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We're Over the "Telehealth Cliff"- What Next?

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When Congress failed to pass a Continuing Resolution (CR) by September 30, 2025, a number of legislative payment provisions that have allowed broader Medicare coverage of telehealth services since the COVID-19 public health emergency (PHE) expired (effective October 1, 2025). This puts providers and practitioners who have come to rely on this expanded coverage to provide telehealth service to patients in their homes and urban clinical settings in a very difficult position with respect to the ongoing provision of these services.

On October 1, the Centers for Medicare and Medicaid Services (CMS) issued a Medicare Learning Network (MLN) Matters notice that directs all Medicare Administrative Contractors (MACs) to implement a temporary claims hold (typically around ten business days) in response to the expiration of the flexibilities. This hold could prevent the need for reprocessing large volumes of claims if the telehealth flexibilities are extended soon through a CR or other Congressional action. Providers may continue to submit claims during this period, but payment will not be released until the hold is lifted. While this provides some temporary relief, providers and practitioners are still dealing with significant uncertainty regarding their telehealth programs and services due to the fact that a more permanent solution has not been implemented.

What's Changed?

Before the COVID-19 PHE, Medicare payment for telehealth services was extremely limited. In response to the pandemic, Congress and CMS established certain waivers and flexibilities to expand access to care. Many of these flexibilities were well-received by patients and providers and have been incorporated into the care continuum. At this point, it would be very difficult and contrary to the interest of patients and providers to unwind telehealth arrangements that benefitted from broader Medicare coverage of telehealth services. As a result, Congress repeatedly extended many of the COVID-19 telehealth flexibilities. The most recent extension was set to expire September 30, but there has been widespread anticipation that another extension would be included in a CR. Such language was, in fact, included in a bill that recently passed in the House and was sent to the Senate for consideration. Given that a CR was not passed into law, telehealth flexibilities expired as of October 1, 2025.

Below is a summary of the telehealth coverage policies that relied upon the flexibilities that expired and the policies now in effect based on their expiration.

Topic	Coverage Policy Due to Legislative Flexibility (Through September 30, 2025)	Current Coverage Policy (Effective October 1, 2025)
Originating Site/Geographic Restrictions	Medicare beneficiaries were able to receive telehealth services in any location in the United States, including their	With limited exceptions (e.g, behavioral health services and services provided under accountable care organizations (ACO) waivers), providers can only deliver Medicare-covered telehealth from

	homes and urban clinical sites, including but not limited to urban hospitals, skilled nursing facilities (SNFs), and physicians' practices.	designated originating sites. These include provider offices, hospitals, and SNFs – **not the patient's home**, and telehealth is only covered if these sites are in rural Health Professional Shortage Areas, counties outside Metropolitan Statistical Areas, or federal telehealth demonstration sites.
Audio-Only Services	Medicare has covered audio-only telehealth services, if clinically appropriate.	Medicare will only cover audio-only services if the patient receives services from home and the patient cannot or will not use audio/visual technology. Providers must maintain the capability for audio-video technology and thoroughly document the circumstances necessitating audio-only care.
Eligible Practitioners	All practitioners who are eligible to bill Medicare for covered services (e.g., physical therapists, occupational therapists, speech-language pathologists, audiologists, marriage and family therapists, and mental health counselors) have been eligible to deliver telehealth services (i.e., serve as the distant site practitioner).	Eligible practitioners have been limited to physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists, nurse-midwives, clinical psychologists, clinical social workers, mental health counselors, registered dietitians and nutrition professionals, marriage and family therapists, and certified registered nurse anesthetists.
In-Person Requirement for Mental Health	Practitioners were not subject to in-person visit requirements before providing behavioral health services to patients via telehealth when patients were not in Medicare-eligible originating sites.	An in-person visit is required within six months of an initial Medicare behavioral/mental telehealth service, and annually thereafter, in order to provide behavioral health telehealth services to patients in their homes (under an exception to the originating site requirements referenced above). For federally qualified health centers (FQHCs) and rural health clinics (RHCs), the in-person visit requirement for mental health services furnished via communication technology to beneficiaries in their homes is not required until January 1, 2026.
FQHCs/RHCs as Distant Sites	FQHCs and RHCs have been eligible to serve as distant site providers.	FQHCs and RHCs can no longer serve as distant-site providers of telehealth services.
Acute Care	The Acute Care Hospital at Home waiver has allowed	Medicare will no longer cover services furnished to patients in their homes through the Acute Care

Hospital at Home	acute care services to be provided to patients in their homes (subject to waiver requirements).	Hospital at Home program.

Who's Feeling the Impact?

This will impact health care providers and practitioners who have come to rely on expanded coverage of Medicare telehealth services and the patients who have benefitted from expanded access.

Why Should Health Care Providers Care?

Based on the expiration of the Medicare flexibilities, MACs and commercial and Medicare payors who follow Medicare's coverage policies may begin denying claims based on the new coverage restriction once CMS's temporary hold referenced above is lifted.

What's Your Next Move?

Providers should act now to mitigate compliance and revenue risks. Below are action steps providers can take in light of the expiration of these Medicare flexibilities.

- Continue to monitor Congressional action, as additional legislation could reinstate and extend the Medicare flexibilities that expired. The CR that passed the House of Representatives on September 19 would extend the flexibilities through November 22.
- Consider holding claims associated with the services that will not be payable by Medicare if CMS lifts its hold before Congress authorizes an extension of the flexibilities.
- Engage counsel to review the impact of the discontinuation of these flexibilities on existing telehealth arrangements and agreements.
- Monitor for changes from other payors and review contracts to determine if there is reliance on Medicare coverage.
- Determine whether certain telehealth services and arrangements will no longer be covered under Medicare if there is not a legislative fix.
- Develop and implement operational changes to continue effective patient care within the new coverage guidelines.
- Develop and implement plans for transitioning patients back to in-person care or to care from an eligible originating site location.
- Adopt a clear communication strategy for staff and patients so they understand the changes coming. This should include updating patient consents to reflect the policy and coverage changes, such as providing beneficiaries with an Advance Beneficiary Notice of Noncoverage when applicable.

We will continue to provide updates as the situation evolves. For more information, please contact Allison M. Cohen, Alex S. Lewis, Sam Cottle, or any member of Baker Donelson's Telehealth Group.