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What to Know About Medicare Coverage of Telehealth

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Use of telehealth (https://telehealth.hhs.gov/patients/why-use-telehealth), which allows patients to see health care providers without being in the same location, has grown rapidly in recent years, among both privately-insured patients (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2777779) and Medicare beneficiaries (https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/medicare-telehealth-trends). Prior to the COVID-19 pandemic, telehealth utilization in traditional Medicare was very low, but it rose dramatically (https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf) in 2020 following temporary measures put in place at the start of the COVID-19 public health emergency that greatly expanded the scope of Medicare coverage of telehealth. Since early 2021 telehealth use has declined steadily, but it remains higher than pre-pandemic levels (https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch7_MedPAC_Report_To_Congress_SEC.pdf#page=20), with considerable variation by income level, race and ethnicity, and urban versus rural location, among other factors.

Congress has extended a number of pandemic-era flexibilities around Medicare coverage of telehealth beyond the COVID-19 public health emergency, which ended on May 11, 2023 (https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html), but most of these flexibilities are due to expire in December 2024 (https://www.congress.gov/bill/117th-congress/house-bill/2617/text). There is bipartisan support for proposed (https://www.congress.gov/bill/118th-congress/house-bill/8261?s=1&r=72) legislation (https://www.congress.gov/bill/118th-congress/house-bill/7623) to extend these provisions for another two years, and Congress is weighing the potential benefits, risks, and costs of permanently expanding Medicare coverage of telehealth services. Medicare beneficiaries are generally satisfied (https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch7_MedPAC_Report_To_Congress_SEC.pdf#page=31) with their telehealth visits, and many health care providers are supportive (https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch7_MedPAC_Report_To_Congress_SEC.pdf#page=32) of keeping these services accessible, but questions remain about the longer-term impact on patient care, Medicare spending, and program integrity.

These FAQs provide answers to key questions about the current scope of Medicare telehealth coverage, including both temporary and permanent changes adopted through legislation and regulation, and policy considerations that lie ahead.

Prior to the declaration of the COVID-19 public health emergency (https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html), Medicare coverage of telehealth was largely restricted to beneficiaries in rural areas and to certain types of providers, facilities, and services. At the time, beneficiaries were typically required to travel from their homes to approved clinical sites where they could receive care from providers at other locations. To make it easier and safer for beneficiaries to seek medical care during the pandemic, the Secretary of the Department of Health and Human Services (HHS) waived many of these restrictions (https://telehealth.hhs.gov/providers/telehealth-policy/policy-changes-after-the-covid-19-public-health-emergency#:~:text=Recent%20legislation%20authorized%20an%20extension,emergency%20through%20December%2031%2C%202024.) in March 2020, enabling broader use of telehealth services for all Medicare beneficiaries. While the pandemic-related expansion of telehealth coverage under Medicare was initially due to expire at the end of the COVID-19 public health emergency, subsequent legislation extended many of these flexibilities through December 2024 (https://www.congress.gov/bill/117th-congress/house-bill/2617/text) and incorporated others into the program on a permanent basis (https://www.congress.gov/bill/116th-congress/house-bill/133/text) (Figure 1).

Figure 1

Timeline of Major Medicare Coverage Expansions for Telehealth

Congressional legislation related to Medicare coverage of telehealth services (2020-2023)

March 2020	December 2020	November 2021	March 2022	December 2023
Coronavirus Preparedness and Response Supplemental Appropriations Act provides waiver authority that significantly **expands** Medicare coverage of telehealth during **public health emergency** **Coronavirus Aid, Relief, and Economic Security (CARES) Act** includes provisions that amend **additional telehealth flexibilities** in the Medicare program, such as allowing **FQHCs and RHCs** to provide telehealth services to beneficiaries	**Consolidated Appropriations Act of 2021** permanently expands Medicare coverage of telehealth for **mental health services**, allows **audio-only** mental health telehealth services, allows beneficiary to use telehealth services **in their home**, and requires **in-person exam**	**2022 Physician Fee Schedule Final Rule** extends payment for a subset of expanded telehealth services through **December 2023** (or the year the public health emergency ends) to give **CMS and stakeholders** time to **evaluate** whether services should be **included permanently**	**Consolidated Appropriations Act of 2022**, extends telehealth flexibilities that were tied to the public health emergency for an **additional 5 months** (151 days) after the end of the **public health emergency**	**Consolidated Appropriations Act of 2023**, further extends telehealth flexibilities through **December 2024**

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The following list summarizes key provisions of current law related to coverage of telehealth in traditional Medicare, both temporary and permanent. (See section below for a discussion of telehealth coverage by Medicare Advantage plans.)

including their home as the "originating site." Prior to the expansion, telehealth coverage in traditional Medicare was limited to rural areas (with certain exceptions), and patients were required to travel to an approved originating site, such as a clinic or doctor's office, when receiving telehealth services. (Providers participating in select accountable care organizations (ACOs) (https://www.cms.gov/files/document/shared-savings-program-telehealth-fact-sheet.pdf) are permitted to waive these requirements under the Bipartisan Budget Act of 2018 (https://www.congress.gov/115/plaws/publ123/PLAW-115publ123.pdf), and may continue to provide telehealth services without geographic restrictions, and to beneficiaries in their homes, should the current flexibilities expire.)

- **Expansion of covered telehealth services**: Medicare currently offers coverage for an expanded set of telehealth services (https://www.cms.gov/medicare/coverage/telehealth/list-services), including physical and occupational therapy, emergency department visits, and nursing facility care. Prior to the expansion, Medicare offered coverage for a more limited set of telehealth services, such as preventive health screenings, office visits, and psychotherapy. The Centers for Medicare & Medicaid Services (CMS) has the authority to expand the list of allowable telehealth services (https://www.cms.gov/medicare/coverage/telehealth/list-services) when there is a demonstrable clinical benefit and continues to evaluate select services for permanent inclusion on this list.
- **Coverage of audio-only services**: Medicare currently allows a limited set of telehealth services to be provided to patients via audio-only platforms, such as a telephone or a smartphone without video. Prior to the expansion, Medicare required all telehealth services to be provided via a two-way audio/video connection, such as an interactive audio-video system or a smartphone with video enabled.
- **Expansion of eligible "distant site" telehealth providers**: Currently, any health care provider who is eligible to bill for Medicare-covered services can provide and bill for telehealth as a "distant site" telehealth provider and may conduct an initial telehealth visit whether or not they have treated the beneficiary previously. Additionally, federally qualified health centers (FQHCs) and rural health clinics (RHCs) are now authorized to provide and bill for telehealth. Prior to the expansion, only physicians and certain other providers (e.g., physician assistants, clinical social workers, and clinical psychologists) were permitted to bill for telehealth services as the distant site provider and must have treated the beneficiary receiving those services within the last three years. FQHCs and RHCs were not authorized to serve as distant site providers but could serve as originating sites if located in a qualifying area.
- **Waiver of in-person visit requirement for behavioral health**: Currently, Medicare beneficiaries receiving behavioral health services may opt to receive these services via telehealth with no in-person visit requirements. The Consolidated Appropriations Act of 2021 (https://www.congress.gov/bill/116th-congress/house-bill/133/text) made numerous changes to Medicare coverage of behavioral telehealth (see below), including a provision that beneficiaries must have an in-person visit with their behavioral health provider no more than six months before their initial telehealth appointment and annually thereafter. Subsequent legislation delayed this requirement (https://www.congress.gov/bill/117th-congress/house-bill/2617/text) until January 2025.
- **Use of telehealth for hospice recertification**: Patient recertification for the Medicare hospice benefit can currently be conducted via telehealth, provided there is a two-way audio/video connection that allows for real-time interaction between the patient and hospice provider. Prior to the expansion, only in-person encounters could be used for the purposes of hospice recertification.

PERMANENT TELEHEALTH PROVISIONS

- **Behavioral health**: The Consolidated Appropriations Act of 2021 (https://www.congress.gov/bill/116th-congress/house-bill/133/text) permanently removed geographic and originating site restrictions for any telehealth service used to diagnose, evaluate, or treat a mental health disorder. (These restrictions had already been lifted for treatment of substance use disorders and co-occurring mental health disorders in 2018 (https://www.congress.gov/bill/115th-congress/house-bill/6)). While many other provisions related to telehealth coverage expire at the end of 2024, Medicare beneficiaries may continue to receive behavioral

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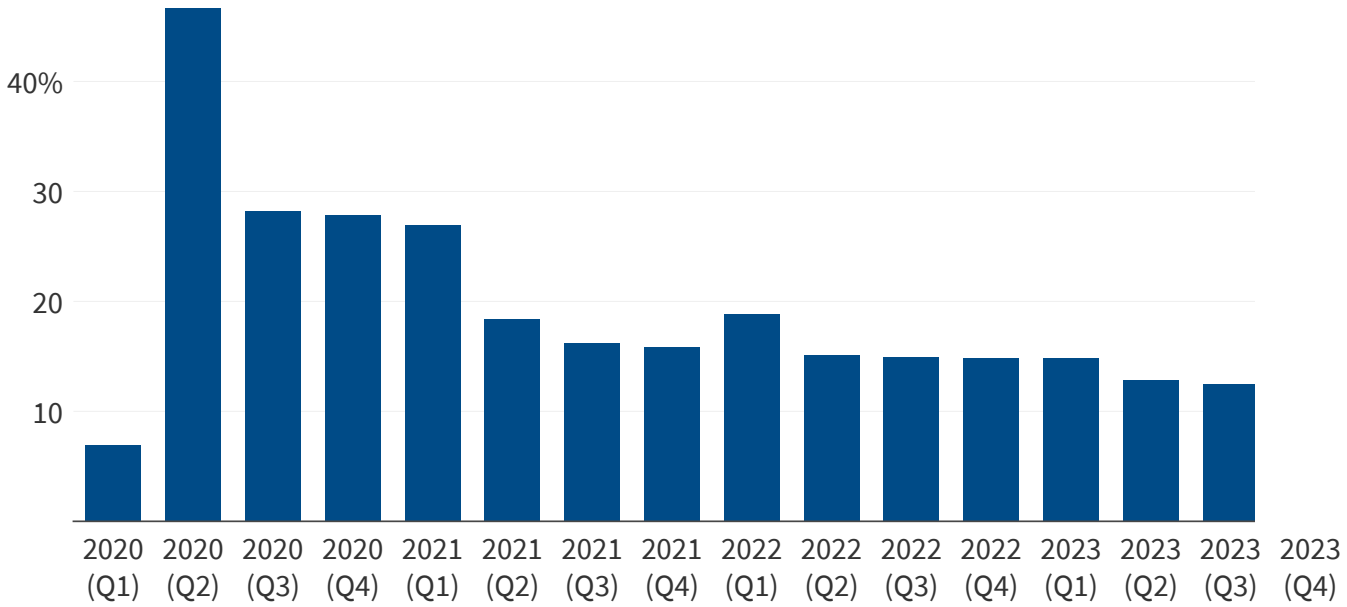
What trends have emerged in Medicare beneficiaries' use of telehealth services?

Telehealth use in traditional Medicare increased dramatically at the start of the COVID-19 public health emergency, with nearly half (46.7%) of all eligible beneficiaries receiving at least one telehealth service in the second quarter of 2020, compared to just 6.9% in the first quarter (Figure 2). While use has declined since that time, it remains nearly two times higher than pre-pandemic levels, with more than one in ten (12.7%) eligible beneficiaries receiving a telehealth service in the final quarter of 2023.

Figure 2

More than 1 in 10 Traditional Medicare Beneficiaries Used Telehealth at the End of 2023, a Decline from Early in the COVID-19 Pandemic but Higher Than Pre-Pandemic Levels

Share of eligible beneficiaries who received a telehealth service (2020-2023)



Note: Beneficiaries are considered telehealth-eligible if (1) they were enrolled in Part B and (2) they received at least one service listed on the CMS list of covered telehealth services during the period (either in person or via telehealth). Services provided via telehealth include audio-only and audio-video services.

Source: CMS, Medicare Telehealth Trends Report (Jan 1, 2020 - December 31, 2023) • Get the data • Download PNG KFF

Use of telehealth services varies by geography, race and ethnicity, reason for Medicare eligibility, and dual enrollment in Medicare and Medicaid (Figure 3).

Figure 3

Telehealth Use Varies by Race and Ethnicity, is Higher Among Urban Beneficiaries, Duals, and Beneficiaries with Disabilities or End-Stage Renal Disease

	2020	2021	2022	2023
Rural	40%	28%	23%	19%
Urban	50%	36%	31%	27%

Note: Beneficiaries are considered telehealth-eligible if (1) they were enrolled in Part B and (2) they received at least one service listed on the CMS list of covered telehealth services during the period (either in person or via telehealth). Services provided via telehealth include audio-only and audio-video services.

Source: CMS, Medicare Telehealth Trends Report (Jan 1, 2020 - December 31, 2023) • Get the data • Download PNG KFF

Geography: Rates of telehealth use in 2023 were higher among beneficiaries living in urban areas than those in rural areas (27% vs. 19%), which may be due in part to disparities in access to broadband (https://www.brookings.edu/articles/why-the-federal-government-needs-to-step-up-their-efforts-to-close-the-rural-broadband-divide/#:~:text=As%20even%20the%20FCC%20has,fixed%20broadband%20by%2054%20percent.&text=Only%2019%20percent%20of%20rural%20Americans%20have%20more%20than%20one%20broadband%20option.) and other communication technologies. Beneficiaries in rural or underserved areas may lack the infrastructure to support reliable video telehealth visits or the means to afford internet access, which may further impede access to telehealth (https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-rural-areas/access-to-internet-and-other-telehealth-resources) if coverage of audio-only services is reduced or eliminated.

Race and ethnicity: Rates of telehealth use in 2023 were highest among Asian and Pacific Islander (31%) and Hispanic (30%) beneficiaries, and somewhat lower among Black (26%), American Indian or Alaska Native (25%), and non-Hispanic White beneficiaries (24%). Given that beneficiaries of color are more likely than non-Hispanic White beneficiaries to report difficulty accessing needed health services (https://www.kff.org/report-section/racial-and-ethnic-health-inequities-and-medicare-access-to-care-and-service-utilization/), telehealth use may help to improve access to care for certain groups.

Reason for Medicare eligibility: Rates of telehealth use in 2023 were higher among beneficiaries who qualify for Medicare based on having end-stage renal disease (ESRD) (37%) or a long-term disability (37%), relative to those who qualify based on age (23%). This may be due in part to higher overall rates of service use among people with ESRD and disabilities (whether in-person or via telehealth) but may also reflect a preference for telehealth services among these populations, or a greater ease of accessing care via telehealth relative to in-person care. Beneficiaries under age 65 who qualify for Medicare based on having long-term disabilities are more likely than older beneficiaries (https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00501) to report having three or more limitations in activities of daily living, and may be more likely to benefit from the increased flexibility of receiving health care services from their home via telehealth.

Dual-eligible individuals: Rates of telehealth use in 2023 were higher among beneficiaries dually eligible for both Medicare and Medicaid compared to Medicare beneficiaries who were not Medicaid-eligible (34% vs. 23%). Dual-eligible individuals are four times more likely (https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/) than other Medicare beneficiaries to live on incomes of less than $20,000. Prior studies have found that having lower income (https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch7_MedPAC_Report_To_Congress_SEC.pdf#page=26) or living in a socioeconomically deprived neighborhood (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9843604/) is associated with higher rates of telehealth use, suggesting that telehealth may have the potential to improve health care access for beneficiaries with limited access to in-person services.

physician fee schedule (https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_physician_final_sec.pdf), payment rates for telehealth services currently vary based on the location of the provider, with services furnished by providers based in a non-facility setting, such as a doctor's office, reimbursed at a higher rate than services furnished by providers based in a facility setting, such as a hospital outpatient department.

Prior to the COVID-related temporary expansion, Medicare paid for all covered telehealth services at the lower facility rate, regardless of provider location. This means that providers in non-facility settings currently receive higher payment for telehealth services than they did before the temporary expansion. However, assuming no change to current law, Medicare will resume paying for most telehealth services (with the exception of behavioral health services) at the lower facility rate beginning in January 2025. The Consolidated Appropriations Act of 2021 (https://www.congress.gov/bill/116th-congress/house-bill/133/text) permanently established payment parity between in-person and telehealth services in the context of behavioral health. Should the current flexibilities expire, Medicare will continue to pay providers for behavioral telehealth services at the same rate they would receive if the service were delivered in person.

CMS permanently authorized (https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule) FQHCs and RHCs to provide and bill for behavioral telehealth services in 2022. As with other types of providers, clinicians in these settings are paid the same rate for behavioral telehealth services as they would receive if the service were delivered in person on a permanent basis. However, for all other types of telehealth services, FQHCs and RHCs are only eligible for reimbursement through December 2024. Medicare currently pays FQHCs and RHCs at rates comparable to those set under the physician fee schedule, which are lower than what they would receive for comparable in-person care, since Medicare typically pays more for clinician services provided by FQHCs and RHCs than those provided in other types of settings.

How do Medicare Advantage plans cover telehealth?

Medicare Advantage plans are required to cover all Part A and Part B benefits covered under traditional Medicare, and have some flexibility to offer additional benefits (https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/) as well, including telehealth benefits not routinely covered by traditional Medicare (outside of the current telehealth expansion), such as telehealth services provided to enrollees in their own homes, services provided outside of rural areas, and services provided through audio-only platforms.

Since 2020, Medicare Advantage plans have been permitted to include (https://www.cms.gov/newsroom/fact-sheets/contract-year-2020-medicare-advantage-and-part-d-flexibility-final-rule-cms-4185-f) the costs associated with select telehealth services in their basic Medicare Part A and B benefit package, and may continue to do so after December 2024 regardless of the status of the temporary telehealth expansions in traditional Medicare. Telehealth services may be included in a plan's basic benefits package if they meet certain requirements, such as coverage under Medicare Part B when the same service is provided in person. When these requirements are not met, plans may continue to offer supplemental telehealth benefits via remote access technologies and/or telemonitoring services, but must cover the cost of these benefits using rebates or supplemental premiums.

(https://www.finance.senate.gov/hearings/ensuring-medicare-beneficiary-access-a-path-to-telehealth-permanency) and the House (https://energycommerce.house.gov/events/health-subcommittee-hearing-legislative-proposals-to-support-patient-access-to-telehealth-services) of Representatives (https://energycommerce.house.gov/events/health-subcommittee-hearing-legislative-proposals-to-support-patient-access-to-telehealth-services). Bipartisan bills such as the Preserving Telehealth, Hospital, and Ambulances Act (https://www.congress.gov/bill/118th-congress/house-bill/8261/all-actions?overview=closed&s=1&r=72#tabs) and the Telehealth Modernization Act of 2024 (https://www.congress.gov/bill/118th-congress/house-bill/7623/all-actions?overview=closed#tabs) include provisions that would temporarily extend the current flexibilities through December 2026. However, outside of select changes, such as permanently allowing FQHCs and RHCs to provide non-behavioral telehealth services, neither bill provides for a permanent expansion of Medicare telehealth coverage.

The Biden-Harris Administration has announced additional measures to preserve telehealth access for Medicare beneficiaries, such as a grant program to support the development of an interstate licensure compact (https://www.hhs.gov/about/news/2024/07/16/biden-harris-administration-launching-initiative-build-multi-state-social-worker-licensure-compact-increase-access-mental-health-substance-disorder-treatment-address-workforce-shortages.html) that would make it easier for licensed social workers to practice across state lines, and provisions in a recent CMS proposed rule (https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-proposed-rule) that would permanently extend certain telehealth flexibilities, such as coverage of audio-only services that meet all other conditions for Medicare telehealth coverage. However, in the absence of Congressional action, implementation of these provisions will be limited to the types of providers, services, and settings where telehealth was permitted before the current flexibilities were put in place (with the exception of behavioral health flexibilities, which have been made permanent).

Related to licensure, Medicare providers are generally required to be licensed in any state where they are practicing, and this requirement extends to telehealth. In most cases, a distant site telehealth provider must be licensed in the state where the beneficiary receiving services is located when the telehealth visit takes place. However, certain states have taken action to develop multi-state licensure compacts (https://telehealth.hhs.gov/licensure/licensure-compacts), which has allowed for additional flexibility related to licensure in participating states. These compacts are formed when states agree upon a uniform standard of care and enact state laws which allow qualified providers to practice across state lines while maintaining a single license or to maintain multiple licenses or which expedite the process of gaining additional licensure across member states. These compacts may be continued beyond December 2024, though other restrictions may limit their use if the current flexibilities are allowed to expire.

What are the implications of telehealth for Medicare program integrity?

As policymakers weigh whether to extend or make permanent current flexibilities around Medicare coverage of telehealth, several questions have been raised about the impact of telehealth services on patient care quality and program spending, as well as the potential for fraud and overuse.

Since the current flexibilities were introduced, state and federal agencies have filed several lawsuits (https://www.justice.gov/opa/pr/justice-department-charges-dozens-12-billion-health-care-fraud#:~:text=Telemedicine%20schemes%20account%20for%20more%20than%20%241%20billion%20of%20the%20total%20alleged%20intended%20losses%20associated%20with%20today%E2%80%99s%20enforcement%20action?trk=article-ssr-frontend-pulse_little-text-block) regarding the submission of fraudulent claims (https://www.justice.gov/opa/pr/national-enforcement-action-results-78-individuals-charged-25b-health-care-

during the period engaged in excessive billing patterns that posed a high risk to the Medicare program, and clinicians generally complied (https://oig.hhs.gov/oas/reports/region1/12100501.asp) with Medicare requirements when providing Evaluation and Management services through telehealth, suggesting little evidence of widespread misuse to date. MedPAC has recommended that CMS take certain precautions (https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch7_MedPAC_Report_To_Congress_SEC.pdf#page=17) if the current telehealth flexibilities are extended, such as applying additional scrutiny to "outlier" clinicians who deliver more telehealth services than others and requiring in-person visits before high-cost tests and medical equipment are paid for.

What is the expected impact of telehealth use on Medicare spending and the estimated cost of expanding coverage?

Expanding telehealth coverage is expected to lead to an increase in Medicare spending, but the overall magnitude in the long term is uncertain. Some telehealth services may replace in-person care, as in the case of behavioral health visits, but easier access to telehealth may also lead to an overall increase in use of services and higher costs. Prior research has found modest increases in clinical encounters and spending per person among Medicare beneficiaries in geographic areas (https://www.medpac.gov/wp-content/uploads/2022/07/Tab-H-Telehealth-April-2023.pdf) and health systems (https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.01142?utm_source=Tradeoffs&utm_campaign=107728a25a-EMAIL_CAMPAIGN_2024_05_28_01_53&utm_medium=email&utm_term=0_-107728a25a-%5BLIST_EMAIL_ID%5D) with higher rates of telehealth use. At the same time, there is evidence to suggest (https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.01142?utm_source=Tradeoffs&utm_campaign=107728a25a-EMAIL_CAMPAIGN_2024_05_28_01_53&utm_medium=email&utm_term=0_-107728a25a-%5BLIST_EMAIL_ID%5D) that beneficiaries with greater access to telehealth services may have fewer emergency department visits and improved adherence to certain medications. Additional research would help policymakers and other interested parties determine whether any increases in Medicare spending as a result of expanded telehealth coverage are offset by improvements in quality of care or decreases in other costs, such as spending on preventable hospital admissions and other types of acute care services.

The Congressional Budget Office (CBO) scored the extension of telehealth flexibilities through December 2024 under the Consolidated Appropriations Act of 2023 (https://www.congress.gov/bill/117th-congress/house-bill/2617/text) as costing $2.4 billion (https://www.cbo.gov/system/files/2023-01/PL117-328_1-12-23.pdf), on top of the $663 million (https://www.cbo.gov/system/files/2022-03/HR2471_As_Cleared_by_the_Congress.pdf) estimated for a prior extension under the Consolidated Appropriations Act of 2022 (https://www.congress.gov/bill/117th-congress/house-bill/2471/text). CBO has not yet scored the cost of the most recent bills (https://www.congress.gov/bill/118th-congress/house-bill/7623/all-actions?overview=closed#tabs) under consideration (https://www.congress.gov/bill/118th-congress/house-bill/8261/all-actions?overview=closed&s=1&r=72#tabs) by the House of Representatives (see above), which include provisions to extend these flexibilities through December 2026.

As policymakers weigh the implications of legislation to maintain or broaden Medicare coverage of telehealth, a key consideration is how to set payment rates for telehealth services across different care settings and provider types. Payment parity between in-person and telehealth services may encourage providers to invest more time and resources into telehealth, but some have raised questions about how to ensure that this investment does not come at the expense of patient care quality or access to in-person services for beneficiaries who prefer them. MedPAC has recommended (https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch14_sec.pdf#page=13) that CMS return to paying the lower facility

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