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Pharmacist Executive Jocelyn Freimuth Sizes Up Telehealth's Two-Year Runway

Our Friends · Thursday, October 8th, 2026

Medicare's telehealth coverage went dark on September 30, 2025, the day the federal government shut down. Congress restored it retroactively on November 12, only for the fix to run toward a new cliff on January 30, 2026. A budget package signed February 3, 2026 ended the cycle for a while, **extending the flexibilities through December 31, 2027.**

Providers billed through the gap on faith. CMS ultimately paid claims from the lapse period as if there hadn't been a lapse, yet for six weeks no one could promise that a home video visit would be reimbursed at all. Virtual care ran on a legal footing that expired and revived twice in five months.

Jocelyn Freimuth reads the new expiration date as something rarer than a reprieve: a planning horizon. A pharmacist and former nurse who co-founded the consulting firm Camino Compass, she has co-authored operational research on telemedicine-integrated care models and presented the findings at industry and academic conferences, and she advises the virtual-care organizations now deciding what to do with two guaranteed years. Certainty through 2027 is the longest runway Medicare telehealth has had since the pandemic created the field.

Three Cliffs in Eighteen Months

Whiplash was the policy through early 2026. Flexibilities tied to pandemic-era law kept arriving in short extensions, each one expiring before the next was assured, and the shutdown turned a scheduled cliff into an actual lapse. Every cycle forced the same wasteful ritual: contingency memos, patient reschedules, hold-and-bill decisions made without knowing the rules.

During the six-week gap, virtual programs chose among absorbing the cost of unbillable visits, pushing patients toward in-person appointments many could not attend, or pausing care outright. Each option damaged something: margins, schedules, or continuity. Retroactive payment later repaired the ledger and none of the disruption.

Churn like that taxes exactly the organizations telehealth was supposed to help. A rural clinic weighing a virtual program cannot hire against a benefit that might vanish in ninety days, and a health system will not integrate pharmacy support into visits that may stop being billable. Uncertainty, not regulation, was the binding constraint on the field's growth.

Behavioral telehealth escaped the cycle years ago with permanent Medicare coverage, which explains why every cliff fight centers on everything else: primary care follow-ups, chronic disease

management, specialist consults, therapy-adjacent services. [Jocelyn Freimuth points clients](#) at that split as the tell. Congress has already shown it will make virtual care permanent where the evidence and the constituency demand it, one category at a time.

What the Extension Actually Buys

Through the end of 2027, the core flexibilities hold:

- Patients' homes remain eligible originating sites for non-behavioral telehealth services, without the old geographic restrictions
- Audio-only visits stay billable, preserving access for patients without reliable video
- Retroactive payment continuity covers the shutdown gap, so providers who kept treating are made whole

None of this is permanent law. Each item runs on a clock that stops on December 31, 2027, absent new congressional action. Two budget cycles, two hiring cycles, and a full accreditation cycle all fit inside the window, which is exactly how planning-minded operators are scheduling them.

Retroactivity deserves its own footnote in the planning file. Claims from the shutdown gap were paid the same way they had been paid before October 1, 2025, per CMS guidance, which rescued providers who kept treating on faith. Counting on that rescue twice would be a business plan built on luck. Clean date-stamped records are what converted retroactive policy into actual payment last time, and they will be again.

The Build Window Jocelyn Freimuth Sees

Two years is enough time to build what ninety-day extensions never allowed. [Jocelyn Freimuth's counsel](#) to virtual-care operators starts with the unglamorous foundations: licensure footprints matched to where patients actually live, compliance programs that assume audits rather than hope against them, and documentation habits sturdy enough to survive whatever rules follow 2027. Licensure follows the patient rather than the provider, so a network treating across state lines needs coverage mapped to its actual patient roster, not its headquarters address.

Pharmacy integration sits on the same construction schedule. Jocelyn Freimuth's [research on integrated provider-pharmacy models](#) pointed at continuity as the ingredient virtual care most often lacks, and a stable benefit finally makes that continuity worth engineering: medication follow-up woven into the visit cycle, delivery logistics that match how patients actually receive care, and a pharmacist reachable between appointments. Jocelyn Freimuth's advice to the operators she works with fits in one line: "Build for the rules you can see, and document for the ones you cannot."

Staffing math changes too. Programs can now recruit clinicians and pharmacists against a benefit with a 2027 horizon, a pitch that was impossible while coverage renewed in monthly increments. Organizations that spent the whiplash era in a defensive crouch have their first real chance to plan offense.

What Happens When the Runway Ends?

January's near-miss previewed expiration in concrete terms. Before the extension passed, CMS had already notified physical therapists, occupational therapists, speech-language pathologists, and

audiologists that their Medicare telehealth authority would end on January 31, 2026. A whole profession's virtual practice sat one missed vote from shutdown, and the same mechanics apply to everyone when the current clock runs out.

Contingency planning is the discipline that near-miss should institutionalize. Programs **need an expiration playbook** the way coastal hospitals need a hurricane plan: which services convert to in-person, which patients get priority scheduling, what the billing team does on day one. Writing it during calm months costs little; improvising it during a lapse costs patients.

Permanence remains the unfinished business. Nothing in the February package converts telehealth from rented policy ground into owned ground, and the 2027 debate will arrive with the same stakes and, likely, the same brinksmanship. Advocates get two years to produce the utilization and outcomes evidence that makes expiration unthinkable.

Evidence is a build project too. Programs that log outcomes, track spending against in-person baselines, and document fraud controls will hand Congress the file it needs; programs that only bill will hand critics theirs. Data collected casually over the next two years becomes testimony in 2027.

Jocelyn Freimuth puts the assignment plainly: the extension is not the win, it is the window. Virtual-care organizations that spend it building infrastructure, evidence, and pharmacy-integrated care will walk into the next cliff negotiation indispensable. The ones that treat two years of certainty as a nap will wake up in 2027 exactly where they stood in 2025, waiting on a vote.

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