These Four Telehealth Changes Should Stay, Even After the Pandemic

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The national COVID-19 crisis has proven that telehealth can transform access to care, but only if we unshackle it from outdated and unnecessary regulations.

Federal and state regulatory changes have facilitated a rapid rise in telehealth during the COVID-19 pandemic, expanding access to care. A recent Harris poll found that 15% of U.S. adults used telehealth for the first time during the pandemic and nearly one-third of all adults have now used telehealth at some point.[1] Additionally, 76% of the respondents indicated they were very or somewhat likely to continue using telehealth after the pandemic. As we plan for a post-pandemic environment, the current regulatory changes need to be reviewed with a focus on promoting health equity, supporting primary care practices, improving health outcomes, coordinating care, and protecting patient privacy.

Pandemic-related telehealth regulatory changes can be classified into four main categories:

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1. HIPAA flexibility:[2] This change allows physicians and other health care providers to use any "non-public facing" (i.e., theoretically accessible only to those invited) video conferencing technology, even if it does not meet the usual HIPAA privacy, security, and breach notification rules. This has allowed patients and clinicians to connect for telehealth visits via common applications like FaceTime and Facebook Messenger Video.

2. Medicare and Medicaid policies: The Centers for Medicare & Medicaid Services has instituted several changes that directly affect reimbursement for telehealth, including the following:

- Recognizing a patient's home as an originating site,
- Expanding eligibility to all Medicare recipients, not just those who live in rural areas,
- Allowing telehealth visits for new patients, in addition to established patients,
- Expanding recognized provider types, such as physical therapists,
- Recognizing Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) as the distant (provider) site in a telehealth encounter,
- Allowing audio-only telehealth.

State-by-state Medicaid policies have also changed extensively, with a similar focus on expanding provider types and originating sites.[3]

3. Licensure requirements: Multiple states have allowed temporary licenses to physicians licensed in other states to increase access to care via telehealth during the pandemic. Additionally, for licensed physicians providing specific COVID-19 countermeasures, licensure requirements have been waived.

4. Prescribing controlled substances: Prescribers are now allowed to prescribe controlled substances to patients regardless of location, and qualified prescribers can initiate buprenorphine treatment for opiate use disorder via both audio-only or audiovisual telehealth visits.

> Policy changes in response to the pandemic have helped regulations catch up to the evolution of telehealth technology.

RECOMMENDATIONS

Reviewing each of these policy changes with a focus on their long-term impacts on patients, families, and family physicians will allow telehealth to move from being a stopgap measure during the pandemic to something that transforms how care is delivered going forward.

HIPAA flexibility. Allowing FaceTime and other "non-public facing" video conferencing

platforms for telehealth has helped individuals with limited technology literacy or other access barriers. However, the risk to patient confidentiality must be addressed. Some of these platforms have proven less than secure. After the pandemic, it will be necessary to reverse the HIPAA flexibility policy, but that must be accompanied by a federal effort to increase broadband access, and practice-based efforts to help patients improve their technology literacy so they can access telehealth through truly secure platforms. There also may be a role for insurers and health systems to provide secure, easy-to-use telehealth technology to patients that allows for a more comprehensive physical exam. But there should be incentives for patients to seek telehealth services from their usual primary care physician when possible, rather than from those with whom they have no ongoing relationship.

> We must make our voices heard on this issue, both individually and collectively.

Medicare and Medicaid policies. Historically, Medicare telehealth policies were highly restrictive, focusing on telehealth mainly as a tool to increase access to subspecialty care. Federal and state policy changes in response to the pandemic have helped regulations catch up to the evolution of telehealth technology by allowing primary care physicians to be compensated for the telehealth services they provide. This should continue after the pandemic. Also, FQHCs and RHCs must continue to be allowed to be the distant site in telehealth encounters. This has improved health care access for historically marginalized populations and will be beneficial as we continue to strive for health equity. Prior to the pandemic, many state and federal policies restricted the use of telehealth to patients in rural areas. But the pandemic has proven that telehealth has the potential to benefit all patients, regardless of their home address. Originating site requirements for Medicare, Medicaid, and commercial insurance reimbursement should be eliminated entirely.

On the other hand, audio-only visits must be further evaluated to determine the quality of care. Limiting audio visits to established patients, and only reimbursing for them when they are part of an ongoing care plan that also includes some video or in-person visits, may improve overall quality.

Licensure requirements. The growth of the Interstate Medical Licensure Compact highlights the need to reconsider state-based licensure in the context of telehealth.[4] Moving forward, family physicians must advocate for the continued growth of the compact and decreased barriers to care. Physicians should be able to continue to prescribe attention deficit hyperactivity disorder medications to patients they have known since birth after those patients go off to college in another state, for example, or adjust the blood pressure medications of a long-time patient who is visiting family in another state. The interstate licensing compact is a step in the right direction, but more should be done to permanently remove the barriers for treating across state lines now that telehealth has made it more feasible and common. However, we should be wary of national telehealth platforms that draw patients away from their primary care physician. Continuity of care must be maintained by requiring that medical records from telehealth visits are shared with the patient's medical home and warm handoffs are made when a patient has medical needs that cannot be addressed via telehealth.

Prescribing controlled substances. Rates of depression and other mental illnesses have increased during the COVID-19 pandemic, and there has been a 20% increase in deaths due to opiate overdoses.[5] The suspension of the Ryan Haight Act, which required an in-person medical exam before prescribing controlled substances, has allowed more people to receive lifesaving medication for opioid use disorders via telehealth (including audio-only). But it also has allowed opiate pain medications, as well as other substances with a high

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propensity for abuse, to be prescribed without an in-person visit. After the pandemic, access to controlled substances via telehealth should be maintained, but with some restrictions. The following targeted adjustments would maintain access to care while supporting patient safety and continuity of care:

• For non-hospice/cancer patients, require an in-person physical exam by the prescriber or a colleague in the same practice for the specific issue before prescribing opiate pain medications,

• Ensure that stimulant medications for attention deficit hyperactivity disorder can be initiated in schools and other non-clinical settings following a comprehensive evaluation,

• Require a video visit (or in-person visit) prior to initiating medications for opioid use disorder treatment to evaluate the objective components of the Clinical Opiate Withdrawal Scale that require the physician to see the patient.

ADVOCACY

Federal and state telehealth policy changes during the pandemic have resulted in increased adoption of telehealth by family physicians and their patients. Sustaining the majority of these changes would encourage family physicians to make larger organizational investments in telehealth, increasing access to health care for all patients and potentially improving health equity.

So how do we, as family physicians, make that happen? Where do we go from here? We must make our voices heard on this issue, both individually and collectively. Get to know your state legislators, if you haven't already, and contact them about licensure and Medicaid issues. In many states, these lawmakers represent relatively small numbers of people. Your opinion, as a physician and a constituent, can make a big impression on them. Consider submitting public comments to Medicare on these issues when the opportunity arises as well.

Our voices are more effective when we raise them together. Stay connected to the American Academy of Family Physicians (AAFP) and other professional organizations and support their efforts to advocate for ongoing telehealth flexibility at the federal level (for more on the AAFP's telehealth advocacy efforts, go to https://www.aafp.org/advocacy/advocacy-topics/health-it/telehealth-telemedicine.html). They may also be able to provide information or templates that can help you target your individual advocacy efforts.

The COVID crisis has provided the opportunity to rethink how we provide care going forward. Now is the time to seize it. FPM

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