



Bipartisan Policy Center

Positioning Telehealth Policy to Ensure High-Quality, Cost-Effective Care

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HEALTH PROGRAM

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Executive Summary

Without congressional action, Medicare's telehealth flexibilities will expire at the end of 2024. Although an extension is likely, Congress and the administration must also begin crafting policies that support high-quality, cost-effective virtual care for the long-term.

It is critical for Congress to preserve telehealth access and commit to 1) establishing a more sustainable, long-term telehealth reimbursement strategy, and 2) ensuring high-quality virtual care through robust oversight and quality assurance. This brief offers targeted solutions to accomplish both goals, as well as recommendations for permanent telehealth policy where the evidence supports it.

Congress is considering bipartisan proposals to maintain current telehealth provisions through 2026. Key committees in the House and Senate have expressed interest in extending telehealth policies, and the House Ways and Means and Energy and Commerce committees have advanced legislative proposals ([H.R. 8261](#) and [H.R. 7623](#), respectively). The Bipartisan Policy Center anticipates that Congress will extend telehealth flexibilities before authorities expire.

This brief builds on BPC's extensive work to craft balanced, evidence-based telehealth policy. In 2022, two years into the federal COVID-19 public health emergency, BPC released [federal telehealth policy recommendations](#) and a [Medicare fee-for-service data analysis](#) that assessed the usage of telehealth before and during the pandemic. BPC also developed a dynamic Medicare [telehealth spending estimator](#) to assist policymakers weighing coverage decisions.^{1,2,3}

Since then, BPC has assessed peer-reviewed research and government reports that have emerged since Congress's last telehealth extension, as well as interviewed payers, providers, provider associations, federal agencies, consumer advocates, technology leaders, policy experts, and other stakeholders. Based on the latest research and policy developments, this brief offers targeted suggestions to guide policymakers as they consider the future of telehealth.

POLICY RECOMMENDATIONS

A. Develop a Long-Term Reimbursement Strategy

Congress should direct the Centers for Medicare & Medicaid Services (CMS) to propose a long-term telehealth reimbursement strategy that balances access to services, quality of care, and cost considerations.

- Congress should require CMS to study the cost of telehealth, propose a long-term reimbursement strategy, and submit a report on its findings by June 2026. As part of this work, CMS should propose new reimbursement models that account for virtual care services delivered as part of a hybrid model of care (in-person, plus virtual).
- CMS should permanently maintain all telehealth flexibilities for providers participating in value-based payment arrangements with two-sided risk.

B. Ensure High-Quality Virtual Care

Telehealth is an effective tool to expand access to care, but variations in quality and occasional system misuse persist. Congress and the administration should implement strategies to promote high-quality virtual care.

- Congress should ensure that the Office of Inspector General (OIG) at the Department of Health and Human Services (HHS) and CMS have sufficient funding to promote high-quality telehealth and track fraud, waste, and abuse.
- CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) should work with medical specialty societies and states to develop and promote best practices for prescribing controlled substances via telehealth.
- CMS should require that providers offering audio-only telehealth services attest that they have the capabilities to deliver two-way video visits at the time of service and that they offered the patient the choice of a video visit, but the patient was either unable or unwilling to complete a video visit.
- CMS should promote continuity of care by requiring telehealth providers to have protocols for sharing progress notes with a patient's usual care team. CMS should also require that providers offering telehealth services have the capacity to deliver or refer patients to in-person care, particularly in emergency situations.
- Congress and CMS should establish guardrails around providers ordering high-cost services for patients via telehealth.

- CMS should enhance its ability to evaluate the cost and quality of telehealth by 1) prohibiting incident to billing by any provider who can bill Medicare directly, and 2) establishing a new modifier or provider category for fully virtual providers.

C. Explore Opportunities for Permanency

Policymakers should push for permanent telehealth policy where the evidence warrants it. Permanent policy will provide stability for patients and providers and offer the certainty needed for health systems and practices to feel comfortable investing in telehealth technology. Specifically, Congress should amend Section 1834(m) of the Social Security Act to:

- remove geographic and originating site restrictions;
- authorize Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to serve as distant providers;
- allow all eligible Medicare providers to deliver services via telehealth, thus permanently including temporarily eligible providers, such as physical therapists and occupational therapists; and
- repeal in-person visit requirements for telemental health services.

Policy Recommendations

A. DEVELOP A LONG-TERM REIMBURSEMENT STRATEGY

Now that the most challenging stretches of the COVID-19 pandemic are behind us—and patients have largely settled into new normal patterns of care—policymakers must develop a long-term telehealth reimbursement strategy. This strategy should aim to reflect the true cost of telehealth, encourage access to high-value services, and reduce administrative burden on providers.

Central to this discussion is how to structure telehealth reimbursement across three settings: facility settings (i.e., hospital-affiliated providers), nonfacility settings (i.e., independent practice providers), and safety net clinics (i.e., providers working for a FQHC or RHC).

CMS should assess whether to continue reimbursing facility and nonfacility providers for telehealth at parity with in-person services, as the agency has done since the onset of the pandemic.^a This approach was critical to ensure access to care during pandemic lockdowns, and many providers say they need this higher rate to maintain offices for in-person services. However, other policy experts raise concerns about the impact of parity on federal spending, claiming that it overpays relative to the cost of telehealth and incentivizes providers to shift to fully virtual care.⁴

Notably, several large private payers—which have traditionally followed Medicare’s lead on coverage and reimbursement policies—have reverted to paying less for virtual care in recent years.

CMS should also examine its reimbursement strategy for FQHCs and RHCs. Since 2020, Medicare has set a single telehealth rate for safety net clinics (approximately \$95 in 2024), calculated as the average Physician Fee Schedule payment across all telehealth codes.⁵ This uniform rate is lower than what FQHCs and RHCs earn for the same in-person service. Notably, in 2022, CMS established payment parity at these clinics specifically for telemental health services.⁶

^a In the 2023 Physician Fee Schedule, CMS introduced a place of service code for telehealth services delivered to beneficiaries at home and established reimbursement for these services at parity with in-person. Absent a change in CMS’ 2025 Physician Fee Schedule, services that have permanent authorization to provide telehealth to patients at home (i.e., treat the home as the originating site)—including mental health, substance use disorders or co-occurring mental health disorders, and end-stage renal disease—will continue to receive reimbursement at parity with in-person rates. If Congress extends originating site flexibilities for additional services, those will also qualify for the higher rate.

For a detailed analysis of how Medicare reimbursement varies by modality and provider setting in 2024, see Appendix A.

Finally, CMS should consider how to pay for brief virtual interactions. Providers across all settings express frustration at the complex and evolving nature of telehealth billing, including the extra time spent on short virtual interactions (e.g., portal messages), sometimes without reimbursement.^{7,8}

Congress should require CMS to study the cost of telehealth, propose a long-term reimbursement strategy, and submit its findings by June 2026. As part of this work, CMS should propose new reimbursement models that account for virtual care services delivered as part of a hybrid model of care (in-person, plus virtual).

Ideally, CMS should submit a comprehensive proposal to Congress before the expiration of the next telehealth extension. With Congress likely to extend these flexibilities an additional two years, CMS should submit its proposal by June 2026.

This timeline would allow CMS to use data from more recent years that provide a clearer picture of telehealth's impact post-COVID-19. Much of the existing research is still based on information from the first few years of the pandemic, when lockdowns affected patients' health-seeking behaviors. However, telehealth utilization is stabilizing since its peak in 2020, when 48% of Medicare beneficiaries used the modality. In 2022, usage dropped to 29% and early 2023 data shows only a slight further decrease.⁹

CMS' strategy should carefully balance access to services, quality of care, and cost considerations while addressing the following questions:

- *How much does telehealth cost providers?* Stakeholders disagree about how much telehealth costs. Some providers assert that their hybrid operations have similar overhead because they must finance telehealth platforms while still paying for in-person infrastructure. Other providers and researchers contend that telehealth costs less than in-person visits, even in offices that provide both options.¹⁰ Additionally, many providers say telehealth visits tend to be shorter and less complex than in-person appointments, resulting in lower reimbursement because they bill less complex codes. However, a [MedPAC report](#) found similar levels of coding between telehealth and in-person visits. This discrepancy could suggest that some providers might be over-coding telehealth visits.¹¹ CMS should gather data on practice expenses and provider coding to inform this debate.

Assessing the cost of telehealth is complex and involves considering the overall number of visits Medicare pays for (i.e., to what extent is telehealth introducing new utilization, versus substituting for in-person visits?), as well as how much Medicare pays for each visit. Medicare payments vary based on service type, provider type, and modality. (See Appendix A for a full comparison for two common procedure codes.)

- *How much does telehealth cost Medicare?* Despite initial concerns about the cost implications of expanded telehealth access, recent studies suggest that the impact on overall utilization of medical services and associated spending is modest.^{12,13} For example, [one study](#) estimates that Medicare patients at health systems with the highest use of telemedicine had an increase of 0.21 outpatient visits per patient per year, accompanied by a 1.6% increase in health care spending.¹⁴ These estimates use data from the first few years of the pandemic; it is reasonable to assume that as telehealth utilization declines, the spending impact will further decrease. CMS should incorporate these telehealth cost estimates into its proposal.
- *How does telehealth reimbursement affect patients' access to high-quality care and their preferred modality of care?* Some experts worry that payment parity distorts the market by giving private-equity-funded telehealth companies a competitive advantage and incentivizing providers to shift to fully virtual care, thus limiting options for patients who want in-person services. A [MedPAC analysis](#) found that approximately 20% of behavioral health providers had shifted toward fully virtual care by 2022, whereas very few nonbehavioral health providers were fully virtual.¹⁵ For some services, such as behavioral health, CMS should balance patient preferences with the reality that telehealth can help address provider shortages in many areas of the country—especially rural communities—and evidence that telehealth is largely comparable to in-person care.^b Further, CMS should ensure that safety net providers receive sufficient reimbursement to maintain their telehealth operations, which are crucial for reaching underserved communities.

^b In 2021, Congress passed permanent payment parity for telebehavioral health. There are several unique considerations that CMS should keep in mind for behavioral health. Telebehavioral health services can address problems associated with the paucity of behavioral health providers and help patients overcome the stigma related to these services, especially in more rural, tight-knit communities. Behavioral health accounted for 40% of all Medicare telehealth services in 2022, and a large body of evidence shows that mental health services delivered via telehealth are comparable to in-person care. Paying telehealth services at parity can also help retain providers in network at a time when many behavioral health providers are outside insurance networks—citing insufficient reimbursement and complicated paperwork.

- *What lessons can we learn from telehealth use within value-based payment models?* Several Medicare demonstrations allow for telehealth flexibility within value-based payment models, which reward providers for quality and cost savings. In 2019, CMS' Center for Medicare and Medicaid Innovation (CMMI) launched the [Primary Care First](#) and [ACO REACH](#) models, both of which waive geographic and originating site requirements for telehealth.^{c,d,16} In May 2024, CMS proposed an episode-based alternative payment model that emphasizes telehealth as a tool to enhance care coordination and outcomes for Medicare patients undergoing certain surgical procedures.¹⁷ The agency should draw lessons from these models to inform the best way to incorporate virtual care services.

After gathering data on the cost of telehealth and considering its impact on access and quality, CMS should propose a long-term telehealth reimbursement strategy. This strategy should aim to reflect the true cost of care, promote high-value services, support patient access, and be feasible to implement. Below are several options for CMS to consider.

One approach could involve CMS establishing an optimal percentage difference in reimbursement between in-person and telehealth and applying that difference to any code with the telehealth modifier. CMS uses a similar method to pay nurse practitioners 85% of the amount paid to a physician for the same service. In 2020, the Alliance of Community Health Plans, a group representing nonprofit, community-based health plans, [proposed](#) a Medicare reimbursement model that would transition from payment parity to reimbursing telehealth at 80% of in-person rates; providers would be eligible for bonus payments if they demonstrated high-quality care and reduced costs.¹⁸ This approach would simplify administrative processes by applying a uniform percentage, but it might not capture important differences between service types. For example, behavioral health services—which are well suited for telehealth—likely warrant a different reimbursement strategy than visits for acute conditions that typically require physical exams. Nonetheless, such standardization could enhance CMS's ability to easily monitor and adjust telehealth rates.

CMS could also consider bundled payments or partial capitation to pay for brief virtual interactions. Health systems during the pandemic saw steady increases in the use of brief virtual interactions, such as secure email and phone calls, as a percentage of total outpatient visits.^{19,20} Currently, Medicare reimburses for two types of brief virtual interactions—e-visits and virtual check-ins—

c Primary Care First provides a flat monthly payment per beneficiary and makes performance-based adjustments; the model gives primary care providers flexibility to meet patients' needs outside of regular office visits, including through telehealth and broader care management strategies. The model has committed to offering certain telehealth flexibilities—including waiving geographic and originating site requirements—regardless of congressional action.

d ACO REACH offers primary and specialty providers flexibility in payment models, including partial or full capitation, and promotes telehealth as a tool to enhance access for patients in remote or underserved areas. Participating entities have the option to remove geographic restrictions, deliver telehealth to patients in their home, and offer asynchronous services.

but billing these services individually under the fee-for-service model is administratively burdensome. Physicians have voiced frustration at the extra time they spend on portal messages and similar interactions, often without reimbursement.^{21,22} Conversely, a provider might choose to conduct and bill for a full telehealth visit for interactions that were not previously billed separately, such as a phone call to communicate test results. Bundled payments may be better suited to reimburse these brief virtual interactions.

CMS should permanently maintain all telehealth flexibilities for providers participating in value-based payment arrangements with two-sided risk.

CMMI should allow telehealth flexibilities in all models that incorporate two-sided risk. Providers in these models—which incentivize high-quality care at reduced costs—are more likely to use cost effective telehealth solutions. Given these incentives, they should be able to choose when to use flexible telehealth options, such as audio-only visits and ordering costly services via telehealth.

Telehealth flexibilities could also incentivize fee-for-service providers to move further down the value-based continuum. In rural and underserved areas, value-based models have generally seen lower participation from providers, particularly those with two-sided risk, and CMS has committed to identifying and addressing barriers to participation for providers serving those populations.²³ Telehealth flexibilities alongside a suite of other financial incentives could help entice providers into value-based payment.

CMS could also gradually transition telehealth towards value-based payment. The Alliance of Community Health Plans proposed a framework that would evaluate telehealth within a fee-for-service model to inform a new value-based arrangement. Providers would continue to receive reimbursement at parity, while an independent entity evaluates which services are best suited to telehealth. This evaluation would inform a new capitated model that reimburses providers on a per-member/per-month basis, paying more for services considered most effective in a virtual setting.^{24,e} Others have suggested applying a similar phased approach to episode-based models, in which a period of parity could allow CMS to evaluate how telehealth affects quality and use.²⁵ CMS could then use that information to adjust telehealth reimbursement as part of episode spending targets.

e For example, a primary care provider managing patients with diabetes via telehealth could receive a higher rate, reflecting the effectiveness of virtual care for ongoing monitoring. Conversely, telehealth for acute conditions like kidney stones, which often require physical assessments, might receive a lower rate.

B. ENSURE HIGH-QUALITY VIRTUAL CARE

Telehealth has become a permanent fixture in the nation's health care system and holds immense promise. For instance, studies show that telehealth can improve medication adherence and reduce downstream emergency department visits.²⁶

However, the quality of telehealth can vary by service type and setting. Early evidence suggests that it may be an effective modality for behavioral health care and chronic disease management, but less so for acute care.^{27,28} Moreover, access to and the quality of telehealth services varies widely across sociodemographic groups.^{29,30,31,32} For instance, Medicare beneficiaries who are older, have lower incomes, are Black or Hispanic, or live in rural areas are less likely to have smartphones with wireless plans or computers with high-speed internet, which limits their access to video visits.^{33,34,35}

Further, although the vast majority of health care providers act in their patients' best interests, telehealth flexibilities might increase opportunities for bad actors to abuse the system.

Congress should work with the Office of Inspector General (OIG) at the Department of Health and Human Services (HHS) and the CMS Center for Program Integrity to address these issues. The following recommendations focus on promoting high-quality virtual services, enhancing telehealth oversight, and reducing fraudulent billing.

Congress should ensure that OIG and CMS have sufficient funding to promote high-quality telehealth services and track fraud, waste, and abuse.

Congress should provide sufficient funding to ensure OIG and CMS can effectively oversee telehealth services and promote high-quality virtual care. The two agencies play complimentary roles in telehealth oversight. CMS screens providers before enrollment, monitors billing practices, offers provider education, and conducts audits, while OIG focuses on investigating and prosecuting fraud after it occurs.

An OIG audit found that telehealth practitioners generally complied with Medicare billing requirements during the first nine months of the public health emergency.³⁶ However, the audit focused on compliance with Medicare's existing documentation standards and may not have captured some common schemes, such as billing for unnecessary services or ones that never occurred.³⁷ OIG has issued numerous alerts and reports about purported fraudulent activity from telehealth companies in recent years.^{38,39}

In the 2023 Consolidated Appropriations Act, Congress required the secretary of HHS to complete a study on telehealth and Medicare program integrity; the secretary must submit an interim report by October 1, 2024, and a final report by April 1, 2026.⁴⁰

Congress should review these reports to ensure oversight agencies have sufficient funding to uphold high-quality virtual care, robustly monitor telehealth, and track fraud, waste, and abuse. Congress should also require HHS to delve into key areas with significant quality variability—such as teleprescribing and audio-only—in subsequent evaluations.

Adequate resources will ensure that the rapid expansion of telehealth does not compromise the quality of patient care or the integrity of the Medicare program.

CMS and SAMHSA should work with medical specialty societies and states to develop and promote best practices for prescribing controlled substances via telehealth.

Telehealth can be an effective tool to expand access to high-quality care, but significant variations in quality exist. One area with notable variability is the virtual prescribing of controlled substances.

Although telehealth can help to expand access to necessary treatment, numerous providers and researchers told BPC that there is a need for enhanced guidance and education on high-quality virtual prescribing practices.

Experts have raised safety concerns associated with increased or off-label prescribing of certain controlled substances, such as Adderall, Ketamine, and Xanax. One notable example is Cerebral: This mental health startup has faced scrutiny for allegedly pressuring providers to overprescribe, offering insufficiently brief appointments, inadequately screening and monitoring patients, and failing to properly train providers on crisis management.⁴¹ And in June 2024, the Department of Justice (DOJ) issued an indictment against telehealth company Done for a \$100 million scheme to fraudulently distribute Adderall.⁴²

The practice of prescribing controlled substances using virtual platforms is relatively new, so the evidence base is still emerging. Consequently, existing prescribing guidelines have not yet included best practices for telehealth.⁴³ Currently, providers offering telehealth do not have to undergo screening or training to virtually prescribe controlled substances, leading to inconsistencies in prescribing and to potential risks to patients. To address this gap, CMS and SAMHSA should develop and widely disseminate best practices for virtually prescribing controlled substances.

These best practices would necessarily vary by substance type. For instance, evidence shows that telehealth prescribing of buprenorphine is safe, effective, and well received by patients and providers; HHS should focus on promoting this essential medication for treating opioid use disorder.⁴⁴ For other substances, such as Adderall and Ketamine, HHS should prioritize establishing best practices to minimize off-label and excessive prescribing via telehealth.^{45,46,47}

CMS' Center for Program Integrity, particularly its provider compliance group, should play a crucial role in overseeing this initiative. CMS should also work with medical specialty societies and states to develop, disseminate, and adapt best practices for local regulations and needs.

Although policymakers should focus on controlled substances as a first step, CMS and SAMHSA could also explore broader guidance to raise the quality and uniformity of virtual services. BPC recently recommended that CMS establish [clinical guidelines for remote patient monitoring](#), and the agency could explore a broader suite of guidelines to inform the optimal use of virtual care. Such guidelines could outline which types of services are best suited for telehealth, when audio-only consultations may be insufficient, and circumstances in which it is important to have a preexisting patient-provider relationship.

CMS could look to existing health care accreditation standards to inform telehealth guidelines. The Joint Commission—a health care accrediting organization—introduced [telehealth-specific standards](#) in early 2024. CMS could encourage telehealth companies to adopt such seal-of-approval type recognitions.⁴⁸ And Congress could authorize CMS to require telehealth companies serving Medicare beneficiaries to adhere to standards or authorize CMS to use another approach to set stricter evaluation criteria for registering fully virtual providers in Medicare.

CMS should require that providers offering audio-only telehealth services attest that they have the capabilities to deliver two-way video visits at the time of the service and that they offered the patient the choice of a video visit, but the patient was either unable or unwilling to complete a video visit.

Access to audio-only services is critical for patients who lack broadband, especially in rural and remote areas, or for those who have difficulty accessing and using video. Audio-only visits can be effective for behavioral health, chronic disease management, and certain other services, but some experts caution that telephone visits may not deliver the same standard of care as video or in-person visits. There is currently insufficient evidence to assess the quality of audio-only services.^{49,50}

Some health plans have cut audio-only coverage in recent years. Aetna has stopped this coverage for certain employer-funded health plans, and UnitedHealthcare only reimburses the modality for select codes used for behavioral health, speech-language pathology, genetic counseling, nutrition, and advanced care planning.^{51,52}

Given coding challenges, it is hard to discern the extent of audio-only visits in Medicare. One study found that audio-only accounted for 25% of all telehealth evaluation and management visits in 2022, a decrease from 31% in 2020.^{53,54}

Many factors drive the use of audio-only telehealth in Medicare, including preferences and access limitations among patients and providers.

Some patients face barriers to accessing video visits or lack digital literacy and prefer the telephone. Medicare beneficiaries who are older, have lower incomes, are Black or Hispanic, or live in rural areas are less likely to have smartphones with wireless plans or computers with high-speed internet.^{55,56,57} A BPC [analysis](#) of enrollees in traditional Medicare found that in 2021, American Indians and Alaska Natives used audio-only services at twice the rate of other Medicare beneficiaries—at least 40% of the telehealth services received by this group were provided by phone.⁵⁸

Some health care practices rely exclusively on audio for their telehealth services. Concerningly, even in practices equipped with video technology, some patients continue to receive audio-only visits, and not by their choice.⁵⁹ One study found that providers were more likely to use telephone visits for Hispanic adults and those with limited English proficiency, even though these patients were not more likely to choose a telephone visit when given the option of telephone or video.⁶⁰ This trend might reflect implicit biases or logistical challenges, such as difficulty syncing interpreter services with video visits.⁶¹

CMS must ensure that patients, and not providers, dictate whether to use video or audio-only for a telehealth service. Although coverage of audio-only services is important for patients who lack other options, unrestricted use of these services could perpetuate a two-tiered system in which some patients use higher quality, face-to-face interventions and others use the phone.

CMS should require that providers offering audio-only services attest that they offered patients the choice of a video visit. In 2023, the agency implemented new service-level modifiers to better track audio-only visits and specified that providers may only initiate an audio-only visit at the patient's request. However, early uptake of these modifiers is low, and there is currently no enforcement mechanism to ensure it is indeed the patient initiating these audio-only visits.⁶² CMS should enforce this policy, use the new modifiers to evaluate audio-only, and, as evidence emerges, retain the authority to limit its use or implement other guardrails.

To help patients overcome barriers to accessing video services, the federal government and states should continue to promote programs that expand broadband and the use of digital navigators. In 2021, the Infrastructure Investment and Jobs Act invested \$65 billion in broadband—the largest broadband investment in U.S. history. The law aimed to improve Americans' access to internet services and reduce the digital divide for rural areas, low-income families, and tribal communities. It is crucial that policymakers sustain these efforts to help more patients access video-based telehealth visits.

CMS should promote continuity of care by requiring telehealth providers to have protocols for sharing progress notes with a patient's usual care team. CMS should also require that providers offering telehealth services have the capacity to deliver or refer to in-person care, particularly in emergency situations.

The rise in virtual care options expands Medicare beneficiaries' access to services, but it also risks further fragmenting patient care.^{63,64,65} To mitigate these concerns, CMS should require that fully virtual providers establish protocols to connect with a patient's usual care team and quickly link patients with emergency in-person services, as needed.

To maintain continuity of care, providers delivering telehealth should establish mechanisms to share progress notes with a patient's primary care team. While not all patients will have a primary source of care or consent to share information, CMS should require that telehealth providers at least have the capability to communicate with a patient's usual provider. These mechanisms could range from fully virtual providers using the same electronic health record as in-person providers, to simpler digital solutions for sharing patient records.

Additionally, it is crucial that providers have protocols to respond to emergency situations during a virtual visit. A subset of patients who access virtual services will inevitably require immediate in-person care. CMS should require that providers offering telehealth services have the capacity to deliver or refer to in-person care, particularly in emergency situations. Providers must establish clear guidelines for triaging such cases and ensure prompt communication with local health care facilities.

CMS could also encourage providers to develop guidelines for referring patients to in-person care, as needed by the patient, in the context of nonemergency situations. Depending on the symptoms, a virtual visit will not always be sufficient to resolve a patient's health care need. Further, many patients prefer in-person services: A 2023 study found that one-third of surveyed adults using behavioral health services did not receive their preferred modality (telehealth versus in-person), and nearly half felt their provider did not consider their preference.⁶⁶

Ideally, providers delivering virtual services should be prepared to respond when a patient needs a nonurgent referral or prefers in-person care. Providers could maintain updated lists of local in-person services or develop robust referral networks. The feasibility of implementing these protocols may vary by state; for instance, some states already have comprehensive provider directories that can simplify the referral process.⁶⁷ CMS should ensure that any new requirements do not place undue burden on telehealth providers or inadvertently reduce access to virtual care.

Numerous states have enacted policies to address care fragmentation and help connect patients to in-person services. For example, Nebraska Medicaid requires providers to give patients a list of alternative options, including in-person services, before an initial telehealth visit.⁶⁸ California Medi-Cal mandates that providers either offer or facilitate referrals to in-person care.⁶⁹ And Texas has professional requirements that all telehealth providers must offer guidance to patients on appropriate follow-up care and, if the patient consents, share a report of the encounter with the patient's primary care provider within 72 hours.⁷⁰

Members of Congress from both parties have expressed support for similar requirements that mental health providers—who constitute the largest share of fully virtual providers—either deliver or have the capacity to refer to in-person care.⁷¹

CMS should establish guardrails around providers ordering certain high-cost services for patients via telehealth.

High-cost durable medical equipment (DME) and lab tests are frequent targets for fraud, with myriad schemes employed to exploit the system.^f For example, in 2022, OIG issued a [fraud alert](#) about purported telehealth companies that paid practitioners in exchange for prescribing medically unnecessary services, such as DME, genetic testing, and wound care items (in violation of the federal anti-kickback statute).⁷² And in 2023, authorities in Texas arrested three individuals linked to \$142 million in Medicare fraud involving a genetic testing company that manipulated patient data, fabricated diagnoses, and altered service dates to enable repeated billing.⁷³ In May 2024, OIG found that Medicare lost \$1.2 billion from telemarketers illegally promoting orthotic braces directly to beneficiaries, often without a provider ever speaking to or properly assessing the patients.⁷⁴

Although law enforcement sometimes catches and prosecutes the perpetrators of these schemes, Congress must enact guardrails to prevent them from happening in the first place. Ideally, Congress should require an in-person visit before ordering high-cost lab tests and durable medical equipment (providers

^f Durable medical equipment is defined as equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury and is appropriate for use in the home. See: <https://secure.ssa.gov/poms.nsf/lnx/0600610200>

participating in alternative payment models involving two-sided risk could be exempt).

The two bills marked up by House panels in May 2024 ([H.R. 8261](#) and [H.R. 7623](#)) included limited fraud protections; the legislation would require an OIG study on certain fraudulent practices and call on CMS to use its existing authority to perform prepayment review of claims for durable medical equipment items with aberrant billing patterns. During the House Ways and Means Committee markup of [H.R. 8261](#), Rep. Lloyd Doggett (D-TX) proposed an amendment to strengthen these fraud protections, by directing CMS to also conduct a prepay review of certain high-cost laboratory tests, and highlighted previous bipartisan attempts to introduce other preventative measures. Several committee members expressed interest in working on additional measures to reduce fraud, but the amendment did not pass.

MedPAC, members of Congress, and policy experts have called for preventive measures to stop fraudulent telehealth companies and outlier providers from ordering medically unnecessary items.^{75,76} The bipartisan Telehealth Extension Act of 2021 ([H.R. 6202](#)) would have required an in-person visit with the prescribing provider within six months before ordering high-cost durable medical equipment or major clinical laboratory tests. The Medicare Fraud Detection and Deterrence Act of 2023 ([H.R. 1745](#)) mandates that CMS deactivate the National Provider Identifier of providers excluded from federal health care programs because of fraud, waste, or abuse.

CMS should enhance its ability to evaluate the cost and quality of telehealth services by 1) prohibiting incident to billing by any provider who can bill Medicare directly, and 2) establishing a new modifier or provider category for fully virtual providers.

CMS should actively track the quality of telehealth services to identify whether additional guardrails would improve the quality and cost effectiveness of virtual care. To facilitate this monitoring, CMS should eliminate incident to billing—which allows nonphysician providers to bill under a supervising physician’s identification—and create a modifier to distinguish between traditional and fully virtual providers.

To help policymakers understand who is delivering video and audio-only visits and in what quantity, CMS should prohibit incident to billing by any provider who can bill Medicare directly. Before COVID-19, incident to billing enabled nonphysician providers—such as nurse practitioners or physician assistants—to bill under a supervising physician’s higher rate, provided the physician was physically present in the same office. Since COVID-19, CMS has allowed for “virtual supervision,” in which the physician is available online as needed.⁷⁷ MedPAC has raised concerns about incident to billing—for telehealth and more

broadly—noting that it makes it harder to monitor the quality of services.⁷⁸ Ending this practice will support research into quality of care as well as efforts to detect and investigate fraud.

Although BPC recommends eliminating incident to billing, a good first step would be for CMS to identify and monitor this type of billing. The Telehealth Modernization Act of 2024 ([H.R. 7623](#)) and the Telemental Health Act of 2024 ([H.R. 7858](#)) would create a modifier code to better track incident to billing in telehealth.

CMS should also create a modifier to identify and monitor fully virtual providers in Medicare. Data on the prevalence and quality of fully virtual telehealth providers is limited because Medicare claims do not include information on a provider's employer or corporate affiliation. Notably, MedPAC estimates that 20% of behavioral health providers operated exclusively online in 2022.⁷⁹

Investigative reporting and government oversight have documented that some fully virtual providers have engaged in aggressive direct-to-consumer advertising and increased and off-label prescribing of substances such as Adderall and Ketamine.^{80,81,82,83} In 2024, the Federal Trade Commission (FTC) and DOJ took significant actions against telemental health companies, including banning Cerebral from using health data for advertising and indicting Done in a fraudulent scheme involving Adderall.^{84,85}

CMS should create a modifier or provider category for fully virtual providers, or use another approach determined appropriate by the HHS secretary. If feasible, CMS should also evaluate what portion of telehealth providers are fully virtual companies, versus individual practitioners who have shifted their practices to remote.

The Telehealth Modernization Act ([H.R. 7623](#)) and the Medicare Fraud Detection and Deterrence Act ([H.R. 1745](#)) would require telehealth companies to use a specialized CMS modifier when submitting claims for Medicare telehealth services.

C. EXPLORE OPPORTUNITIES FOR PERMANENCY

Policymakers should enact permanent telehealth policy where the evidence is clear, as Congress did for mental health services in the Consolidated Appropriations Act of 2021 ([P.L.116-260](#)).⁸⁶ Establishing broader permanent policy will help to provide stability for patients and providers, and offer the certainty needed for health systems and practices to feel comfortable investing in telehealth technology.^g

Congress should remove geographic and originating site restrictions.

Congress should remove geographic and originating site restrictions to ensure that telehealth coverage is available for all Medicare beneficiaries at any site across the United States. There is near universal agreement that telehealth should remain a widely available option and that it would be administratively burdensome to limit it to certain sites, patients, or conditions.

Congress should authorize Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to serve as distant site providers and allow all eligible Medicare providers to deliver services via telehealth.

Congress should permanently authorize FQHCs, RHCs, and all eligible Medicare providers to deliver services via telehealth. FQHCs and RHCs are crucial providers of care to medically underserved populations.

Further, patients appreciate the option to use telehealth with newly eligible telehealth providers—physical therapists, occupational therapists, speech-language pathologists, and audiologists—and research shows promise for the use of telehealth for some of their services. For example, studies show that telephysical therapy may help reduce pain and improve quality of life among patients with knee osteoarthritis, and teleoccupational therapy may help older adults to perform daily activities.^{87,88}

Congress should repeal in-person visit requirements for telemental health services.

Finally, Congress should permanently remove in-person visit requirements for mental health services to address the worsening mental health crisis and the shortage of behavioral health providers. Providers can use clinical judgement

g It is important to consider that implementing permanent telehealth policies could influence provider behaviors and telehealth utilization. Such policies could encourage providers to adopt fully virtual platforms, which in turn could affect the range of options available to patients. By implementing the recommendations in this report, the government would be equipped to actively monitor and address these potential effects.

to decide when in-person visits are necessary but requiring them would substantially disrupt access to care.⁸⁹

Behavioral health accounted for 40% of all Medicare telehealth services in 2022, and a large body of evidence shows that mental health services delivered via telehealth are comparable to in-person care.⁹⁰ Importantly, the burden of in-person visit requirements would fall disproportionately on those living in rural areas who lack access to behavioral health providers, must travel longer distances for care, or face the stigma of accessing in-person behavioral health services in small communities.⁹¹

Conclusion

Congress faces a critical deadline at the end of this year with the expiration of Medicare's telehealth flexibilities. As deliberations progress on Capitol Hill, BPC urges Congress and the administration to embed two critical components into any telehealth extension: a long-term reimbursement strategy and measures to ensure high-quality virtual care.

Telehealth has become a permanent fixture of the nation's health care delivery system. BPC's forward-looking policy recommendations aim to secure the integrity of telehealth and ensure it continues to be a transformative force in health care for years to come.

Appendix A: Total Medicare Reimbursement by Modality and Provider Setting

Medicare reimbursement for the same service can vary significantly based on who the provider works for and where the patient is at the time of service. These variations factor into shaping a long-term reimbursement strategy for telehealth. To shed light on this complexity, BPC compared total Medicare reimbursement in 2024 for two common telehealth procedure codes: one evaluation and management service (99213) and one behavioral health service (90834). The following charts illustrate how much Medicare pays depending on the modality—in-person or telehealth—and the provider's setting—facility setting (e.g., provider who works for a hospital), nonfacility setting (e.g., provider who works for an independent practice), or Federally Qualified Health Center (FQHC).

Figure 01. CPT code 99213: Established patient office or other outpatient visit, 20-29 minutes

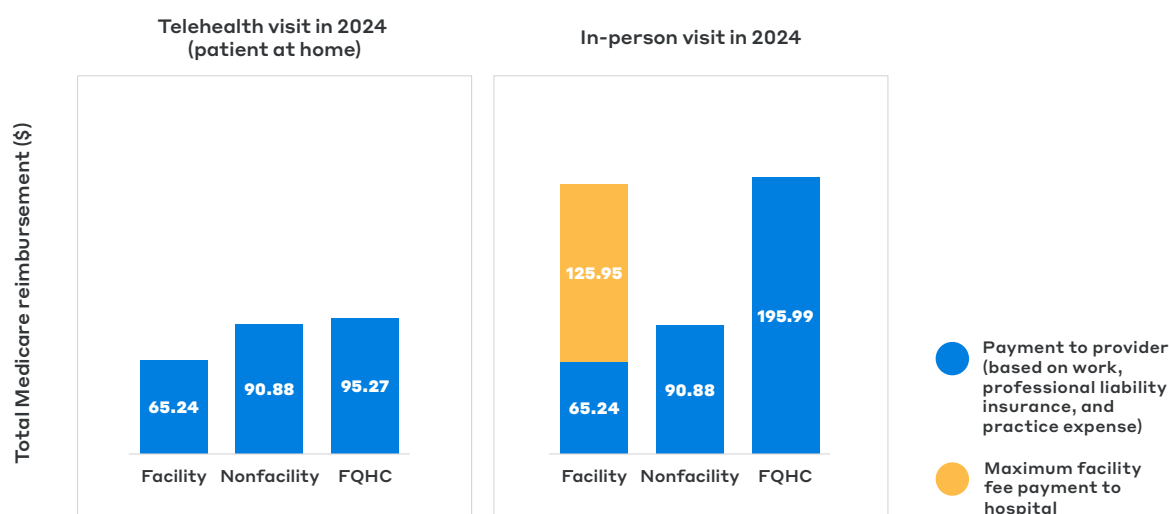
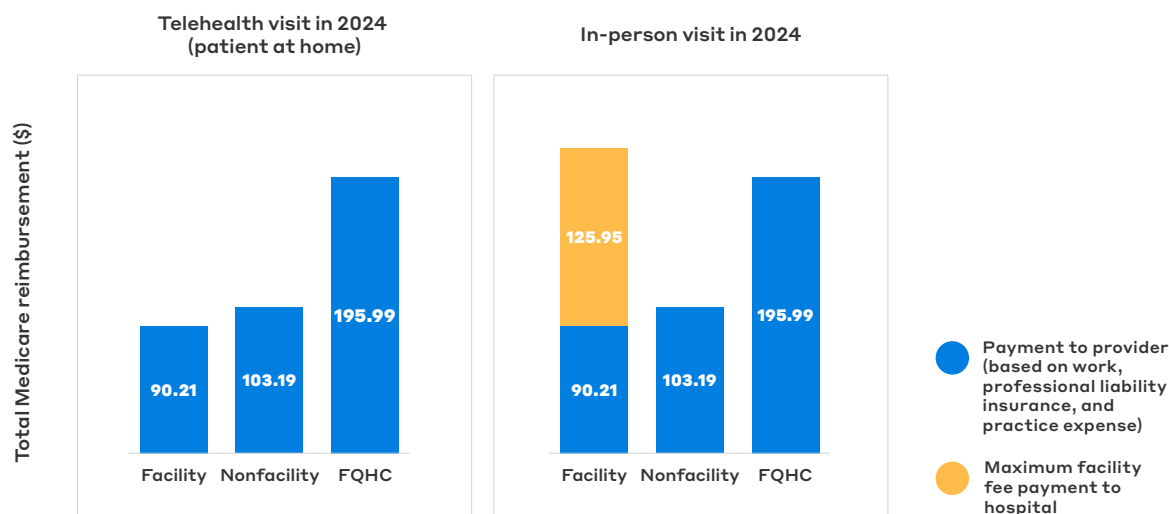


Figure 02. CPT code 90834: Psychotherapy, 45 minutes



Sources:

Physician Fee Schedule Facility & Nonfacility Rates (base rate payment to distant site provider, before geographic adjustment): <https://www.cms.gov/medicare/physician-fee-schedule/search?Y=1&T=4&HT=0&CT=3&H1=99213&M=5>.

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