



Telehealth Decoded: A Health Center Telehealth Factsheet

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Nearly every Community Health Center (CHC), also called Federally Qualified Health Centers (FQHCs), utilizes telehealth to provide services remotely to their patients.¹ Telehealth has become an indispensable tool for CHCs in delivering care to the 52 million patients they serve,² particularly patients in rural, underserved, and low-income areas who face significant barriers to in-person care. Over the last five years, telehealth utilization has surged, demonstrating its potential to extend access to primary care, behavioral health, and chronic disease management services.

As telehealth policy continues to evolve across Medicare, Medicaid, and private insurance, CHCs must navigate a complex and shifting landscape of coverage rules, payment rates, and regulatory requirements. **This factsheet provides specific information for CHCs, including:**

- Key [definitions](#) essential to understanding telehealth policy
- An overview of telehealth coverage and payment under [Medicare](#), [Medicaid](#), and [private insurance](#)
- A [summary comparison table](#) across payers
- [Other relevant telehealth policy issues](#) facing CHCs
- [NACHC's advocacy](#) priorities on telehealth

Term	Definition
Telehealth	The use of telecommunications systems allowing two-way, real-time audio-video or eligible audio-only interactive communication between the patient and the physician or other qualified health care practitioner (adapted from 42 CFR 410.78 -- Telehealth services).
Originating Site	"The location of an eligible...beneficiary at the time the service is being furnished" through telehealth (adapted from 42 CFR 410.78 -- Telehealth services).
Distant Site	"The site at which the physician or practitioner delivering the service is located at the time the service is provided" through telehealth (42 CFR 410.78 -- Telehealth services).
FQHC Medical Visit in Medicare	<p>"(1) A medical visit is a face-to-face encounter between a Rural Health Center (RHC) or FQHC patient and one of the following:</p> <ul style="list-style-type: none"> (i) Physician. (ii) Physician assistant. (iii) Nurse practitioner. (iv) Certified nurse midwife. (v) Visiting registered professional or licensed practical nurse. <p>(2) A medical visit for a FQHC patient may be either of the following:</p> <ul style="list-style-type: none"> (i) Medical nutrition therapy visit. (ii) Diabetes outpatient self-management training visit. <p>(Source - Federal Regulation)</p>

<p>FQHC Mental Health Visit in Medicare</p>	<p>“A mental health visit is a face-to-face encounter or an encounter furnished using interactive, real-time, audio and video telecommunications technology or audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of video technology for the purposes of diagnosis, evaluation or treatment of a mental health disorder. Not before October 1, 2025, in the case of mental health visits furnished via interactive, real-time, audio and video telecommunications technology or audio-only interactions, within 6 months prior to the furnishing of the telecommunications service and that an in-person mental health service (without the use of telecommunications technology) must be provided at least every 12 months while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders, unless, for a particular 12-month period, the physician or practitioner and patient agree that the risks and burdens outweigh the benefits associated with furnishing the in-person item or service, and the practitioner documents the reasons for this decision in the patient’s medical record, between an RHC or FQHC patient and one of the following:</p> <ul style="list-style-type: none"> (i) Clinical psychologist. (ii) Clinical social worker. (iii) Marriage and family therapist. (iv) Mental health counselor. (v) Other RHC or FQHC practitioner, in accordance with paragraph (b)(1) of this section, for mental health services.” <p>(Source - Federal Regulation)</p>
<p>Remote Patient Monitoring or Remote Physiologic Monitoring (RPM)</p>	<p>“Remote physiologic monitoring involves the use of non-face-to-face technology to monitor and analyze a patient’s physiological metrics. Examples of physiological metrics include oxygen saturation, blood pressure, blood sugar or blood oxygen levels, weight loss or gain.”</p> <p>(Source - HHS Website)</p>
<p>Self-insured/self-funded health plans</p>	<p>“Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees’ and dependents’ medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered.” (Source - healthcare.gov)</p>

Medicare

Before 2020, Medicare services were reimbursed only when the patient was in a designated rural area, and the visit originated from a qualifying health facility.³ CHCs were not recognized as eligible distant sites under traditional Medicare telehealth rules.

In March 2020, Congress authorized the use of a [Section 1135 waiver](#) in response to the public health emergency (PHE), expanding Medicare telehealth coverage on a temporary basis. The waiver allowed for key flexibilities including:

- Telehealth services to originate from a patient's home
- Recognition of CHCs as eligible distant sites for telehealth billing
- Coverage of audio-only services for patients unable to use video
- Elimination of geographic restrictions, allowing patients living outside rural areas to receive telehealth services

These flexibilities allowed a qualified provider physically located at a CHC to deliver a medical visit to a patient in their home via video or audio-only telehealth.

Since the end of the PHE, Congress has repeatedly extended many of these telehealth flexibilities while policymakers continue to consider permanent reforms. **Effective January 1, 2025, CMS permanently updated the definition of an interactive telecommunications system to include two-way, real-time audio-only communication** for clinically appropriate Medicare telehealth services furnished to patients in their home when the practitioner has audio-video capability but the patient cannot use or does not consent to video technology. The [Consolidated Appropriations Act of 2026 \(H.R. 7148\)](#) extended key Medicare telehealth flexibilities through December 31, 2027, providing critical continuity for CHCs and the patients they serve. However, because these flexibilities were extended only temporarily, Congress will need to act again before the end of 2027 to prevent another Medicare telehealth cliff in 2028.

An important distinction for CHCs under Medicare telehealth is the difference between mental health (also called behavioral health) visits and medical visits. While Congress permanently expanded mental health telehealth through the [Consolidated Appropriations Act of 2021 \(H.R.133\)](#) – a meaningful win for CHCs – it did not permanently explicitly expand medical telehealth visits, creating a confusing, two-track system.

Mental health telehealth services include:

- Psychiatric diagnostic evaluation
- Psychiatric diagnostic evaluation with medical services
- Psychotherapy (30-60 minutes)
- Psychotherapy for crisis
- Psychoanalysis



The [FQHC qualifying visit list](#) includes the full description and codes that CHCs can bill for mental health services.⁴ A grey area exists as to whether CMS already has the authority to include telehealth services in the medical visit definition or whether direct statutory instruction from Congress is needed.

Important to note, the [Consolidated Appropriations Act 2026](#) delayed the mental health in-person visit requirement until January 1, 2028. Originally, the 2026 [Physician Fee Schedule \(PFS\)](#) established that starting in 2025, a patient would have to have an in-person, non-telehealth visit annually within 6 months prior to the first mental health telehealth service. Established patients were exempt from the initial six-month rule. Patients would still need to have an annual in-person visit thereafter CMS's telehealth factsheet clarifies that if the mental health practitioner that would be conducting the telehealth service is not available for a non-telehealth visit, a physician or practitioner of the same specialty within the same group practice can also conduct the qualifying in-person visit.⁵ A permanent exception to the annual in-person visit is if the mental health practitioner and patient agree that the risks of an in-person visit outweigh the benefits.

For CHCs providing integrated care, staying current on these evolving and distinct requirements is essential to maintaining compliant, patient-centered telehealth programs.⁶

Medicaid

Medicaid telehealth policy is determined at the state level within a federal framework, creating significant variation in coverage, eligible providers, covered services, and reimbursement rates across states, presenting both opportunities and challenges for CHCs.

In 2024, states largely had robust Medicaid telehealth coverage policies:⁷

- All **50** states and the District of Columbia (DC) provide some form of Medicaid reimbursement for live video visits, up from just 44 states in 2013
- **45** states plus DC allow reimbursement for audio-only telehealth services
- **42** states allow reimbursement for remote patient monitoring (RPM)

While these trends reflect broad progress, states differ significantly in the details of their telehealth policies. Some states allow any licensed provider to deliver telehealth, while others maintain specific lists of eligible provider types. For example, Connecticut and Massachusetts allow doulas to deliver and be reimbursed for telehealth visits.⁸ Additionally, covered services vary by state, with some states limiting telehealth to specific visit types or specialties. Reimbursement rates for telehealth may also differ from in-person rates, depending on state policy.

Like Medicare, Medicaid continues to grapple with challenges around originating and distant sites. However, progress continues as:

- **48** states and DC have recognized a patient's home as an acceptable originating site.
- **41** states and DC have also allowed school-based sites to be eligible as originating sites.
- **35** states and DC have recognized CHCs as originating sites so that patients could see a provider via telehealth while they were physically at a CHC.
- Regarding the distant site issue, **40** states and DC have explicitly recognized CHCs and RHCs as eligible distant sites.⁹

For CHCs specifically, Medicaid telehealth policy intersects with PPS billing requirements, which can affect how, and whether, a telehealth visit qualifies for the full FQHC encounter rate. Primary Care Associations (PCAs) play a critical role in helping CHCs navigate and clarify their state's specific Medicaid telehealth rules.



Private Payers

Similar to Medicaid, private insurance telehealth coverage is shaped primarily by state laws, insurer policies, and the type of health plan. **As of 2024, 41 states and DC have enacted some form of telehealth coverage parity law**, requiring private insurers to cover telehealth services similarly to coverage of in-person services.¹⁰



However, state telehealth coverage parity laws do not apply to self-funded employer-sponsored health plans. These plans are governed by the [Employee Retirement Income Security Act \(ERISA\)](#) and are exempt from state insurance mandates. Employees covered under self-funded plans may have very different telehealth coverage than those covered under fully-insured state-regulated plans, even if they work in a state with a strong parity law. According to a 2025 KFF survey, 67 percent of covered workers are in a self-funded plan.¹¹

The private payer landscape is generally less central than Medicare and Medicaid for CHCs, given their patient population. However, as CHCs increasingly serve a mix of insurance types, understanding private payer telehealth policies remains relevant.

Comparison Table of Medicare and Medicaid

Private insurance is not included in this chart as it is extremely variable, and insufficient data on coverage is available.

	Medicare	Medicaid
Audio-Video Coverage	Yes (temporary extension for medical visits through 12/31/2027)	Yes- all 50 states + DC
Audio Only Coverage¹²	Yes (temporary extension for medical visits through 12/31/2027)	Majority of states reimbursed for audio-only telehealth in 2025; six states and territories did not ¹³
Mental Telehealth Visit Coverage	Yes (permanent Medicare coverage)	Varies by state
FQHC as Eligible Distant Site	Yes (temporary extension for medical visits through 12/31/2027)	Yes- 35 states + DC
Codes for Medical Telehealth Visit	Before October 1, 2026: G2025 After October 1, 2026: ¹⁴ Individual CPT or HCPCS codes that describe the distant site telehealth service furnished with the 93 (audio-only) or 95 (video) modifier See NACHC's reimbursement tipsheet here .	Varies by state
Codes for Behavioral Telehealth Visit	PPS Payment Codes G0469 and G0470: Qualifying visit codes: <ul style="list-style-type: none"> • 90791 Psychiatric diagnostic evaluation • 90792 Psychiatric diagnostic evaluation with medical services • 90832 Psychotherapy patient &/family 30 minutes • 90834 Psychotherapy patient &/family 45 minutes • 90837 Psychotherapy patient &/family 60 minutes • 90839 Psychotherapy crisis initial 60 minutes • 90845 Psychoanalysis See NACHC's reimbursement tipsheet here .	Varies by state
Remote Patient Monitoring	Covered for some conditions (e.g. weight, blood pressure, pulse oximetry, respiratory flow rate) See NACHC's reimbursement tipsheet here .	42 states allow ¹⁵

Teleprescribing of Controlled Substance

In addition to payment issues, other barriers to telehealth care remain. Providers at CHCs have been using telehealth to manage a wide variety of conditions safely and effectively. Historically, the [Ryan Haight Online Pharmacy Consumer Protection Act](#) required an in-person evaluation before a practitioner could prescribe controlled substances via telemedicine. During the PHE, the Drug Enforcement Administration (DEA) and the Department of Health and Human Services (HHS) implemented temporary telemedicine flexibilities that allowed practitioners to prescribe certain controlled substances without a prior in-person medical evaluation when applicable requirements were met. Since the end of the PHE, the DEA and HHS have extended these telemedicine flexibilities through December 31, 2026.¹⁶ These flexibilities help support continuity of care and access to treatment for CHC patients, particularly those in rural, underserved, and medically vulnerable communities.



NACHC's Advocacy

The National Association of Community Health Centers (NACHC) is committed to ensuring that CHCs can continue to deliver high-quality telehealth services to the patients and communities they serve. Our telehealth advocacy priorities include:



- ▶ **Permanent Expansion of Medicare Telehealth Flexibilities.** NACHC supports permanent authorization of key Medicare telehealth flexibilities that expand access to care and provide long-term stability for CHCs and Medicare beneficiaries. The current extension through 2027 provides important critical continuity for CHCs and Medicare beneficiaries, but a permanent solution is needed to provide long-term stability and preserve access to telehealth services.
- ▶ **Medicare Payment Parity.** Medicare currently reimburses CHCs for telehealth medical visits at less than half the rate for in-person medical visits (nationally around \$98, compared to \$208 in 2026). This limits seniors' choices for access to primary care, which increases long-term spending on preventable emergency room visits and hospital admissions. NACHC supports payment policies that appropriately recognize the resources required to deliver high-quality telehealth services and promote sustainable access to care.
- ▶ **Fair Reimbursement for Audio-only Visits.** CMS has recognized certain clinically appropriate audio-only telehealth services as a covered Medicare benefit when statutory and regulatory requirements are met. Audio-only services can be a lifeline for patients who face barriers to video-based care, including limited broadband access, technology limitations, disabilities, or other circumstances that make video telehealth impractical. NACHC supports policies that allow CHCs to furnish and receive appropriate reimbursement for clinically appropriate audio-only services, ensuring patients can access care through the modality that best meets their needs.
- ▶ **Permanent Expansion of Teleprescribing of Controlled Substances.** CHCs play a critical role in providing behavioral health services, substance use disorder treatment, and medication-assisted treatment in underserved communities. NACHC supports permanent policies that allow eligible practitioners to prescribe controlled substances via telemedicine when clinically appropriate, helping maintain access to care for patients who rely on telehealth services.
- ▶ **Modernization of Medicare Telehealth Coding.** As CMS continues to modernize telehealth policy and expand access to care, coding frameworks should accurately reflect the modality through which services are delivered. Streamlined coding would reduce administrative burden, improve data accuracy, promote consistency across payers, and help health centers maintain compliance while delivering telehealth services. NACHC supports adoption of a modern telehealth coding framework that accurately captures both the service furnished and the telehealth modality used to deliver care.

Additional NACHC Resources:

- **NACHC's 2026 Reimbursement Tips: Medicare Reimbursement, Coding, & Documentation Guidance for FQHCs** helps CHCs navigate Medicare reimbursement, coding, and documentation in line with CMS guidelines. These resources are available to Health Center Program staff who complete the VTF Assessment at <https://reglantern.com/vtf>. Individuals completing the assessment can request access to the suite of Reimbursement
- [NACHC Resource: Medicare Billing Terms Made Simple](#)

For more information or questions,
please reach out to regulatoryaffairs@nachc.org.

SOURCES

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- 2 Weitzman, 2025.
- 3 <https://www.kff.org/medicare/what-to-know-about-medicare-coverage-of-telehealth/>
- 4 Page 6-7
- 5 Telehealth FAQ
- 6 eCFR :: 42 CFR Part 405 Subpart X -- Rural Health Clinic and Federally Qualified Health Center Services
- 7 <https://www.ncsl.org/health/the-telehealth-explainer-series/medicaid-reimbursement-for-telehealth>
- 8 State Telehealth Laws and Reimbursement Policies Report, Fall 2025 - CCHP
- 9 State Telehealth Laws and Reimbursement Policies Report, Fall 2025 - CCHP
- 10 <https://www.ncsl.org/health/the-telehealth-explainer-series/telehealth-private-insurance-laws>
- 11 <https://www.kff.org/health-costs/2025-employer-health-benefits-survey>
- 12 CMS permanently revised the definition of an interactive telecommunications system effective January 1, 2025 to include certain audio-only communications when Medicare requirements are met.
- 13 https://www.cchpca.org/2025/10/2025_SummaryChartfinal.pdf
- 14 <https://www.cms.gov/files/document/mm14468-rural-health-clinics-federally-qualified-health-centers-billing-distant-site-telehealth.pdf>
- 15 Medicaid Reimbursement for Telehealth
- 16 <https://www.federalregister.gov/documents/2025/12/31/2025-24123/fourth-temporary-extension-of-covid-19-telemedicine-flexibilities-for-prescription-of-controlled>