MGMA
Medical Group Management Association®

TELEHEALTH

2025 ISSUE BRIEF

MGMA has long advocated for expanding coverage and reimbursement of virtual services to increase patient access to care. In response to the COVID-19 pandemic public health emergency (PHE), Congress and the Centers for Medicare & Medicaid Services (CMS) allowed greater flexibility in how telemedicine is delivered to safely treat patients. While the COVID-19 PHE ended on May 11, 2023, many of these flexibilities were renewed multiple times in the subsequent years following the PHE. In addition to these PHE-related waivers, Congress and CMS have used subsequent legislation and rulemaking, such as the annual Medicare Physician Fee Schedule (PFS) and temporary statutory extensions, to further expand or maintain telehealth access and payment policies. MGMA believes that the flexibilities implemented under the COVID-19 PHE should be reinstated and made permanent to allow practices to continue to provide virtual care to vulnerable patient populations.

CURRENT STATUS OF MEDICARE TELEHEALTH POLICIES

POLICY	PRE-PHE POLICY	POST_PHE	EXPIRATION
Originating site/geographic location	Beneficiaries must receive services at originating site in a rural area (not the home)	Location is waived –patients can be seen anywhere	January 30, 2026
Qualifying providers	Certain providers are allowed to deliver telehealth services	Provider types extended to PTs, OTs, and SLPs	January 30, 2026
Audio-only services	CMS does not cover audio visits without a visual component	CMS will reimburse for services via phone (E&M visits)	January 30, 2026 (Per the 2025 Medicare PFS services provided in a beneficiary's home under certain conditions will be permanently covered)
FQHCs and RHCs	FQHCs and RHCs could not qualify as distant site providers	Can qualify as distant site providers	December 31, 2026
FQHCs and RHCs	Required supervising and teaching physicians to be physically present in the same location to provide direct supervision of care.	Allows virtual direct supervision using real-time audio/video	N/A
Payment parity	Telehealth services are reimbursed at typically lower facility rates	Telehealth services billed using Place of Service Code 10 will be reimbursed at the higher non-facility rate	January 30, 2026 **exception: mental health services
Requirements for telehealth prescriptions	Required in-person evaluation before prescribing controlled substances via telehealth	Waived in-person requirement	December 31, 2026
Home Enrollment	Providers must separately enroll and bill for each location from which they deliver telehealth services	Providers may bill from their existing practice location when delivering telehealth from home. Virtual-only providers must list their home address as their practice location	N/A (Per the 2026 Physician Fee Schedule, virtual-only providers can suppress opt to suppress street addresses when providing telehealth services from home for privacy concerns)

MGMA
Medical Group Management Association®

TELEHEALTH

2025 ISSUE BRIEF

Frequency Limits	CMS allowed one telehealth subsequent inpatient visit every 3 days, one telehealth nursing facility visit every 14 days, and only one telehealth critical care consultation per day	Telehealth frequency limits for subsequent inpatient visits, nursing facility visits, and critical care consultations fully eliminated starting CY 2026	N/A
Behavioral Health In-Person Visit Requirements (Initial & Annual)	In-person visit required before starting telehealth services for behavioral health and periodic in-person visits to continue them.	In-person requirements waived.	January 30, 2026. (In-person visit required within 6 months before the first telehealth service for behavioral health and every 12 months thereafter, with documented exceptions when an in-person visit poses greater risks or burdens.)

CATEGORIES OF DIGITAL MEDICINE

There are other modalities to improve healthcare beyond interactive, live-video conferencing, as described in the Medicare statute. CMS now recognizes new digital health solutions and provides payment for certain services, including virtual check-ins, store-and-forward technology, and remote patient monitoring. These digital health services are not subject to the same restrictions as traditional Medicare telehealth.

ADVOCACY PRIORITIES

- **Expand access to telehealth services** under the Medicare program by permanently removing current geographic and originating site restrictions
- **Cover and reimburse audio-only visits** at a rate that adequately pays for the cost of delivering that care
- **Appropriately reimburse medical practices** for telehealth services to allow them to provide cost-effective, high-quality care
- **Support improving coverage of telehealth** by removing administratively burdensome billing requirements, such as collecting patient co-pays for virtual check-ins
- **Ensure continuity of care** between a practice and its patients through telehealth
- **Allow practitioners offering telehealth services from their home to continue reporting their work address** on their Medicare enrollment to avoid privacy and security concerns

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups in which more than 350,000 physicians practice. These groups range from small private practices in rural areas to large regional and national health systems and cover the full spectrum of physician specialties and organizational forms.

MGMA GOVERNMENT AFFAIRS
1717 Pennsylvania Ave., Suite 600, Washington, DC 20006
202.293.3450 | govaff@mgma.com
www.mgma.com/advocacy
@MGMA | #MGMAAdvocacy