Ep. 9: Telehealth: The Policy, the Politics, and Outlook for Action

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Matthew Hittle: Welcome to another episode of *OnAir: Health Care*, the Akin Gump health care podcast that gets at the intersection of policy, politics and health care. I am Matt Hittle, a senior policy advisor here at Akin Gump.

Dr. Mario Ramirez: I'm Mario Ramirez, a consultant here at Akin Gump. I'm super excited that we're coming back for our second season of this podcast, Matt.

Matthew Hittle: Yeah. We decided to do seasons when I was out for three months, with a little baby. So it just worked out nicely. A congressional recess—people actually have time to listen.

Dr. Mario Ramirez: Great. Congratulations, Matt.

Matthew Hittle: Hey, thank you very much. We have a wonderful episode today. We've got Kyle Zebley, who's with the American Telemedicine Association (ATA), here with us today to talk about the word that's on everybody's lips: telehealth.

Kyle has a distinguished career here in D.C. He started out in the office of Congressman Tom Price, a member of the Ways and Means Committee in the House, of Georgia.

He moved then, over to the Department of Health and Human Services (HHS). He was head of the Office of Global Affairs, which is a pretty neat position. Then he moved over to the American Telemedicine Association. He is also now with ATA Action, a new organization that acts as the advocacy arm of the ATA. Kyle, welcome to the podcast.

Kyle Zebley: It's great to be here. Thanks so much, Matt.

Matthew Hittle: Of course. Why don't you give us a little bit of a taste of Kyle Zebley beyond the bio?

Kyle Zebley: Well, like you said, been here in Washington, D.C. for 13 years. Always been a lifelong, passionate advocate of good policies and loved politics from a young

age. Married and try to travel as much as I can. It's great now that COVID's over, now that I can go beyond my living room into other corners of the country and the world.

Matthew Hittle: Well, it's a pleasure to have you here, Kyle. It's a pleasure to know you and have known you for some time.

Kyle Zebley: Absolutely. Another interesting thing beyond my bio is that I knew Matt way back when we both worked in Congress, and ran into each other in the House gym. Ran into each other in the back rooms of the Ways and Means committee as well.

Matthew Hittle: In the House gym, where we were both lifting, I think 500, 550 pounds?

Kyle Zebley: Easy, to start. Then you worked up from there. Yeah.

Matthew Hittle: Podcast math. Well, let's jump in. We've got a really meaty topic here today, obviously, telehealth. This can get really complicated. A lot of our listeners are probably familiar with it, but let's set out a base of information and go from there.

As many folks know, the rules that are related to the provision of telehealth are based mostly in the Medicare program. Medicare is such a big payer. It's so influential, it, effectively, sets the standard for the rest of the health care system.

Medicare, under normal circumstances, will generally not pay for telehealth unless certain criteria are met. Some of these include, for example, a requirement under which Medicare will reimburse for telehealth only when it is furnished at an approved location, generally not in a patient's home.

Additionally, in some circumstances, Medicare will only pay for telehealth if a patient physically visits a health care provider for an initial visit first.

Under the COVID-19 public health emergency (PHE), most if not all of these restrictions were temporarily waived, in part to prevent patients from physically visiting health care providers when they didn't need to, to keep the facilities available for those people who had COVID and to stop the spread in those facilities.

The catch, though, is that these flexibilities go away upon the conclusion of the public health emergency. The Consolidated Appropriations Act of 2022 did contain a provision to extend those flexibilities for 151 days, which is about five months after the expiration of the public health emergency. But after that, it's anybody's guess. So, if Congress declines to further extend those flexibilities at the end of those 151 days, those pre-pandemic Medicare restrictions will snap back into place.

With that base of information, Kyle, what is ATA and ATA Action pushing for? Do you think there's a realistic opportunity for action at the end of those 151 days?

Kyle Zebley: Hopefully there's going to be action well before the end of that five-month window. But as you know very well, Matt, of course, Congress tends to only really act when their back is up against the wall, and they have no alternative.

I am very optimistic. We have broad bipartisan support. We are really lucky to be working on an issue, as the ATA and ATA Action, where we had friends on either side of the last inauguration day.

President Trump implemented—and worked with Congress to do so—a lot of those public health emergency flexibilities that you had talked about at the beginning, that lifted those geographic and originating site restrictions that are embedded in law.

The Biden administration has been as great on these issues as the Trump administration has been. We've got all the right support in Congress. We've got strong bipartisan and bicameral support.

There's the right pieces of legislation out there that would really make permanent a lot of these PHE flexibilities that we seek to make sure folks have access to, after the end of the pandemic, after the end of the public health emergency. So, it's really a question of when, not if, in my mind, that the vast bulk of these will eventually get to permanency.

But in the meanwhile, Congress might have us sweat it out a little bit. We might be in a circumstance that's not unfamiliar to Washington, D.C. and to advocates, where we might have a few more extensions in store for us, prior to it finally getting to that permanent place.

Dr. Mario Ramirez: Kyle, I just got back from the Telehealth Academy in Nashville. One of the things that really struck me was this divide in how people inside the Beltway look at telehealth legislation and what the rest of America thinks is necessarily going to happen with telehealth legislation.

There are a lot of bills that have come through Congress. Some have been circulating for years, including things like the CONNECT for Health Act, but then others that have more recently passed the House.

What does the ATA look at as far as telehealth legislation goes? Are there particular things that you support, other things that maybe you oppose?

Kyle Zebley: Well, there's no major piece of legislation out there right now that we oppose. You're right: There are a number of bills that do different things, that would go a long way towards meeting our goals.

There's something like the CONNECT for Health Act, which is mostly focused on those Medicare-related flexibilities and which would make those flexibilities permanent. Obviously, that's something that we're extremely supportive of. It's a bill that, like you said, has been introduced many Congresses running. Right now, it has a filibuster-proof majority, a super majority of senators that have signed on as co-sponsors. It shows you just how far the telehealth community has come, in terms of the support that we've got.

There's the recent passage of H.R. 4040 in the House of Representatives, that was introduced by Congresswoman Liz Cheney and was bipartisan in nature, like all these bills tend to be. It was co-sponsored by Rep. Debbie Dingell of Michigan. It would extend until the end of 2024 most of the flexibilities that have

come about during the pandemic. It passed overwhelmingly in the House at the end of July, 416 to 12. We're hoping that the Senate will take that up.

Actually, we hope not only will the Senate take that up, but we're hoping that it will include provisions that were left out of H.R. 4040, like the High Deductible Health Plan tax provision that makes it easier for the 35 million Americans that have HDHP healthcare. It would allow them to have inducements to use telehealth.

Also, there's a really important issue to the ATA, which is the ability for those providers that have prescribing authority to remotely prescribe controlled substances without an in-person requirement, the Ryan Haight Act waiver. That has allowed for this huge cohort of patients who receive clinically appropriate care wherever they are. That's been in place, like these other PHE-era flexibilities, since the beginning of the pandemic.

It is set to expire actually when the PHE ends, unlike so many of these other flexibilities that would be in existence for five months post-PHE, that Matt had talked about. But we hope that the Senate will act on responding to H.R. 4040 and go further.

There are also things like the Acute Hospital Care at Home program that will expire at the end of the PHE, items like telehealth as an excepted benefit that will expire when the PHE ends.

So we have a number of asks. There's the right bills out there to make it permanent. It's just a question of getting Congress to bundle it all together.

Finally, I'll just say, while there's lots of bills that we're supportive of, there's lots of provisions that we want to see action on, we know how Congress works. All too often, it does end up being relatively last minute, like I had said in response to the last question. Also, really tends to be in an omnibus bill or a comprehensive piece of legislation that's seeking to address other things that are expiring. We're obviously very supportive of getting ourselves attached to any moving piece of legislation that would get Congress to actually pass it into law.

Matthew Hittle: Staying on that topic, I know all the Hill staffers and former Hill staffers listening know what's coming next. If there's anything on Capitol Hill that makes members of Congress sing “Kumbaya,” it's telehealth. However, Congress has yet to coalesce around a specific policy other than that five-month extension. It doesn't take a genius to know that cost is part of that reason.

The Congressional Budget Office, by way of background, which analyzes legislation to estimate its cost to the federal government, says that telehealth is very, very expensive. CBO's cost estimate for that five-month extension was $663 million. The Committee for a Responsible Federal Budget extrapolated that out to about $25 billion over 10 [*years*]. That H.R. 4040, which you mentioned, Kyle, costs something like $2.5 billion.

There's been a lot of ink spilled on this topic. I think the question is, the assumption CBO uses to get to those high cost estimates, where do you come down on this? I suspect I might have an idea, but what are you telling folks right

now when it comes to those high costs? Is CBO wrong in the way that it estimates telehealth costs?

Kyle Zebley: Well, CBO has a hard job in front of it. Obviously, it's a running game in Washington, DC to quibble with the CBO. That goes back to my time working for a member of Congress who was Chair of the Budget Committee and still struggled to get CBO to change some of its analysis to be a little bit more dynamic, which has been a long-running challenge.

I think one of the things that we have seen CBO respond to is the fact that it is actually continually shrinking down the number that's attached to extending these provisions.

So anything like $25 billion over 10 years, I think, is a rather outrageous sum. It doesn't really take into account the new normal rate of utilization. That's come down a good deal since the peak, at the beginning of the pandemic, when we were trying to keep, like you had said at the beginning, people out of emergency rooms, out of hospitals, out of an environment where they might infect themselves and others with COVID-19. That's when telehealth was maybe upwards of 50-52% of all reimbursed medical encounters in the Medicare program. It's come down significantly since then. What we have seen is, in large part, this is care in lieu of what would have been in-person care, rather than additive care.

Also, if you look at what has happened with some of these providers we're actually seeing, it tended to be patients with whom they'd already had pre-existing relationships.

So, it's really helped accentuate and maintain the continuum of care, rather than being what some people just have a feeling is the case, but we don't think it's borne out by the facts, which is additive care and care that's going to be growing the cost of Medicare reimbursement.

Dr. Mario Ramirez: Do you think, Kyle, is there any risk with a potential price tag like that, that Congress approaches this more of a sustainable growth rate (SGR) type saga, where they intermittently intervene but don't really come with an all-out fix from the get-go?

Kyle Zebley: I have used the SGR analogy myself, maybe just because of flashbacks from my time on Capitol Hill. As you recall, the SGR dynamic, which isn't exactly analogous, but it's something that's often pointed to, resulted in 18 years of kicking the can because of the cost associated with it.

Obviously, we're nowhere in the same ballpark as the SGR in cost, but I don't think you're wrong that the dynamics might be replicated, in that we might be in store for another few extensions.

Like I said, Congress tends to go down the path of least resistance. That might mean that we've got a couple of extensions in store, prior to permanency, like you had suggested. So, I think it's a very fair analogy, even if the particulars might be a little different.

Matthew Hittle: Let's back up and look at the industry wide. Obviously, to Republicans' delight and Democrats' chagrin, I think the President recently declared the pandemic over. Obviously, the White House has walked that back, but it does represent the reality for many people. Maskless walking down the street, maskless in Ubers now in Washington, D.C. So it's hard to imagine the administration is going to pursue many additional extensions of the PHE unless there are some serious issues this winter.

If that PHE expires, and Congress fails to pass legislation, what are the implications for this industry that has had quite a bit of investment over the past couple of years? What's the contingency plan for these providers and other companies that have made these investments?

Kyle Zebley: Well, a couple of things in direct response. That's a great question. One is, of course, that the administration is committed to following the science, as they have said many different times. The pandemic's not behind us. My wife and others that I know, are just getting COVID for the first time. So, it's hardly something that's over.

We know that there have been big COVID surges over the last two winters. It wouldn't be mistaken to think that we might be in store for yet another surge here over the next couple of months. If there is, I would fully expect the administration to extend the PHE again.

That being said, this is no way to run a health care system, in terms of that long-term certainty that folks want, in order to make these kinds of sustained investments. That's why we think there's no time like the present for Congress to act.

If Congress were to fail to act, and the PHE were to end, let's say that the PHE might end after the next extension, which could be in mid-January, we do have that five months in place for most of the Medicare Part B fee-for-service flexibilities.

That would allow us to continue to make the case that there shouldn't be any backsliding towards a place and time prior to the pandemic. That's where we were, where only a small, minute number of Medicare beneficiaries had access to reimbursable care.

As you had noted, if the PHE expires in that five months' worth of flexibilities, and Congress has not acted, then we'll go back to a place and time where Medicare Part B beneficiaries have to be within a defined rural area and within the four walls of a provider's office in order to receive reimbursable virtual care services. We'll have gone off that telehealth cliff. Folks that have access to clinically appropriate care now will lose access to it. That's, I think, a real shame. It'll be a real step backwards. It'll mean that Medicare beneficiaries don't have access to all of what is technologically possible and clinically appropriate in the 21st century.

That being said—and that is a dire situation; it's an unacceptable situation—I don't think it's one that the administration and Congress would allow to transpire. Even if that were to come to pass, telehealth is here to stay in so many other ways. Medicare Advantage has all sorts of flexibilities that mean that the

Medicare beneficiaries that receive their care through Medicare Advantage plans would continue to have access to virtual care services.

At the federal level, you look at other programs that have coverage and reimbursement of telehealth, such as the Indian Health Service and TRICARE for active duty military personnel. The Veterans Administration has robust coverage and reimbursement of telehealth services.

If you look at the state front, just about every Medicaid program in the country reimburses some variation of telehealth, particularly audiovisual synchronous telehealth.

If you look at commercial coverage across the country, there has been robust and sustained investment to the point where it's very much a permanent fixture of commercial coverage plans.

Finally, of course, we have our direct-to-patient, direct-to-consumer providers that are out there, who, at a very reasonable low cost, are delivering all kinds of clinically appropriate services remotely to patients across the country.

So Medicare, huge thrust of our federal advocacy. It covers millions of Americans, and it does set the standard for what so much else is done in the U.S. health care system. But that is not the only way that people are receiving access to telehealth services now. Even if all those flexibilities go away, there's lots of different ways that folks can maintain that access.

Dr. Mario Ramirez: Well, and Kyle, one of the areas that maybe has gotten more attention recently, as things with the pandemic have started to taper off a little bit, I think, in those early days, people were getting all of their care through telehealth. There has been an ongoing push in the mental health space, and the ability of telehealth to expand access to those resources and that help during a time in American history that's been particularly stressful for many Americans and many people.

One thing that has gotten more press lately, though, is the prescribing of some medicines that have not traditionally been prescribed through telehealth. I'm thinking about some of the different psychotropic drugs or other things. I think there's a lot of disagreement about whether or not a virtual platform is really the safest or the most appropriate venue to prescribe some of those drugs.

Tell us a little bit about what you guys think. How should we approach that aspect of it?

Kyle Zebley: Well, at the end of the day, telehealth is health care. It's not something separate and apart. The same standard of care that applies to a provider practicing in person, applies virtually. If the standard of care is not being met virtually, then that licensed medical professional has violated the terms of their license and is subject to scrutiny, from both federal authorities and state authorities. Indeed, they could lose their license. They could go to civil or criminal adjudication, if they have improperly prescribed a controlled substance, in direct answer to your question.

So there are layers of accountability in place, at the federal level and the state level, that should allow folks to understand that this is not the Wild West, that it

continues to be an extremely well-regulated aspect of the overall health care industry.

We think, at the ATA and at ATA Action, that the ability for licensed medical professionals to prescribe clinically appropriate controlled substances without an in-person requirement—that has been in effect during the pandemic—has been a great success. It has meant that more underserved and vulnerable populations have had access to that clinically appropriate care.

We think it should be the new status quo. We think that Congress could do that through legislation, or that the administration could do that through something that they have been instructed to do by Congress now for 14 years, which is through the Drug Enforcement Administration (DEA): Implement a special registration rule, that would allow for licensed medical professionals with the prescribing authority, in good standing, to register with the DEA and continue for the remote prescription controlled substances.

Just as there are challenges in in-person care and mistakes that are made or negligent decisions that are made in person, so too, of course, that can happen virtually. But there is every capability in place, with federal authorities and state authorities, to bring to justice those kinds of providers that are not abiding by that really important standard of care.

Matthew Hittle: Continuing on the theme of potential malfeasance, the HHS Inspector General recently released a report that said that, broadly speaking, telehealth doesn't seem to pose a high risk to Medicare.

But the IG also said that there's no systemic way for *[the Centers for Medicare & Medicaid Services (CMS)*] to identify those providers with improper billing practices, despite the fact that those folks are generally connected to larger entities that also have troubling billing practices.

So if Congress decides to pursue telehealth flexibilities in a more permanent way, what do you think CMS should do in terms of preventing improper payments, preventing fraud?

Kyle Zebley: Well, CMS and HHS and the Office of Inspector General (OIG) at HHS have a lot of processes already in place to determine at what rate CMS will reimburse for services and the accountability measures that need to be in place to make sure that the taxpayers are getting value for that money.

The same standards that are applied to in-person care obviously are extended to virtual care services. That should continue. That report, I think as you noted, did show an extraordinarily small number of inappropriate and questionable reimbursements, even during this massive expansion of telehealth services during the pandemic.

Well less than 1% of payments raised questions from the Office of Inspector General, as they looked into the data. So, really, let's not come up with new guardrails that would be solutions in search of a problem. Instead, let's continue to allow for access to clinically appropriate care services.

Now, if there's other identifiers that can give a greater peace of mind to the great folks at OIG or at HHS, in terms of ensuring accountability for the taxpayer dollars, then the ATA and ATA Action will be all supportive of it—provided that it's not another barrier to access to care.

The worst type of guardrail imaginable are in-person requirements that aren't clinically appropriate, are barriers that are more difficult for certain underserved populations versus others and that don't allow for the full potential of telehealth services.

So, barring the implementation of those kinds of guardrails, we're very open to look at any other new suggested guardrails. That being said, we don't think we should be handled in a different way that puts us at a higher standard as compared to in-person care.

Dr. Mario Ramirez: Do you think, Kyle, is the uncertainty around some of this, is that influencing, or are you guys seeing any impact to provider adoption of wider spread telehealth platforms?

One of the themes that came up when I was down in Nashville was our ability to try to turn telehealth not into just a standalone care platform, but really a hybrid offering, that health systems fully integrate into the offering that they deliver for their patients.

I know that the ATA has an implementation framework that you guys offer to health systems, to help assess whether they feel like they're ready to utilize telehealth in different capacities. But to what extent do you think the uncertainty is influencing the ability to adopt that model right now?

Kyle Zebley: We've seen a massive expansion of the adoption and implementation of telehealth since the beginning of the pandemic. As such, it really is now a permanent part of the health care landscape, even with the uncertainty that's been engendered by these temporary federal policies or perhaps the expiration of certain telehealth flexibility policies at the state level.

So even with that regulatory and policy uncertainty, we've seen tremendous gains and a tremendous maturation of this industry, such that I don't think there is a major health care system in the country that doesn't have a very robust telehealth program that's moving and transitioning towards more of a hybrid care model as you suggest. So, we're seeing tremendous levels of investment and a huge degree of permanency for telehealth.

That being said, there's no question there are virtual care services that are not getting as much investment as they would if we had permanency for the Medicare program, if we had a greater permanency in some of the states, in regards to the ability to use every modality possible in the best interest and in the benefit of patients, for instance.

So as we start really, I think, hopefully clearing up this low-hanging fruit of obvious policies that we need to have, we can then start really thinking about some of the harder and stickier issues around making a true hybrid model possible, a truly interoperable health care system possible.

But first, we've got to take care, like I said, of this low-hanging fruit of just so many obvious decisions that policymakers should make. Once we do have that permanency, I do think it'll drive even greater investment.

Matthew Hittle: Kyle Zebley of the American Telemedicine Association, it's been a pleasure having you.

Kyle Zebley: Thanks so much. It's been a real honor. Like I said, it's great to be working with you all at Akin Gump. I'm a little biased, my wife being an associate there. Thank you so much for all that you're doing.

Matthew Hittle: Thanks, Kyle.

Kyle Zebley: Thank you.

Matthew Hittle: Really fascinating episode, Mario. It was really cool to hear about, obviously there are quite a few folks in the health care industry that are really focused on continuing the pandemic flexibilities. Kyle is obviously a wealth of information.

I will note that I inadvertently gave him a promotion in one of his past jobs, at the Office of Global Affairs at HHS. He wasn't the head. He was the chief of staff, but still influential, nevertheless.

Dr. Mario Ramirez: Well, it's interesting. I actually just learned that Kyle and I came from that same office. I was a director of their Pandemics and Emerging Threats division before him. So, Kyle and I actually had more in common.

But you're right, it's a super fascinating discussion. I think the discussion around the sustainable growth rate model is particularly interesting to me. Seeing how split and how divided Congress is, it's hard to see this getting across the line with just a giant funding bill, but I'm always a little skeptical. What do you think, man?

Matthew Hittle: We will not know until 24 hours before it comes out. It's how things have been working. I think that's probably how things are going to continue to work, hammered out negotiations, although I could be wrong.

There's a lot of time between now and the end of the year, so time will tell. We will obviously provide our listeners any updates we hear.

If you'd like to get in touch with us, for any ideas for new episodes, you can email us. Again, this is Matthew Hittle, a senior policy advisor here at Akin Gump.

Dr. Mario Ramirez: I'm Mario Ramirez, a consultant here at Akin Gump.

Matthew Hittle: I'd like to extend a word of thanks to Sean Feely, policy advisor here at Akin Gump, who works with us on the podcast. He's been on before, and he's just invaluable. So, thanks to Sean.

This has been another addition of *OnAir: Health Care*. We'll catch you next time.

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