the fiscal year (FY) 2024 appropriations bills. The package included healthcare extenders through the end of the calendar year for community health centers, the National Health Service Corps, teaching health centers, the Medicare-dependent hospital program, the low-volume hospital payment adjustment and the Special Diabetes Programs, as well as funding to avert pending Medicaid disproportionate share hospital cuts. This short-term extension lined up these programs' expiration with the expiration of Medicare telehealth flexibilities, creating an opportunity for Congress to address all these extensions in a post-election, lame-duck package.

The FY 2024 package did not address other healthcare policies that are ripe for congressional action, including price transparency efforts, Medicare site neutral payment policies, pharmacy benefit manager reforms, drug price competition policies and healthcare workforce issues, among others. Any action on these items would also likely be included in an end-of-year package.

As the December 31 expiration date draws closer, Congress, the Biden administration and stakeholders have increasingly focused on virtual care policies. Following is a look at the virtual care policy landscape one year after the end of the PHE, along with descriptions of the actions Congress and federal agencies must take for such pandemic-era policies to continue.

MEDICARE TELEHEALTH FLEXIBILITIES

In the Consolidated Appropriations Act, 2023 (CAA, 2023), Congress extended Medicare telehealth flexibilities until December 31, 2024. These flexibilities include:

- ***Waivers to geographic and originating site restrictions***. Before the pandemic, Medicare required that the patient be in a rural or certain health professional shortage area and use telehealth in an approved originating site, such as a hospital or physician office. Together, these restrictions limited beneficiaries' ability to access telehealth in more convenient locations, such as their home. Only about 2% of beneficiaries reside in ZIP codes that meet the traditional geographic and originating site criteria.

- ***Expansions of qualifying providers.*** This provision allows commonly accessed providers like physical therapists, occupational therapists and speech language pathologists to bill for telehealth services. If this flexibility were to expire, the Centers for Medicare & Medicaid Services (CMS) would have to revert to policies that restrict the types of providers that can deliver reimbursable care virtually to Medicare beneficiaries.

- ***FQHCs and RHCs***. This flexibility allows federally qualified health centers (FQHCs) and rural health clinics (RHCs) to serve as distant site telehealth providers. In 2023, FQHCs made up the greatest share of telehealth Medicare fee-for-service (FFS) visits. Expiration of this flexibility would prevent low-income and geographically isolated individuals from utilizing telehealth visits to maintain continuity of care with their existing provider or connect with clinicians best equipped to meet their needs.

- ***Audio-only communications***. Allowing telehealth to be provided through audio-only communications is particularly relevant in rural communities, where unavailable or unreliable broadband access could preclude patients from accessing telehealth through other means. In July, CMS is also expected to consider the matter of reimbursement for audio-only and audio-video visits for new and established patients as part of the calendar year (CY) 2025 Physician Fee Schedule Proposed Rule. This is in response to action taken at the Current Procedural Terminology (CPT) Editorial Panel's February 2023 meeting to revise the codes and guidelines for reporting evaluation and management services delivered via telehealth.

- ***Face-to-face requirement for hospice care.*** Allowing telehealth to be used for a required face-to-face encounter prior to the recertification of a patient's eligibility for hospice care aims to ensure continuity of care, particularly in isolated rural and underserved communities.

- ***In-person requirement for mental telehealth services.*** Waiving the in-person requirement for telehealth treatment of certain mental health conditions expanded mental and behavioral healthcare access for Medicare beneficiaries. In 2022, 50% of FFS Medicare common psychotherapy claims were delivered via telehealth. With this flexibility, whether a patient requires an in-person visit prior to commencing their mental telehealth treatment is left to the clinical judgment of their healthcare provider.

These flexibilities are popular among providers and patients. A series of Medicare Payment Advisory Commission focus groups found that 90% of Medicare beneficiaries who had telehealth visits were satisfied with the care they received. Telehealth stakeholders and congressional champions will have to continue to balance the popularity and expanded access to care conferred by these policies with high-cost estimates from the Congressional Budget Office (CBO). For this reason, Congress is likely to land on a one- to two-year extension.

On May 8, 2024, the House Ways & Means Committee unanimously advanced the Preserving Telehealth, Hospital, and Ambulance Access Act, which would extend the all of the current Medicare telehealth flexibilities for two years (through December 31, 2026). This markup signals which provisions will likely be on the table in a possible end-of-year package. The bill also includes other virtual care provisions, including:

- Extending the acute hospital care at home waiver flexibilities for five years, through December 31, 2029.

- Requiring the US Department of Health and Human Services (HHS) to issue guidance around best practices for providing telehealth to those with limited English proficiency.

- Adding a modifier to hospice telehealth recertifications two years after the enactment of the bill.

- Requiring the US Government Accountability Office (GAO) to conduct a technology assessment of the capabilities and limitations of wearable medical devices used to support clinical decision-making, including an examination of the benefits and challenges of artificial intelligence to augment such capabilities.

HDHP SAFE HARBOR

Outside of Medicare, the safe harbor for first-dollar coverage for telehealth services for those with health savings account (HSA)-eligible high-deductible health plans (HDHPs) was also extended through December 31, 2024, as part of the CAA, 2023. This policy allows employers and health plans to provide coverage for telehealth services on a pre-deductible basis for the more than 32 million Americans with HSA-eligible HDHPs. It aims to expand access to care for individuals who may otherwise have neglected essential care due to high out-of-pocket costs.

H.R. 1843, the legislation to make permanent the HDHP safe harbor, was passed out of the House Ways & Means Committee in June 2023, but the policy still awaits consideration on the House floor and in the Senate.

TELEMEDICINE PRESCRIPTION OF CONTROLLED SUBSTANCES

During the PHE, the prescription of certain controlled substances in limited quantities was allowed via telehealth without an initial in-person medical examination. In February 2023, as the end of the PHE approached, the US Drug Enforcement Administration (DEA) issued two proposed rules (the Telemedicine Controlled Substance Proposed Rule and the Telemedicine Buprenorphine Proposed Rule) to address the state of these flexibilities post-PHE. The proposed rules include the following provisions:

- Telehealth providers would no longer be able to prescribe Schedule II controlled substances or narcotics without an in-person evaluation.
- Telehealth providers would be able to prescribe a 30-day supply of Schedule III – V controlled substances or buprenorphine as medication for opioid use disorder without an in-person evaluation, but an in-person evaluation would be required for any renewal of such prescriptions.
- An in-person evaluation could be conducted by the prescribing telehealth provider, by another DEA-registered provider who participates in a real-time audio-visual telehealth consultation with the patient and the prescribing provider, or by another DEA-registered provider who has performed an in-person evaluation of the patient and refers the patient to the prescribing provider.

Following the release of the proposed rules, the DEA hosted several public listening sessions and received more than 38,000 public comments. Stakeholders noted that patients who were unable to receive controlled medications prior to the PHE flexibilities will likely face the same barriers to getting in-person care. Furthermore, telehealth providers who do not have physical locations would need to rely on other providers to conduct in-person examinations, which could pose issues such as liability or other providers' unwillingness to provide referrals. The proposed rules also would not create a special telemedicine registration process, which was originally included as part of the 2018 SUPPORT for Patients and Communities Act, but which the DEA has not yet implemented.

As a result of the strong response from stakeholders, the DEA is expected to release a revised proposed rule that incorporates this feedback, but the exact timeline remains unclear.

NEXT STEPS

While these virtual care policies have bipartisan, bicameral support in Congress, election year politics make for a challenging legislative environment on Capitol Hill. Key committees are beginning to act on efforts to extend many pandemic-era telehealth flexibilities, but getting such policies across the finish line is more likely to occur later in the year, when election season concludes, and the December 31 cliff draws nearer.

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