U.S. Department of Health & Human Services

Centers for Medicare & Medicaid Services

REPORT TO CONGRESS

Providing Accountable Care Organizations the Ability to Expand the Use of Telehealth

January 2026

Table of Contents

Introduction

Statute

Section 50324 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123) ("BBA of 2018") expanded access to telehealth services for fee-for-service (FFS) Medicare beneficiaries assigned to applicable accountable care organizations (ACOs) starting January 1, 2020.[1] Applicable ACOs must have prospective beneficiary assignment and must participate under two-sided financial risk in the Medicare Shared Savings Program or a model tested or expanded under the Center for Medicare and Medicaid Innovation Center (CMMI) at the Centers for Medicare & Medicaid Services. Furthermore, the statute added the home of a beneficiary assigned to an applicable ACO as an originating site for all telehealth services and allowed access to telehealth services in any geographic location. Section 50324(b) of BBA of 2018 requires the Secretary of Health and Human Services to conduct a study on implementation of section 50324 that analyzes the spending and utilization of these telehealth services and submit a Report to Congress no later than January 1, 2026 containing the results of the study, together with recommendations for legislation and administrative action. This report fulfills the requirements of section 50324(b).

Key Takeaways from this Report

- Most Accountable Care Organizations (ACOs) did not qualify for telehealth flexibilities, though among applicable ACOs, most beneficiaries were attributed to Shared Savings Program ACOs.[2]

- ACO-attributed beneficiaries' telehealth utilization and spending sharply increased in 2020 and then decreased but remained higher than prior to the COVID-19 public health emergency (PHE).

- ACO-attributed beneficiaries had higher rates of telehealth use relative to the full fee-for-service Medicare population throughout the COVID-19 PHE.

- Telehealth utilization for ACO-attributed beneficiaries was greater with health care providers participating in ACOs than health care providers not participating in ACOs, but ACO-attributed beneficiaries more often sought behavioral health services from health care providers not participating in ACOs.

- Telehealth visits for specialty care were most prevalent, with behavioral health services most often delivered by specialists.

[1] Bipartisan Budget Act of 2018 (Pub.L. 115-123) Div. E, Title III, Sec. 50324. Providing accountable care organizations the ability to expand the use of telehealth. Section 50324 added section 1899(l) to the Social Security Act.
[2] "Attributed" and "attribution" are used throughout the report to refer to beneficiaries "assigned" to applicable ACOs under BBA of 2018 since "assignment" is the term used in the Shared Savings Program and "alignment" is the term used in CMMI ACO models.

- Telehealth utilization was more frequent among beneficiaries who qualified for Medicare through a disability and those who were dually eligible for Medicaid, subgroups of beneficiaries likely to have greater overall service needs.

- ACO-attributed beneficiaries in counties without a Health Professional Shortage Area (HPSA) designation had more telehealth use overall but less telehealth use with out-of-state health care providers than beneficiaries in HPSA counties.

Telehealth Waivers in ACOs

Prior to telehealth expansion under BBA of 2018, Medicare beneficiaries could typically only receive telehealth services in rural HPSAs or from entities participating in a federal telemedicine demonstration project. Some ACO models provided additional flexibilities related to furnishing telehealth services through waivers of statutory payment requirements. For example, the Next Generation ACO telehealth waiver allowed beneficiaries to receive telehealth services from any originating site, including their homes.[3] The Vermont All-Payer ACO Model also offered a telehealth expansion waiver,[4] as did the Comprehensive End-Stage Renal Disease Care Model.[5] Other ACO models were launched on or after January 1, 2020 when section 50324 of BBA of 2018 took effect.

Telehealth During the COVID-19 PHE

Within a month of telehealth services expansion under BBA of 2018, the Secretary of Health and Human Services declared a nationwide public health emergency (PHE) on January 31, 2020 in response to the emerging 2019 novel coronavirus (COVID-19).[6] Relying on the flexibilities granted pursuant to the declaration of the COVID-19 PHE and a combination of emergency rulemaking and new statutory authority, the Secretary expanded access to telehealth services by relaxing the originating site and geographic site restrictions for all Medicare beneficiaries to access telehealth services regardless of whether they are attributed to applicable ACOs under BBA of 2018. These telehealth flexibilities were further extended to September 30, 2025, following the end of the COVID-19 PHE on May 11, 2023.[7,8,9]

Telehealth Utilization and Spending in this Report

Because the telehealth services expansion to beneficiaries attributed to applicable ACOs under BBA of 2018 occurred soon before the Secretary expanded access to telehealth services for all Medicare beneficiaries, the spending and utilization of these telehealth services cannot specifically be attributed to the expansion of telehealth services under BBA of 2018. This study covers the COVID-19 PHE period between January 2020, when applicable ACOs were first eligible for telehealth expansion under BBA of 2018, and May 2023, at the conclusion of the COVID-19 PHE. This study's period of analysis was restricted to the COVID-19 PHE as a specific time period with sufficient data available for analysis before the due date of this Report to Congress. This study used

[3] https://www.cms.gov/priorities/innovation/files/x/nextgenaco-telehealthwaiver.pdf
[4] https://www.cms.gov/priorities/innovation/data-and-reports/2021/vtapm-1st-eval-full-report
[5] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNmattersArticles/downloads/MM10314.pdf
[6] https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx
[7] Consolidated Appropriations Act of 2023 (Pub.L. 117-328) Sec. 4113. Advancing telehealth beyond COVID–19.
[8] American Relief Act of 2025 (Pub.L. 118-158) Sec. 3207. Extension of certain telehealth flexibilities.
[9] Full-Year Continuing Appropriations and Extensions Act, 2025 (Pub.L. 119-4) Sec. 2207. Extension of certain telehealth flexibilities.

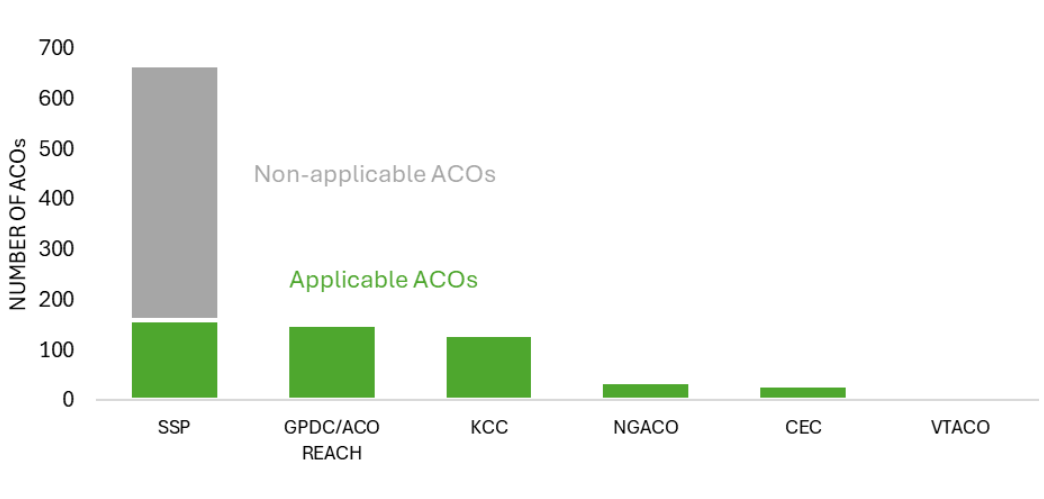
Medicare claims and other administrative data sources available through the Chronic Conditions Data Warehouse as well as publicly available data sources (Appendix A). The telehealth services in this study are defined as synchronous, or real-time, audio or video telecommunications visits furnished or received from any ambulatory, institutional, or residential site (Appendix B). Telehealth services received by ACO-attributed beneficiaries in this study were delivered by health care providers participating or not participating in applicable ACOs, unless noted in an analysis limited to health care providers in applicable ACOs.

Most ACOs did not qualify for telehealth flexibilities under BBA of 2018, though among applicable ACOs, most beneficiaries were attributed to Shared Savings Program ACOs

Applicable ACOs qualifying for the telehealth flexibilities offered through BBA of 2018 participated in the Shared Savings Program or in one of five CMMI ACO models. During the study period of January 2020 to May 2023, a total of 507 ACOs were applicable ACOs; 517 additional ACOs did not qualify as applicable ACOs. Nearly one-third (32%) of applicable ACOs participated in the Shared Savings Program, and more than half of applicable ACOs participated in either GPDC/ACO REACH (30%) or KCC (26%) (**Figure 1**). Applicable Shared Savings Program ACOs represented a little more than a quarter (28%) of all Shared Savings Program ACOs.

FIGURE 1: Most ACOs did not qualify for telehealth flexibilities

Number of applicable and non-applicable ACOs by initiative, January 2020 to May 2023



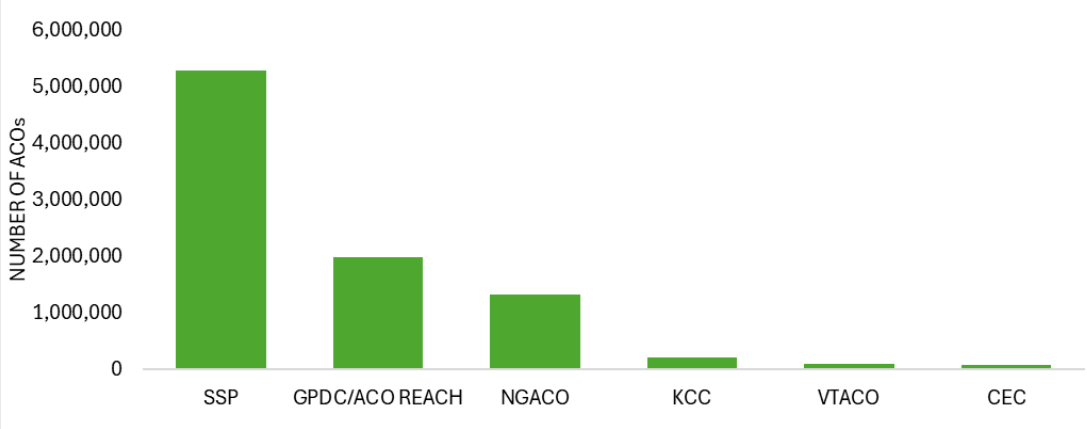
NOTE: Applicable ACOs in green bars have prospective attribution and two-sided financial risk. All GPDC/ACO REACH ACOs were applicable ACOs. Non-applicable ACOs in gray bars are visible in the figure for 506 Shared Savings Program ACOs but not visible for 7 CEC ACOs and 4 KCC ACOs. SSP=Shared Savings Program; GPDC=Global and Professional Direct Contracting; KCC=Kidney Care Choices; NGACO=Next Generation ACO; CEC=Comprehensive ESRD Care; VTACO=Vermont All-Payer ACO

SOURCE: CMS analysis of 2020-2023 Shared Savings Program ACO Public-Use Files, 2020-2023 provider-level ACO Research Identifiable Files, and Master Data Management provider extract.

Applicable ACOs had 8,936,285 attributed beneficiaries during the study period. More than half of beneficiaries (59%) were attributed to an applicable Shared Savings Program ACO (Figure 2). Among CMMI ACO initiatives, GPDC/ACO REACH and NGACO had the highest enrollment levels, representing 22% and 15% of total beneficiaries, respectively.

FIGURE 2: Most beneficiaries were attributed to applicable Shared Savings Program ACOs

Number of ACO-attributed beneficiaries by ACO initiative, January 2020 to May 2023



NOTE: Applicable ACOs are those with prospective attribution and two-sided financial risk . SSP=Shared Savings Program; GPDC=Global and Professional Direct Contracting; KCC=Kidney Care Choices; NGACO=Next Generation ACO; CEC=Comprehensive ESRD Care; VTACO=Vermont All-Payer ACO

SOURCE: CMS analysis of 2020-2023 Shared Savings Program ACO Public-Use Files, 2020-2023 beneficiary-level ACO Research Identifiable Files, and Master Data Management beneficiary extract.

ACO-attributed beneficiaries' telehealth utilization and spending sharply increased in 2020 and then decreased but remained higher than prior to the COVID-19 PHE

Baseline telehealth utilization and spending levels were low among beneficiaries attributed to applicable ACOs, with a total of 59,944 telehealth visits in 2019 (**Figure 3**). In 2020, ACO-attributed beneficiaries had 6,524,842 telehealth visits, 109 times the 2019 total. Compared to 2020, the annual telehealth visit counts were lower in 2021 (4,294,696 visits, 72 times the 2019 total) and 2022 (4,826,611 visits, 81 times the 2019 total).

ACO-attributed beneficiaries' telehealth spending trends showed the same pattern as telehealth utilization trends, increasing from $5,685,662 in 2019 to $464,015,793 in 2020. Compared to 2020, spending totals in subsequent years of the COVID-19 PHE were lower ($337,813,987 in 2021 and $369,307,295 in 2022).

FIGURE 3: ACO-attributed beneficiaries had minimal telehealth utilization and spending prior to the COVID-19 PHE

Annual number of telehealth visits and spending among ACO-attributed beneficiaries, January 2019 to May 2023

NOTE: PHE=public health emergency

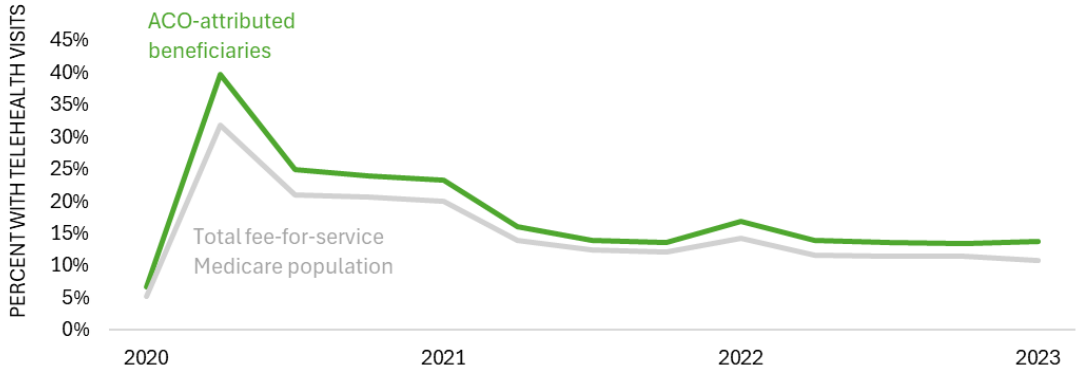
SOURCE: CMS analysis of 2019-2023 beneficiary-level ACO Research Identifiable Files, 2019-2023 Outpatient and Carrier Research Identifiable Files, and Master Data Management beneficiary extract.

ACO-attributed beneficiaries had higher rates of telehealth use relative to the full fee-for-service Medicare population throughout the COVID-19 PHE

Relatively more ACO-attributed beneficiaries received telehealth services than the broader Medicare fee-for-service population, yet they followed similar telehealth utilization trends (**Figure 4**). ACOs appeared to be earlier adopters of telehealth services during the COVID-19 PHE. At the height of telehealth use in 2020 Q2, about 40 percent of ACO-attributed beneficiaries received at least one telehealth visit versus 32 percent of fee-for-service Medicare beneficiaries as a whole. Both rates declined and the gap between them narrowed over time such that by 2023 Q1, about 14 percent of ACO-attributed beneficiaries received any telehealth services compared with 12 percent of the larger Medicare population.

FIGURE 4: A greater percentage of ACO-attributed beneficiaries used telehealth services compared to the total population of fee-for-service Medicare beneficiaries but followed similar trends throughout the COVID-19 PHE

Quarterly percentage of beneficiaries with at least one telehealth visit, January 2020 to March 2023



NOTE: PHE=public health emergency

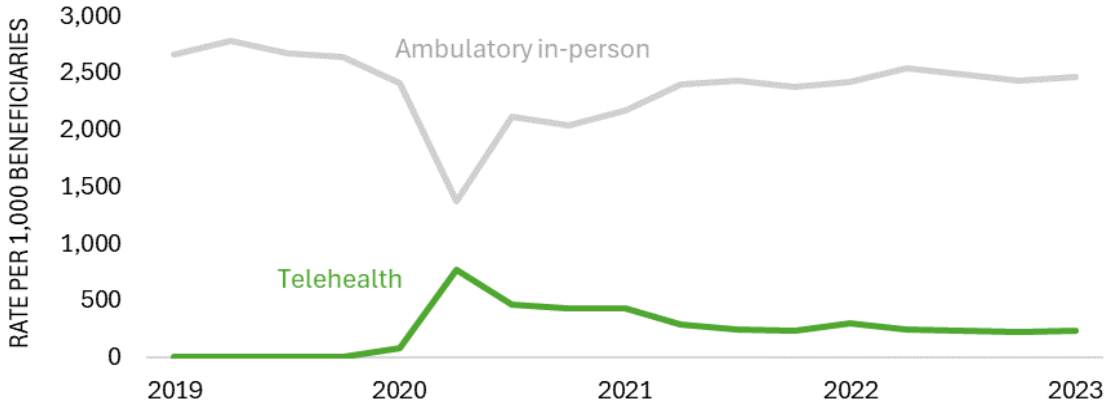
SOURCE: CMS analysis of 2020-2023 beneficiary-level ACO Research Identifiable Files, 2020-2023 Outpatient and Carrier Research Identifiable Files, and Master Data Management beneficiary extract. Total Medicare population telehealth user percentages were calculated using quarterly numbers of Medicare Part B telehealth users and annual Medicare Part B enrollment numbers available at Data.CMS.gov.

Telehealth utilization rates rose at the start of the COVID-19 PHE, though never exceeded the rates of in-person ambulatory care visits

Telehealth utilization among ACO-attributed beneficiaries spiked in the second quarter of 2020, coinciding with a commensurately steep drop in in-person ambulatory care visits at the start of the COVID-19 PHE (**Figure 5**). In the first quarter of 2020, there were 78 telehealth visits per 1,000 ACO-attributed beneficiaries, and in 2020 Q2 the telehealth utilization rate was nearly 10 times higher, with 773 telehealth visits per 1,000 ACO-attributed beneficiaries. During this same period, the quarterly utilization rate of in-person ambulatory services decreased from 2,405 visits per 1,000 ACO-attributed beneficiaries in 2020 Q1 to 1,375 visits per 1,000 ACO-attributed beneficiaries in

FIGURE 5: The rate of telehealth utilization approached the rate of ambulatory in-person visits at the beginning of the COVID-19 PHE, but then the two rates diverged

Quarterly visit rates among ACO-attributed beneficiaries, January 2019 to March 2023



NOTE: PHE=public health emergency

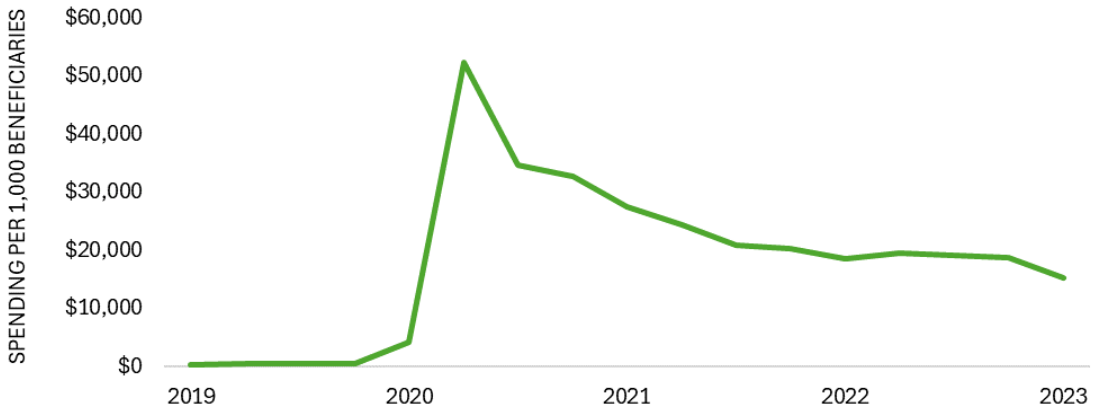
SOURCE: CMS analysis of 2019-2023 beneficiary-level ACO Research Identifiable Files, 2019-2023 Outpatient and Carrier Research Identifiable Files, and Master Data Management beneficiary extract.

2020 Q2, meaning that there were nearly 2 in-person ambulatory visits for every 1 telehealth visit in 2020 Q2. In 2020 Q3, the telehealth utilization rate declined to 459 visits per 1,000 ACO-attributed beneficiaries, and the in-person ambulatory utilization rate increased to 2,116 visits per 1,000 ACO-attributed beneficiaries. Telehealth utilization continued to decrease in subsequent quarters but did not return to pre-COVID-19 PHE levels: in 2023 Q1, there were 229 telehealth visits per 1,000 ACO-attributed beneficiaries, nearly 3 times the 2020 Q1 utilization rate. In-person ambulatory service utilization returned to pre-PHE levels by 2021 Q2 and continued at similar rates throughout the rest of the PHE.

Quarterly telehealth spending rates also spiked in the second quarter of 2020, increasing from $4,196 per 1,000 ACO-attributed beneficiaries in 2020 Q1 to $52,208 per 1,000 ACO-attributed beneficiaries in 2020 Q2 (**Figure 6**). Telehealth spending then decreased to $34,638 per 1,000 ACO-attributed beneficiaries in 2020 Q3 and continued to consistently decrease, reaching $15,103 per 1,000 ACO-attributed beneficiaries in 2023 Q1.

FIGURE 6: Spending on telehealth spiked in 2020 and gradually declined throughout the COVID-19 PHE

Quarterly telehealth spending rate among ACO-attributed beneficiaries, January 2019 to March 2023



NOTE: PHE=public health emergency

SOURCE: CMS analysis of 2019-2023 beneficiary-level ACO Research Identifiable Files, 2019-2023 Outpatient and Carrier Research Identifiable Files, and Master Data Management beneficiary extract.

Annual telehealth visit volumes varied widely at the individual ACO level (**Figure 7**). In 2020, the median number of annual telehealth visits for an ACO was 1,720 per 1,000 attributed beneficiaries, and no ACO had fewer than 473 visits per 1,000 attributed beneficiaries or more than 5,011 visits per 1,000 beneficiaries. The interquartile range (IQR) in telehealth visit rates in 2020 was 1,137 telehealth visits, indicating wide variation in the volume of telehealth visits across ACOs. The ACO-level median rate of telehealth visits decreased substantially in 2021 to 1,138 visits per 1,000 attributed beneficiaries and dropped again in 2022 to 1,021 visits per 1,000 attributed beneficiaries.

FIGURE 7: ACOs' telehealth visit volumes varied substantially in 2020 and declined in subsequent years

Annual ACO-level telehealth visit volume per 1,000 attributed beneficiaries, January 2020 to May 2023

Year	ACO N	Minimum	25th percentile	Median	75th percentile	Maximum	Interquartile range
2020	163	473	1,247	1,720	2,384	5,011	1,137
2021	172	332	777	1,138	1,586	4,039	809
2022	286	201	697	1,021	1,575	7,660	879
2023	380	68	252	372	564	2,828	312

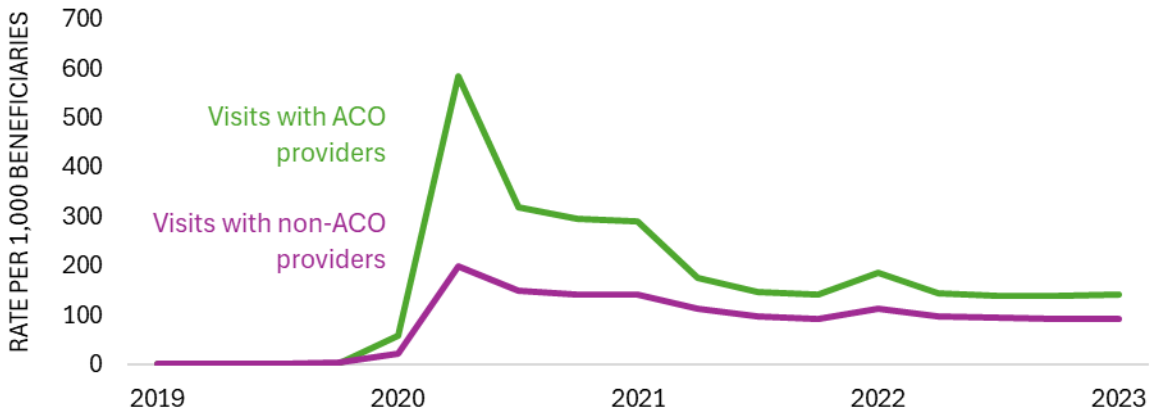
SOURCE: CMS analysis of 2020-2023 beneficiary- and provider-level ACO Research Identifiable Files, 2020-2023 Outpatient and Carrier Research Identifiable Files, and Master Data Management beneficiary and provider extracts.

Telehealth utilization for ACO-attributed beneficiaries was greater with health care providers participating in ACOs than health care providers not participating in ACOs, but ACO-attributed beneficiaries more often sought behavioral health services from health care providers not participating in ACOs

ACO-attributed beneficiaries had more telehealth visits with health care providers participating in ACOs than health care providers not participating in ACOs (**Figure 8**). In 2020 Q1, ACO-attributed beneficiaries had nearly 3 times as many telehealth visits with health care providers participating in ACOs than those not participating in ACOs (58 visits vs. 21 visits per 1,000 ACO-attributed beneficiaries, respectively). With the start of the COVID-19 PHE in 2020 Q2, absolute utilization rates increased substantially for telehealth visits with both health care providers participating in ACOs (584 visits per 1,000 ACO-attributed beneficiaries) and those not participating in ACOs (200 visits per 1,000 ACO-attributed beneficiaries). However, as telehealth utilization rates decreased overall in subsequent quarters, the gap decreased between visits with health care providers participating in ACOs and those not participating in ACOs so that by 2023 Q1, there were 1.6 telehealth visits with a health care provider participating in an ACO for every 1 visit with a health care provider not participating in an ACO.

FIGURE 8: Beneficiaries had more telehealth visits with health care providers participating in ACOs at the start of the COVID-19 PHE and almost the same amount with health care providers not participating in ACOs by the end of the COVID-19 PHE

Quarterly telehealth visit rates among ACO-attributed beneficiaries by provider ACO affiliation, January 2019 to March 2023



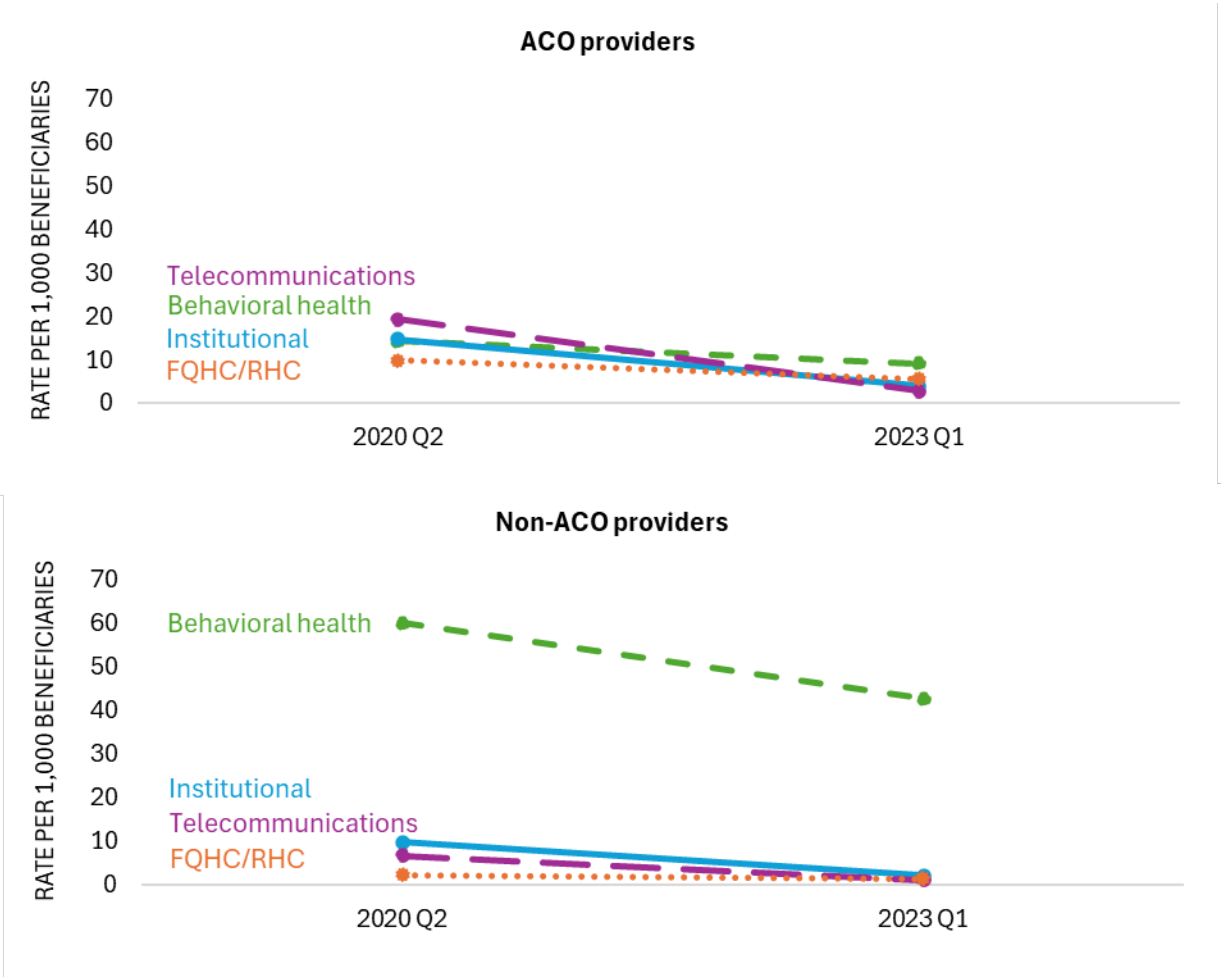
NOTE: ACO providers are health care providers participating in any applicable ACO during the relevant year. PHE=public health emergency

SOURCE: CMS analysis of 2019-2023 beneficiary- and provider-level ACO Research Identifiable Files, 2019-2023 Outpatient and Carrier Research Identifiable Files, and Master Data Management beneficiary and provider extracts.

Among the specific types of telehealth service use that were assessed in this study (Appendix C), behavioral health services were most frequently delivered. Behavioral health services were delivered by health care providers not participating in ACOs at approximately four times the rate as health care providers participating in ACOs, with 60 behavioral health telehealth visits per 1,000 ACO-attributed beneficiaries among health care providers not participating in ACOs and 14 behavioral health telehealth visits per 1,000 ACO-attributed beneficiaries among health care providers participating in ACOs in 2020 Q2 (**Figure 9**). Rates of other services were higher with health care providers participating in ACOs, ranging from 19 telehealth visits per 1,000 ACO-attributed beneficiaries for telecommunications services (e.g., e-visits) to 10 telehealth services per 1,000 ACO-attributed beneficiaries delivered through federally qualified health centers (FQHCs) or rural health centers (RHCs) in 2020 Q2. All types of telehealth service use declined over time between 2020 Q2 and 2023 Q1.

FIGURE 9: Behavioral health services were most frequently delivered by health care providers not participating in ACOs

Quarterly telehealth visit rates among ACO-attributed beneficiaries by service type provider ACO affiliation, 2020 Q2 vs. 2023 Q1



NOTE: ACO providers are health care providers participating in any applicable ACO during the relevant year.

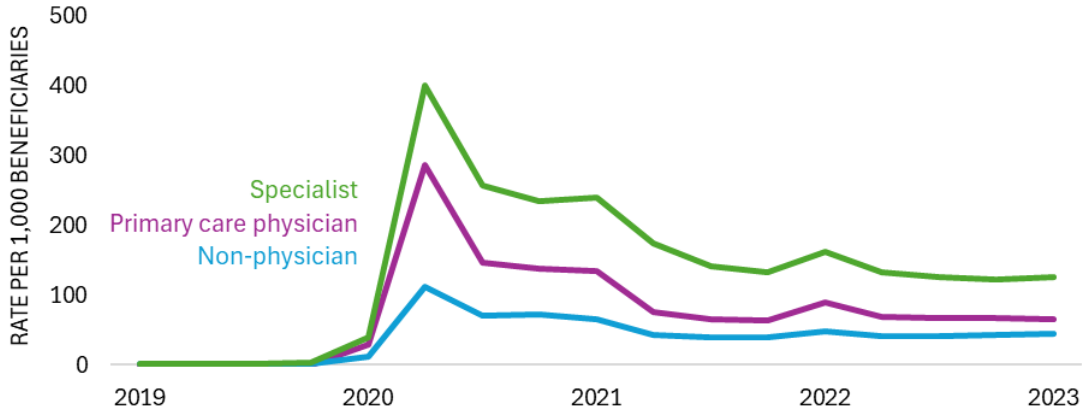
SOURCE: CMS analysis of 2019-2023 beneficiary- and provider-level ACO Research Identifiable Files, 2019-2023 Outpatient and Carrier Research Identifiable Files, and Master Data Management beneficiary and provider extracts.

Telehealth visits for specialty care were most prevalent, with behavioral health services most often delivered by specialists

ACO-attributed beneficiaries received most of their telehealth visits from specialists (**Figure 10**). In 2020 Q2, there were 399 specialist telehealth visits per 1,000 ACO-attributed beneficiaries, and in 2023 Q1, there were 125 specialist telehealth visits per 1,000 ACO-attributed beneficiaries. Primary care physicians were the next most common provider type, with 285 visits per 1,000 ACO-attributed beneficiaries in 2020 Q2 and 65 visits per 1,000 ACO-attributed beneficiaries in 2023 Q1. The remaining telehealth visits occurred with non-physician practitioners, who had utilization rates of 113 visits per 1,000 ACO-attributed beneficiaries in 2020 Q2 and 44 visits per 1,000 ACO-attributed beneficiaries in 2023 Q1.

FIGURE 10: Specialists had the highest rates of telehealth use throughout the COVID-19 PHE

Quarterly telehealth visit rates among ACO-attributed beneficiaries by provider type, January 2019 to March 2023



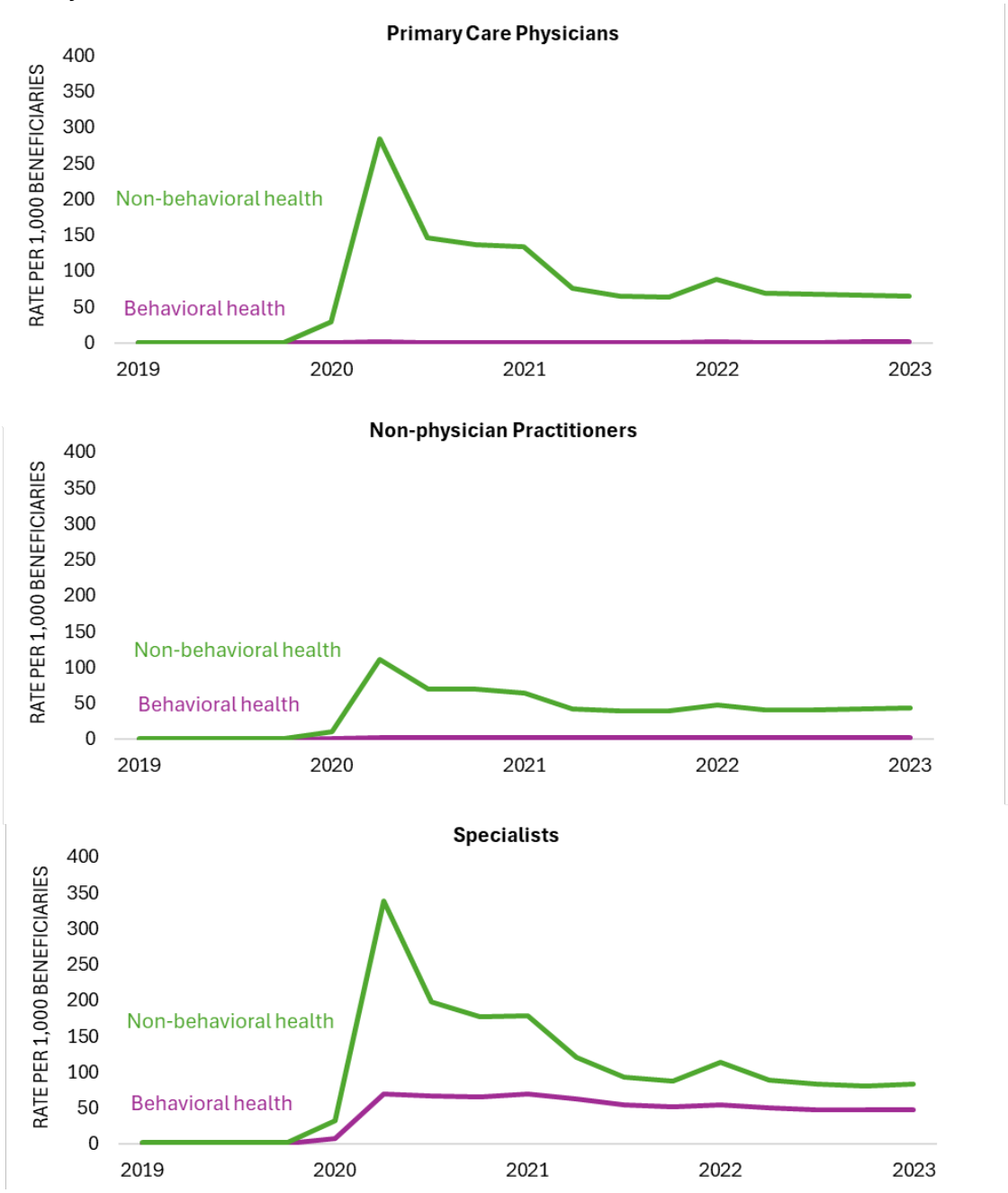
NOTE: Primary care physician denotes general practice, family practice, internal medicine, or geriatric medicine specialties; non-physician denotes physician assistant, nurse practitioner, or certified nurse specialist specialties; and specialist is all other specialties. PHE=public health emergency

SOURCE: CMS analysis of 2019-2023 beneficiary- and provider-level ACO Research Identifiable Files, 2019-2023 Outpatient and Carrier Research Identifiable Files, and Master Data Management beneficiary and provider extracts.

Although non-behavioral health services were more commonly delivered across provider types, behavioral health services delivered via telehealth were almost entirely delivered by specialists (**Figure 11**).

FIGURE 11: Specialists had the highest rates of behavioral health service delivery, but all health care provider types delivered more non-behavioral health services than behavioral health services

Quarterly behavioral health telehealth visit rates among ACO-attributed beneficiaries by provider type, January 2019 to March 2023



NOTE: Primary care physicians are general practice, family practice, internal medicine, or geriatric medicine specialties; non-physician practitioners are physician assistant, nurse practitioner, or certified nurse specialist specialties; and specialists are all other specialties.

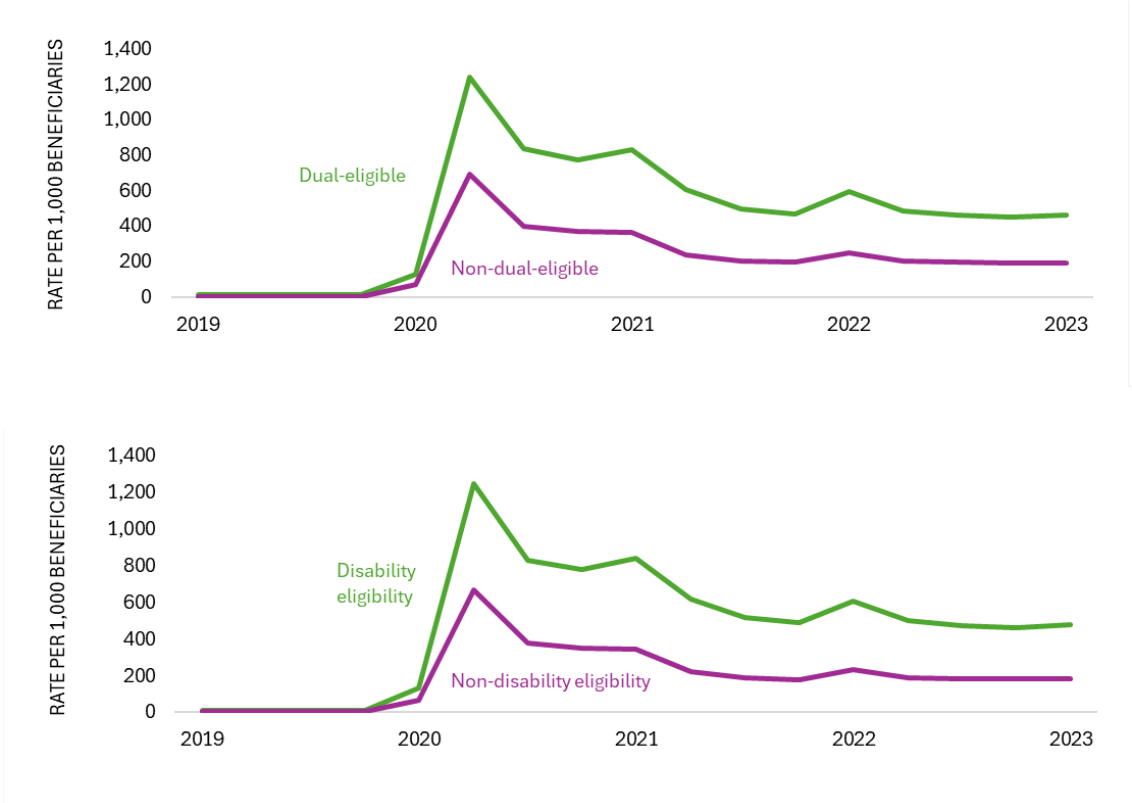
SOURCE: CMS analysis of 2019-2023 beneficiary- and provider-level ACO Research Identifiable Files, 2019-2023 Outpatient and Carrier Research Identifiable Files, and Master Data Management beneficiary and provider extracts.

Telehealth utilization was more frequent among beneficiaries who qualified for Medicare through a disability and those who were dually eligible for Medicaid, subgroups of beneficiaries likely to have greater overall service needs

ACO-attributed Medicare beneficiaries who were dually eligible for Medicaid used telehealth services in Medicare claims at greater rates than non-dual-eligible beneficiaries (**Figure 12**). In 2019, both dual-eligible and non-dual-eligible ACO-attributed beneficiaries had low absolute rates of telehealth utilization, but dual-eligible beneficiaries used telehealth services at a rate more than 7 times the rate of non-dual-eligible beneficiaries in each quarter (e.g., 14 telehealth visits per 1,000 dual-eligible beneficiaries vs. 2 telehealth visits per 1,000 non-dual-eligible beneficiaries in 2019 Q4). When telehealth use became far more prevalent for all beneficiaries in 2020, dual-eligible beneficiaries used telehealth services at a rate roughly 2 times the rate of non-dual-eligible beneficiaries, with use peaking at 1,241 telehealth visits per 1,000 dual-eligible beneficiaries in 2020 Q2 vs. 695 telehealth visits per 1,000 non-dual-eligible beneficiaries. This difference in utilization rate persisted for all quarters through 2023 Q1 as overall telehealth use declined.

FIGURE 12: Medicaid dual-eligible beneficiaries and beneficiaries with disability eligibility had the highest rates of telehealth use

Quarterly telehealth visit rates among ACO-attributed beneficiaries by beneficiary enrollment characteristics, January 2019 to March 2023



SOURCE: CMS analysis of 2019-2023 beneficiary- and provider-level ACO Research Identifiable Files, 2019-2023 Outpatient and Carrier Research Identifiable Files, and Master Data Management beneficiary and provider extracts.

ACO-attributed beneficiaries who qualified for Medicare through a disability used telehealth services at greater rates than beneficiaries without disability eligibility (**Figure 12**). Individuals may qualify for both Medicare and Medicaid based on disability if they are younger than age 65, and nearly 60 percent of dual-eligible, ACO-attributed beneficiaries had an original Medicare entitlement reason of disability or end-stage renal disease (ESRD). Likely reflecting overlap between the subgroups of dual-eligible beneficiaries and those who qualified for Medicare based on disability, telehealth utilization rates among ACO-attributed beneficiaries with disability eligibility (including ESRD) followed a similar pattern to dual-eligible beneficiaries. Throughout the COVID-19 PHE, telehealth utilization rates among beneficiaries with disability eligibility were consistently 2 to 3 times the rates of beneficiaries with non-disability eligibility (e.g., 476 telehealth visits per 1,000 beneficiaries with disability eligibility vs. 182 telehealth visits per 1,000 beneficiaries with non-disability eligibility in 2023 Q1). Telehealth utilization rates were very similar for beneficiaries who were younger versus older than 65 years of age and so are not shown.

ACO-attributed beneficiaries in HPSA counties had less telehealth use overall but more with out-of-state health care providers than beneficiaries not in HPSA counties

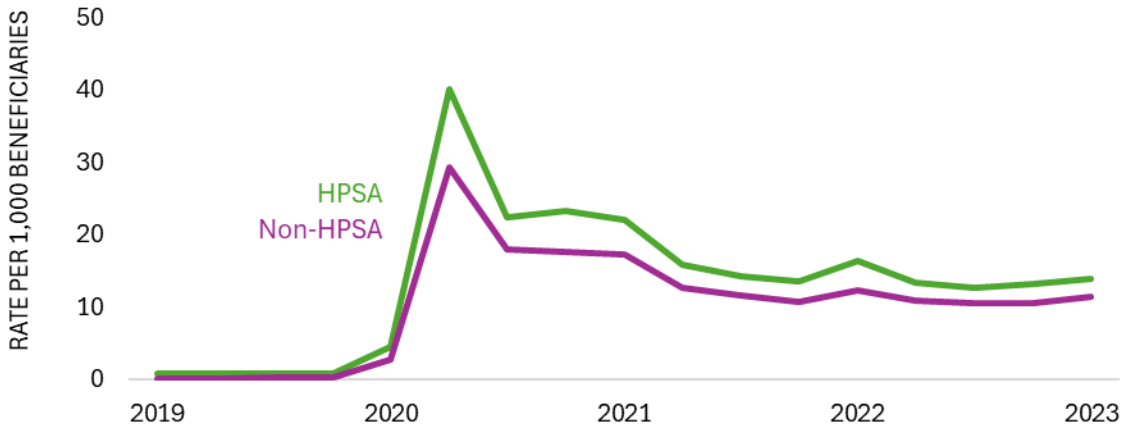
Beginning in 2020 and to May 2023, telehealth utilization rates were lower among beneficiaries in whole counties with a Health Professional Shortage Area (HPSA) primary care or mental health designation,[10] as compared to beneficiaries in non-HPSA counties (**Figure 13**). For example, in 2020 Q2, there were 593 telehealth visits per 1,000 ACO-attributed beneficiaries in HPSA counties and 817 telehealth visits per 1,000 ACO-attributed beneficiaries in non-HPSA counties. Prior to 2020, telehealth utilization was miniscule both among beneficiaries residing in HPSA counties and those in non-HPSA counties.

Telehealth visits with out-of-state health care providers were uncommon overall but more frequently occurred with beneficiaries in HPSA counties (**Figure 14**). For example, in 2020 Q2, there were 40 telehealth visits with out-of-state health care providers per 1,000 ACO-attributed beneficiaries in HPSA counties and 29 telehealth visits with in-state health care providers per 1,000 ACO-attributed beneficiaries in non-HPSA counties.

[10] A Health Professional Shortage Area (HPSA) is a geographic area, population group, or health care facility that has been designated by the Health Resources and Services Administration (HRSA) as having a shortage of health professionals. See https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf

FIGURE 13: Beneficiaries living in counties without a HPSA designation had greater telehealth use than beneficiaries in HPSA counties

Quarterly telehealth visit rates among ACO-attributed beneficiaries by beneficiary county HPSA status, January 2019 to March 2023

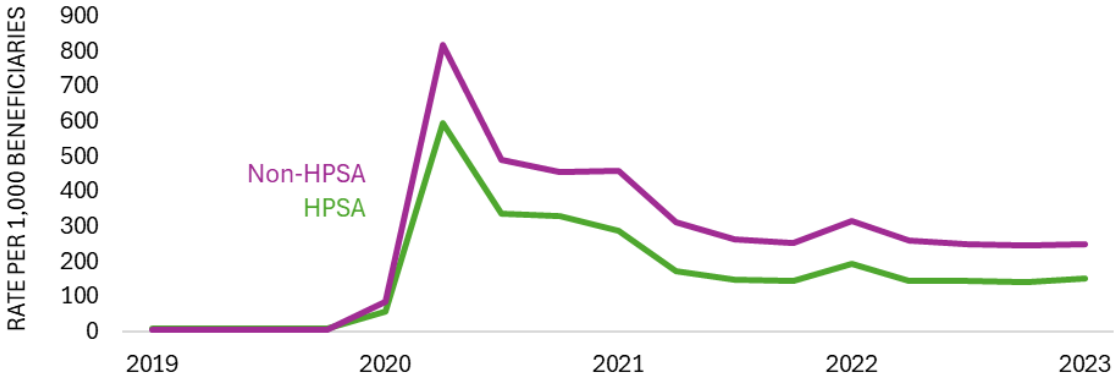


NOTE: HPSA=health professional shortage area

SOURCE: CMS analysis of 2019-2023 beneficiary- and provider-level ACO Research Identifiable Files, 2019-2023 Outpatient and Carrier Research Identifiable Files, and Master Data Management beneficiary and provider extracts.

FIGURE 14: Telehealth visits with out-of-state providers were more common among beneficiaries in HPSA counties

Quarterly out-of-state provider telehealth visit rates among ACO-attributed beneficiaries by beneficiary county HPSA status, January 2019 to March 2023



NOTE: HPSA=health professional shortage area

SOURCE: CMS analysis of 2019-2023 beneficiary- and provider-level ACO Research Identifiable Files, 2019-2023 Outpatient and Carrier Research Identifiable Files, and Master Data Management beneficiary and provider extracts.

Conclusions

Section 50324(b) of BBA of 2018 requires the Secretary of Health and Human Services to submit to Congress a report not later than January 1, 2026 containing the results of the study, together with recommendations for such legislation and administrative action as the Secretary determines appropriate. This report does not offer specific recommendations.

The start date of the expansion of telehealth services under BBA of 2018 coincided with the start of the COVID-19 PHE in January 2020, which led to a broad expansion of telehealth services to all Medicare FFS health care providers and beneficiaries. It is difficult to make conclusive findings regarding the impact of BBA of 2018 on spending and utilization of telehealth services for beneficiaries assigned to applicable ACOs because of the concurrent expansion of telehealth services during the PHE. However, telehealth spending and utilization rates for beneficiaries assigned to applicable ACOs, though lower than their peak in 2020, were notably higher in 2021-2023 relative to both the period prior to the PHE and compared to the general FFS Medicare population. These elevated rates of telehealth spending and utilization may or may not be partially attributed to the telehealth expansion in BBA of 2018.

The BBA of 2018[11] expansion of access to telehealth services among beneficiaries assigned to applicable ACOs is one of several legislative and administrative actions in recent years to make telehealth more widely available to beneficiaries in the Medicare program. Monitoring the use of telehealth under both BBA of 2018 for beneficiaries assigned to applicable ACOs and the COVID-19 PHE-related telehealth waivers and flexibilities that have been extended through September 30, 2025 provides useful lessons for policy makers in considering whether to make telehealth policies permanent in the Medicare FFS program in the future. CMS will implement future legislation and monitor the effectiveness of policies designed to expand telehealth access.

[11] Bipartisan Budget Act of 2018 (Pub.L. 115-123) Div. E, Title III, Sec. 50324. Providing accountable care organizations the ability to expand the use of telehealth.

Appendix A. Methods

Purpose

This document describes the methods used to examine telehealth service utilization and expenditures among Medicare fee-for-service beneficiaries prospectively attributed to accountable care organizations (ACOs) with two-sided financial risk between January 1, 2020 and the end of the COVID-19 public health emergency in May 2023.

Data sources

We identified CMS Center for Medicare and Medicaid Innovation (CMMI) ACO models and applicable ACOs in the Medicare Shared Savings Program with two-sided financial risk and prospective attribution that were active starting one year prior to the beginning of the study period (January 1, 2019) through the end of the study period (May 31, 2023). Applicable Shared Savings Program ACOs were in Track 1+, Track 3, BASIC C, BASIC D, BASIC E, or ENHANCED tracks with prospective assignment according to each year of the 2020-2023 Shared Savings Program ACO Public-Use Files (PUFs).[12] Shared Savings Program ACOs in these tracks in 2019 were assumed to be applicable ACOs since ACO assignment election was not available in the 2019 Shared Savings Program ACO PUF.

Beneficiaries attributed to an ACO and ACO-participating providers were identified using beneficiary and provider-level ACO Research Identifiable Files (RIFs) covering years 2019-2020 of the Comprehensive ESRD Care (CEC) Model, 2019-2021 of the Next Generation ACO (NG) Model, and final RIFs covering 2019-2022 and preliminary RIFs covering the first two quarters of 2023 of the Shared Savings Program. The Master Data Management (MDM) Beneficiary and Provider Extracts from July 3, 2023 were similarly used to identify beneficiaries and participating providers in the Vermont All-Payer ACO Model (VT) (2019-2023), Global and Professional Direct Contracting (GPDC)/ACO REACH Model (2021-2023), and Kidney Care Choices (KCC) Model (2022-2023). We accessed these files through the Chronic Conditions Data Warehouse (CCW).[13]

To identify telehealth claims, this study used 2019-2023 Carrier and Outpatient files from the Medicare fee-for-service RIFs available in the CCW. The Carrier file contains Part B claims for professional services (subsequently referred to as "carrier claims") covering telehealth as well as in-person ambulatory visits. The Outpatient file contains Part B claims for institutional outpatient services (subsequently referred to as "outpatient claims") and was used to identify telehealth originating site facility fee claims and claims for telehealth and in-person ambulatory visits billed by federally qualified health centers (FQHCs) and rural health centers (RHCs).

We used the Master Beneficiary Summary File (MBSF) Base Segment to construct beneficiary characteristics.

[12] Centers for Medicare & Medicaid Services. Accountable care organizations – Information on Medicare Shared Savings Program (Shared Savings Program) accountable care organizations (ACOs). https://data.cms.gov/medicare-shared-savings-program/accountable-care-organizations Published 2024. Accessed August 30, 2024.
[13] Centers for Medicare & Medicaid Services. Chronic Conditions Data Warehouse. https://www2.ccwdata.org/web/guest/home

We identified county-level Health Professional Shortage Area (HPSA) designations using the 2021-2022 and the 2022-2023 releases of the Area Health Resources File (AHRF).[14]

Study population

The study population included Medicare fee-for-service beneficiaries who were attributed to an ACO in a CMMI ACO model or a Shared Savings Program ACO between January 2019 through May 2023. We excluded beneficiaries in seven CEC ACOs and four KCC ACOs without prospective attribution and two-sided financial risk. In 2019, we also excluded a small number of beneficiaries attributed to a Shared Savings Program ACO that was not in the 2019 Shared Savings Program ACO PUF. Beneficiaries were required to have final assignment status, but because beneficiary Shared Savings Program assignment was not yet finalized for the first two quarters of 2023 at the time of analysis, we included beneficiaries with a preliminary Shared Savings Program assignment status in the first and second quarter of 2023. In cases where a single beneficiary was attributed to multiple ACOs within a year, we preferentially retained ACOs eligible for BBA of 2018 telehealth flexibilities and otherwise randomly assigned one ACO to the beneficiary.

The total number of beneficiaries attributed to applicable ACOs is shown below by year and ACO model or program:

Year	Any Applicable ACO	CEC ACO	NG ACO	VT ACO	Shared Savings Program ACO	GPDC/ACO REACH ACO	KCC ACO
2019	4,194,878	60,988	1,338,227	53,973	2,741,690		
2020	3,750,932	62,205	1,081,165	49,301	2,558,261		
2021	3,641,767		1,037,409	53,133	2,203,577	347,648	
2022	4,885,561			49,857	2,924,084	1,767,906	143,714
2023	5,850,570			54,848	3,509,351	2,007,809	278,562

Measures

Definition of telehealth services. This study captured telehealth services covered by Medicare Part B, including both distant site telehealth claims (i.e., claims billed by providers who delivered services from a different location than the beneficiary receiving the services) and originating site telehealth facility fees (i.e., claims billed by sites where a beneficiary was located while receiving telehealth services) (Appendix B). We identified carrier claims for telehealth services using Healthcare Common Procedure Coding System (HCPCS) codes, HPCPS modifiers, and place of service (POS) codes. We identified outpatient claims for telehealth services using HCPCS codes and HCPCS modifiers.

Medicare telehealth billing policies changed over the course of the study period, so our telehealth service definitions sometimes varied by year. We identified telehealth-eligible HCPCS codes based

[14] Health Resources & Services Administration. Area Health Resources Files. https://data.hrsa.gov/topics/health-workforce/ahrf Accessed. August 30, 2024.

on a list developed by the Office of the Assistant Secretary for Planning and Evaluation.[15] This list includes all codes from the CMS list of telehealth-eligible services payable under the Medicare Physician Fee Schedule before and during the COVID-19 PHE;[16] telehealth-eligible codes that can be billed by FQHCs and RHCs; and additional codes for telecommunications services that became eligible for Medicare payment in 2019. We further classified telehealth services as behavioral health or non-behavioral health and institutional or non-institutional based on HCPCS codes. Appendix C shows the full list of telehealth-eligible HCPCS codes and applicable classifications.

Definition of in-person ambulatory visits. As a point of comparison to telehealth service utilization, this study also assessed in-person ambulatory visits among ACO-attributed beneficiaries. We identified ambulatory visits in carrier claims using HCPCS codes for evaluation and management services (shown in Appendix D) and defined these services as in-person if they were not billed with HCPCS modifiers or POS codes indicating telehealth delivery. We classified all outpatient claims billed by FQHCs or RHCs as in-person ambulatory visits if the relevant definition for telehealth was not met.

Utilization measures. To measure utilization, we tried to ensure that distinct telehealth claims were captured without double counting instances where a beneficiary received telehealth from a facility. First, we de-duplicated cases in which a telehealth claim for a unique beneficiary, claim end date, and HCPCS code was billed in both carrier claims and outpatient claims, as this billing pattern was suggestive of duplicate billing for the same service. Next, we de-duplicated claims to ensure that only one record was retained for each unique beneficiary, claim end date, and national provider identifier (NPI) number. Then, in cases where a beneficiary had telehealth visits with multiple distinct NPIs on a given date, we subtracted one visit from the beneficiary ID-date total to avoid double-counting visits for which a facility billed a corresponding originating site facility fee.

Each in-person ambulatory claim was counted as one visit for each unique combination of beneficiary ID, claim end date, and provider NPI.

Spending measures. We calculated telehealth spending by summing line payment amounts for all carrier telehealth claims and revenue center provider payment amounts for all outpatient telehealth claims. Some telehealth claims for services delivered to beneficiaries in CMMI ACOs were reduced as population-based payments (PBPs), which participants in certain CMMI models are eligible to receive. In cases where a claim record indicated that a PBP adjustment had been applied, we substituted the original payment amount for spending calculations.

Provider characteristics. This study stratified telehealth utilization measures by provider characteristics. We identified provider specialty using specialty codes listed on carrier claims and classified specialties as primary care (general practice, family practice, internal medicine, or geriatric medicine specialty), non-physician (physician assistants, nurse practitioners, or certified nurse specialists), or specialty care (all other specialties). We classified outpatient claims billed by FQHC or RHC providers as primary care and all other outpatient originating site facility fee claims as specialty care. We compared the provider state code and beneficiary state code listed on the

[15] U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. Medicare telehealth trends dashboard, 2019-2021. https://aspe.hhs.gov/medicare-dashboard. Accessed August 30, 2024.
[16] Centers for Medicare & Medicaid Services. List of telehealth services. https://www.cms.gov/medicare/coverage/telehealth/list-services. Accessed August 30, 2024.

claim and classified providers as in-state if the provider and beneficiary state codes had the same non-missing value.

We determined whether a beneficiary's telehealth service was delivered by a provider participating in an ACO by merging the NPI on a claim with the ACO participating provider RIFs for the year the service was rendered. For carrier claims, we considered a provider to be a non-ACO provider if no NPI match was obtained. For outpatient claims, if no NPI match was obtained, we also used a list of provider CMS Certification Numbers available in the ACO participating provider RIFs to identify ACO-participating providers.

Beneficiary characteristics. This study also stratified telehealth utilization measures by several beneficiary characteristics. We classified beneficiaries as having a disability if their original Medicare entitlement reason listed in the MBSF was disability insurance benefits (DIB), ESRD, or both DIB and ESRD. We classified beneficiaries as Medicaid dual-eligible in a year if they had at least one month of dual eligibility in the year.

We merged beneficiaries' county code as listed in the MBSF to the AHRF and classified beneficiaries as residing in a county with a HPSA designation if the county had a whole-county primary care or mental health HPSA designation listed in the AHRF. Beneficiaries for whom a match could not be obtained in the MBSF (<1%) or the AHRF (<1%) were excluded from analyses using variables constructed from those data sources.

Analyses

We tabulated telehealth spending of ACO-attributed beneficiaries annually. To examine trends in utilization among ACO-attributed beneficiaries over time, we separately summed the number of telehealth visits by quarter and year and ambulatory visits by quarter and total number of ACO-attributed beneficiaries by year. We calculated quarterly utilization rates by dividing the total number of visits in the quarter or year by the total number of ACO-attributed beneficiaries in the year and multiplied by 1,000. Quarterly utilization rates were measured through the first quarter of 2023 since the second quarter of 2023 was a partial quarter.

To examine the distribution of telehealth utilization across ACOs, we summed the total number of telehealth visits for all beneficiaries attributed to an ACO by ACO each year and calculated the 25th percentile, median,75th percentile, and minimum and maximum values of telehealth visits.

In assessing telehealth utilization trends within beneficiary and provider subgroups, we retained subgroup flags for all claims for each telehealth visit and counted each telehealth visit within all subgroups that applied by quarter. For beneficiary subgroups, we used the annual number of ACO-attributed beneficiaries in the subgroup as the denominator.

Appendix B. Telehealth Service Definitions by Year and Claim Type

Year	Carrier telehealth definition	Outpatient telehealth definition
2019	Include if on ASPE telehealth-eligible list & (HCPCS modifier = “GT”, “GQ”, “95”, “G0” OR place of service code = 02) Include if HCPCS code is telehealth by definition Exclude if temporary PHE code	Include if originating site facility fee (Q3014), any provider type Include if FQHC/RHC claim with ASPE telehealth-eligible list & HCPCS modifier = “GT”, “GQ”, “95”, “G0” Include if FHC/RHC claim with HCPCS code that is telehealth by definition Exclude if temporary PHE code
2020	Include if on ASPE telehealth-eligible list & (HCPCS modifier = “GT”, “GQ”, “95”, “G0” OR place of service code = 02) Include if HCPCS code is telehealth by definition	Include if originating site facility fee (Q3014), any provider type Include if FQHC/RHC claim with ASPE telehealth-eligible list & HCPCS modifier = “GT”, “GQ”, “95”, “G0” Include if FHC/RHC claim with HCPCS code that is telehealth by definition
2021	Include if on ASPE telehealth-eligible list & (HCPCS modifier = “GT”, “GQ”, “95”, “G0” OR place of service code = 02) Include if HCPCS code is telehealth by definition	Include if originating site facility fee (Q3014), any provider type Include if FQHC/RHC claim with ASPE telehealth-eligible list & HCPCS modifier = “GT”, “GQ”, “95”, “G0” Include if FHC/RHC claim with HCPCS code that is telehealth by definition
2022	Include if on ASPE telehealth-eligible list & (HCPCS modifier = “GT”, “GQ”, “95”, “G0”, “FR”, “FQ” OR place of service code = 02 or 10) Include if HCPCS code is telehealth by definition	Include if originating site facility fee (Q3014), any provider type Include if FQHC/RHC claim with ASPE telehealth-eligible list & HCPCS modifier = “GT”, “GQ”, “95”, “G0”, “FR”, “FQ” Include if FHC/RHC claim with HCPCS code that is telehealth by definition
2023	Include if on ASPE telehealth-eligible list & (HCPCS modifier = “GT”, “GQ”, “95”, “G0”, “FR”, “FQ”, “93” OR place of service code = 02 or 10) Include if HCPCS code is telehealth by definition	Include if originating site facility fee (Q3014), any provider type Include if FQHC/RHC claim with ASPE telehealth-eligible list & HCPCS modifier = “GT”, “GQ”, “95”, “G0”, “FR”, “FQ”, “93” Include if FHC/RHC claim with HCPCS code that is telehealth by definition

Appendix C. Telehealth-eligible HCPCS Codes and Classifications

HCPCS Code	Description	Applicable Categories*
77427	Radiation treatment management, 5 treatments	CMS code, PHE code
90785	Interactive complexity	CMS code, Behavioral health code
90791	Psychiatric diagnostic evaluation	CMS code, Behavioral health code
90792	Psychiatric diagnostic evaluation with medical services	CMS code, Behavioral health code
90832	Psychotherapy, 30 minutes	CMS code, Behavioral health code
90833	Psychotherapy, 30 minutes	CMS code, Behavioral health code
90834	Psychotherapy, 45 minutes	CMS code, Behavioral health code
90836	Psychotherapy, 45 minutes	CMS code, Behavioral health code
90837	Psychotherapy, 60 minutes	CMS code, Behavioral health code
90838	Psychotherapy, 60 minutes	CMS code, Behavioral health code
90839	Psychotherapy for crisis, first 60 minutes	CMS code, Behavioral health code
90840	Psychotherapy for crisis	CMS code, Behavioral health code
90845	Psychoanalysis	CMS code, Behavioral health code
90846	Family psychotherapy, 50 minutes	CMS code, Behavioral health code
90847	Family psychotherapy including patient, 50 minutes	CMS code, Behavioral health code
90853	Group psychotherapy	CMS code, PHE code, Behavioral health code
90875	Individual psychophysiological therapy incorporating biofeedback training with psychotherapy, 30 minutes	CMS code, PHE code, Behavioral health code
90901	Biofeedback training by any modality	CMS code, PHE code, Behavioral health code
90951	Dialysis services (4 or more physician visits per month), patient younger than 2 years of age	CMS code
90952	Dialysis services (2-3 physician visits per month), patient younger than 2 years of age	CMS code, PHE code
90953	Dialysis services (1 physician visit per month), patient younger than 2 years of age	CMS code, PHE code
90954	Dialysis services (4 or more physician visits per month), patient 2-11 years of age	CMS code
90955	Dialysis services (2-3 physician visits per month), patient 2-11 years of age	CMS code
90956	Dialysis services (1 physician visit per month), patient 2-11 years of age	CMS code, PHE code
90957	Dialysis services (4 or more physician visits per month), patient 12-19 years of age	CMS code
90958	Dialysis services (2-3 physician visits per month), patient 12-19 years of age	CMS code
90959	Dialysis services (1 physician visit per month), patient 12-19 years of age	CMS code, PHE code

90960	Dialysis services (4 or more physician visits per month), patient 20 years of age and older	CMS code
90961	Dialysis services (2-3 physician visits per month), patient 20 years of age and older	CMS code
90962	Dialysis services (1 physician visit per month), patient 20 years of age and older	CMS code, PHE code
90963	Home dialysis services per month, patient younger than 2 years of age	CMS code
90964	Home dialysis services per month, patient 2-11 years of age	CMS code
90965	Home dialysis services per month, patient 12-19 years of age	CMS code
90966	Home dialysis services per month, patient 20 years of age or older	CMS code
90967	Dialysis services, per day (less than full month service), patient younger than 2 years of age	CMS code
90968	Dialysis services, per day (less than full month service), patient 2-11 years of age	CMS code
90969	Dialysis services, per day (less than full month service), patient 12-19 years of age	CMS code
90970	Dialysis services, per day (less than full month service), patient 20 years of age or older	CMS code
92002	Eye and medical examination for diagnosis and treatment, new patient	CMS code, PHE code
92004	Eye and medical examination for diagnosis and treatment, new patient, 1 or more visits	CMS code, PHE code
92012	Eye and medical examination for diagnosis and treatment, established patient	CMS code, PHE code
92014	Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits	CMS code, PHE code
92507	Treatment of speech, language, voice, communication, and/or hearing processing disorder	CMS code, PHE code
92508	Group treatment of speech, language, voice, communication, and/or hearing processing disorder	CMS code, PHE code
92521	Evaluation of speech fluency	CMS code, PHE code
92522	Evaluation of speech sound production	CMS code, PHE code
92523	Evaluation of speech sound production with evaluation of language comprehension and expression	CMS code, PHE code
92524	Behavioral and qualitative analysis of voice and resonance	CMS code, PHE code
92601	Analysis and programming of inner ear (cochlear) implant, patient younger than 7 years of age	CMS code, PHE code

92602	Analysis and reprogramming of inner ear (cochlear) implant, patient younger than 7 years of age	CMS code, PHE code
92603	Analysis and programming of inner ear (cochlear) implant, patient age 7 years or older	CMS code, PHE code
92604	Analysis and reprogramming of inner ear (cochlear) implant, patient age 7 years or older	CMS code, PHE code
93750	Interrogation of ventricular assistance device (VAD), in person	CMS code, PHE code
93797	Cardiac rehabilitation without continuous ECG monitoring	CMS code, PHE code
93798	Cardiac rehabilitation with continuous ECG monitoring	CMS code, PHE code
94002	Ventilation assistance and management, hospital inpatient or observation	CMS code, PHE code, Institutional code
94003	Ventilation assistance and management, hospital inpatient or observation	CMS code, PHE code, Institutional code
94004	Ventilation assistance and management, nursing facility per day	CMS code, PHE code, Institutional code
94005	Evaluation of home ventilator management care plan, 30 minutes or more	CMS code, PHE code
94625	Outpatient pulmonary rehabilitation without continuous oximetry monitoring	CMS code, PHE code
94626	Outpatient pulmonary rehabilitation with continuous oximetry monitoring	CMS code, PHE code
94664	Demonstration and/or evaluation of patient use of aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing device	CMS code, PHE code
95970	Electronic analysis of implanted neurostimulator pulse generator/ transmitter without programming	CMS code, PHE code
95971	Electronic analysis of implanted neurostimulator pulse generator/transmitter, with simple programming	CMS code, PHE code
95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter, with complex programming	CMS code, PHE code
95983	Electronic analysis of implanted neurostimulator pulse generator/ transmitter with brain neurostimulator pulse generator/transmitter programming, first 15 minutes	CMS code, PHE code
95984	Electronic analysis of implanted neurostimulator pulse generator/ transmitter with brain neurostimulator pulse generator/transmitter programming, additional 15 minutes	CMS code, PHE code
96110	Developmental screening	CMS code, PHE code

96112	Developmental test administration by qualified health care professional with interpretation and report, first 60 minutes	CMS code, PHE code, Behavioral health code
96113	Developmental test administration by qualified health care professional with interpretation and report, additional 30 minutes	CMS code, PHE code, Behavioral health code
96116	Neurobehavioral status examination by qualified health care professional with interpretation and report, first 60 minutes	CMS code, Behavioral health code
96121	Neurobehavioral status examination by qualified health care professional with interpretation and report, additional 60 minutes	CMS code, PHE code, Behavioral health code
96127	Brief emotional or behavioral assessment	CMS code, PHE code
96130	Psychological testing evaluation by qualified health care professional, first 60 minutes	CMS code, PHE code, Behavioral health code
96131	Psychological testing evaluation by qualified health care professional, additional 60 minutes	CMS code, PHE code, Behavioral health code
96132	Neuropsychological testing evaluation by qualified health care professional, first 60 minutes	CMS code, PHE code, Behavioral health code
96133	Neuropsychological testing evaluation by qualified health care professional, additional 60 minutes	CMS code, PHE code, Behavioral health code
96136	Psychological or neuropsychological test administration and scoring by qualified health care professional, first 30 minutes	CMS code, PHE code, Behavioral health code
96137	Psychological or neuropsychological test administration and scoring by qualified health care professional, additional 30 minutes	CMS code, PHE code, Behavioral health code
96138	Psychological or neuropsychological test administration and scoring by technician, first 30 minutes	CMS code, PHE code, Behavioral health code
96139	Psychological or neuropsychological test administration and scoring by technician, additional 30 minutes	CMS code, PHE code, Behavioral health code
96156	Health behavior assessment, or re-assessment	CMS code, Behavioral health code
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	CMS code, PHE code, Behavioral health code
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes	CMS code, Behavioral health code
96160	Administration and interpretation of patient-focused health risk assessment	CMS code
96161	Administration and interpretation of caregiver-focused health risk assessment	CMS code
96164	Health behavior intervention, group, face-to-face; initial 30 minutes	CMS code, Behavioral health code

96165	Health behavior intervention, group, face-to-face; each additional 15 minutes	CMS code, Behavioral health code
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	CMS code, Behavioral health code
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	CMS code, Behavioral health code
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	CMS code, PHE code, Behavioral health code
96171	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes	CMS code, PHE code, Behavioral health code
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes	CMS code, PHE code
97112	Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes	CMS code, PHE code
97116	Walking training to 1 or more areas, each 15 minutes	CMS code, PHE code
97150	Therapeutic procedures in a group setting	CMS code, PHE code
97151	Behavior identification assessment by qualified health care professional, each 15 minutes	CMS code, PHE code, Behavioral health code
97152	Behavior identification assessment by technician under direction of qualified health care professional, each 15 minutes	CMS code, PHE code, Behavioral health code
97153	Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to one patient, each 15 minutes	CMS code, PHE code, Behavioral health code
97154	Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to multiple patients, each 15 minutes	CMS code, PHE code, Behavioral health code
97155	Adaptive behavior treatment with protocol modification administered by qualified health care professional to one patient, each 15 minutes	CMS code, PHE code, Behavioral health code
97156	Family adaptive behavior treatment guidance by qualified health care professional (with or without patient present), each 15 minutes	CMS code, PHE code, Behavioral health code
97157	Family adaptive behavior treatment guidance by qualified health care professional without patient present, each 15 minutes	CMS code, PHE code, Behavioral health code
97158	Group adaptive behavior treatment with protocol modification administered by	CMS code, PHE code, Behavioral health code

	qualified health care professional to multiple patients, each 15 minutes	
97161	Evaluation of physical therapy, typically 20 minutes	CMS code, PHE code
97162	Evaluation of physical therapy, typically 30 minutes	CMS code, PHE code
97163	Evaluation of physical therapy, typically 45 minutes	CMS code, PHE code
97164	Re-evaluation of physical therapy, typically 20 minutes	CMS code, PHE code
97165	Evaluation of occupational therapy, typically 30 minutes	CMS code, PHE code
97166	Evaluation of occupational therapy, typically 45 minutes	CMS code, PHE code
97167	Evaluation of occupational therapy established plan of care, typically 60 minutes	CMS code, PHE code
97168	Re-evaluation of occupational therapy established plan of care, typically 30 minutes	CMS code, PHE code
97530	Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes	CMS code, PHE code
97535	Self-care or home management training, each 15 minutes	CMS code, PHE code
97537	Community/work reintegration	CMS code, PHE code
97542	Wheelchair management, each 15 minutes	CMS code, PHE code
97750	Physical performance test or measurement with report, each 15 minutes	CMS code, PHE code
97755	Assistive technology assessment to enhance functional performance, each 15 minutes	CMS code, PHE code
97760	Training in use of orthotics (supports, braces, or splints) for arms, legs and/or trunk, per 15 minutes	CMS code, PHE code
97761	Training in use of prosthesis for arms and/or legs, per 15 minutes	CMS code, PHE code
97763	Orthotic/prosthetic management, subsequent encounter	CMS code, PHE code
97802	Medical nutrition therapy, assessment and intervention, each 15 minutes	CMS code
97803	Medical nutrition therapy re-assessment and intervention, each 15 minutes	CMS code
97804	Medical nutrition therapy performed in a group setting, each 30 minutes	CMS code
98960	Self-management education & training, 1 patient	CMS code
98961	Self-management education & training, 2-4 patients	CMS code

98962	Self-management education & training, 5-8 patients	CMS code
98966	Nonphysician healthcare professional phone call, 5-10 minutes	Telehealth by definition, Telecommunications code
98967	Nonphysician healthcare professional phone call, 11-20 minutes	Telehealth by definition, Telecommunications code
98968	Nonphysician healthcare professional phone call, 21-30 minutes	Telehealth by definition, Telecommunications code
99201	New patient office or other outpatient visit, typically 10 minutes	CMS code
99202	New patient office or other outpatient visit, typically 20 minutes	CMS code
99203	New patient office or other outpatient visit, typically 30 minutes	CMS code
99204	New patient office or other outpatient visit, typically 45 minutes	CMS code
99205	New patient office or other outpatient visit, typically 60 minutes	CMS code
99211	Established patient office or other outpatient visit, typically 5 minutes	CMS code
99212	Established patient office or other outpatient visit, typically 10 minutes	CMS code
99213	Established patient office or other outpatient visit, typically 15 minutes	CMS code
99214	Established patient office or other outpatient, visit typically 25 minutes	CMS code
99215	Established patient office or other outpatient, visit typically 40 minutes	CMS code
99217	Hospital observation care on day of discharge	CMS code, PHE code, Institutional code
99218	Hospital observation care, typically 30 minutes	CMS code, PHE code, Institutional code
99219	Hospital observation care, typically 50 minutes	CMS code, PHE code, Institutional code
99220	Hospital observation care, typically 70 minutes	CMS code, PHE code, Institutional code
99221	Initial hospital inpatient care, typically 30 minutes per day	CMS code, PHE code, Institutional code
99222	Initial hospital inpatient care, typically 50 minutes per day	CMS code, PHE code, Institutional code
99223	Initial hospital inpatient care, typically 70 minutes per day	CMS code, PHE code, Institutional code
99224	Subsequent observation care, typically 15 minutes per day	CMS code, PHE code, Institutional code
99225	Subsequent observation care, typically 25 minutes per day	CMS code, PHE code, Institutional code
99226	Subsequent observation care, typically 35 minutes per day	CMS code, PHE code, Institutional code
99231	Subsequent hospital inpatient care, typically 15 minutes per day	CMS code, Institutional code
99232	Subsequent hospital inpatient care, typically 25 minutes per day	CMS code, Institutional code

99233	Subsequent hospital inpatient care, typically 35 minutes per day	CMS code, Institutional code
99234	Hospital observation or inpatient care low severity, 40 minutes per day	CMS code, PHE code, Institutional code
99235	Hospital observation or inpatient care moderate severity, 50 minutes per day	CMS code, PHE code, Institutional code
99236	Hospital observation or inpatient care high severity, 55 minutes per day	CMS code, PHE code, Institutional code
99238	Hospital discharge day management, 30 minutes or less	CMS code, PHE code, Institutional code
99239	Hospital discharge day management, more than 30 minutes	CMS code, PHE code, Institutional code
99281	Emergency department visit, self-limited or minor problem	CMS code, PHE code, Institutional code
99282	Emergency department visit, low to moderately severe problem	CMS code, PHE code, Institutional code
99283	Emergency department visit, moderately severe problem	CMS code, PHE code, Institutional code
99284	Emergency department visit, problem of high severity	CMS code, PHE code, Institutional code
99285	Emergency department visit, problem with significant threat to life or function	CMS code, PHE code, Institutional code
99291	Critical care delivery critically ill or injured patient, first 30-74 minutes	CMS code, PHE code, Institutional code
99292	Critical care delivery critically ill or injured patient	CMS code, PHE code, Institutional code
99304	Initial nursing facility visit, typically 25 minutes per day	CMS code, PHE code, Institutional code
99305	Initial nursing facility visit, typically 35 minutes per day	CMS code, PHE code, Institutional code
99306	Initial nursing facility visit, typically 45 minutes per day	CMS code, PHE code, Institutional code
99307	Subsequent nursing facility visit, typically 10 minutes per day	CMS code, Institutional code
99308	Subsequent nursing facility visit, typically 15 minutes per day	CMS code, Institutional code
99309	Subsequent nursing facility visit, typically 25 minutes per day	CMS code, Institutional code
99310	Subsequent nursing facility visit, typically 35 minutes per day	CMS code, Institutional code
99315	Nursing facility discharge day management, 30 minutes or less	CMS code, PHE code, Institutional code
99316	Nursing facility discharge management, more than 30 minutes	CMS code, PHE code, Institutional code
99324	New patient assisted living visit, typically 20 minutes	CMS code, PHE code
99325	New patient assisted living visit, typically 30 minutes	CMS code, PHE code
99326	New patient assisted living visit, typically 45 minutes	CMS code, PHE code
99327	New patient assisted living visit, typically 60 minutes	CMS code, PHE code

99328	New patient assisted living visit, typically 75 minutes	CMS code, PHE code
99334	Established patient assisted living visit, typically 15 minutes	CMS code, PHE code
99335	Established patient assisted living visit, typically 25 minutes	CMS code, PHE code
99336	Established patient assisted living visit, typically 40 minutes	CMS code, PHE code
99337	Established patient assisted living visit, typically 60 minutes	CMS code, PHE code
99341	New patient home visit, typically 20 minutes	CMS code, PHE code
99342	New patient home visit, typically 30 minutes	CMS code, PHE code
99343	New patient home visit, typically 45 minutes	CMS code, PHE code
99344	New patient home visit, typically 60 minutes	CMS code, PHE code
99345	New patient home visit, typically 75 minutes	CMS code, PHE code
99347	Established patient home visit, typically 15 minutes	CMS code, PHE code
99348	Established patient home visit, typically 25 minutes	CMS code, PHE code
99349	Established patient home visit, typically 40 minutes	CMS code, PHE code
99350	Established patient home visit, typically 60 minutes	CMS code, PHE code
99354	Prolonged office or other outpatient service first hour	CMS code
99355	Prolonged office or other outpatient service each 30 minutes beyond first hour	CMS code
99356	Prolonged inpatient or observation hospital service first hour	CMS code, Institutional code
99357	Prolonged inpatient or observation hospital service each 30 minutes beyond first hour	CMS code, Institutional code
99406	Smoking and tobacco use intermediate counseling, greater than 3 minutes up to 10 minutes	CMS code
99407	Smoking and tobacco use intensive counseling, greater than 10 minutes	CMS code
99421	Online digital evaluation and management service, 5-10 minutes	Telehealth by definition, Telecommunications code
99422	Online digital evaluation and management service, 11-20 minutes	Telehealth by definition, Telecommunications code
99423	Online digital evaluation and management service, 21+ minutes	Telehealth by definition, Telecommunications code
99441	Physician telephone patient service, 5-10 minutes of medical discussion	CMS code, Telehealth by definition
99442	Physician telephone patient service, 11-20 minutes of medical discussion	CMS code, Telehealth by definition

99443	Physician telephone patient service, 21-30 minutes of medical discussion	CMS code, Telehealth by definition
99444	Physician or health care professional evaluation and management of patient care by internet (email) related to visit within previous 7 days	Telehealth by definition, Telecommunications code
99468	Initial inpatient hospital critical care of newborn, 28 days of age or younger, per day	CMS code, PHE code, Institutional code
99469	Subsequent inpatient hospital critical care of newborn, 28 days of age or younger, per day	CMS code, PHE code, Institutional code
99471	Initial inpatient hospital critical care of infant or young child, 29 days through 24 months of age, per day	CMS code, PHE code, Institutional code
99472	Subsequent inpatient hospital critical care of infant or young child, 29 days through 24 months of age, per day	CMS code, PHE code, Institutional code
99473	Self-measured blood pressure; patient education/training and device calibration	CMS code, PHE code
99475	Initial inpatient hospital critical care of infant or young child, 2 through 5 years of age, per day	CMS code, PHE code, Institutional code
99476	Subsequent inpatient hospital critical care of infant or young child, 2 through 5 years of age, per day	CMS code, PHE code, Institutional code
99477	Initial intensive care of newborn, 28 days of age or younger, per day	CMS code, PHE code, Institutional code
99479	Subsequent intensive care of recovering low birth weight infant, per day	CMS code, PHE code, Institutional code
99480	Subsequent intensive care of recovering low birth weight infant, per day	CMS code, PHE code, Institutional code
99483	Assessment of and care planning for patient with impaired thought processing, typically 50 minutes	CMS code, PHE code
99495	Transitional care management services, moderately complexity, requiring face-to-face visits within 14 days of discharge	CMS code
99496	Transitional care management services, highly complexity, requiring face-to-face visits within 7 days of discharge	CMS code
99497	Advance care planning by the physician or other qualified health care professional	CMS code
99498	Advance care planning by the physician or other qualified health care professional	CMS code
0362T	Behavior identification supporting assessment for patient exhibiting destructive behavior, each 15 minutes of technicians' face-to-face time	CMS code, PHE code, Behavioral health code
0373T	Adaptive behavior treatment with protocol modification for patient exhibiting destructive behavior, each 15 minutes of technicians' face-to-face time	CMS code, PHE code, Behavioral health code

92526	Oral function therapy	CMS code, PHE code
92550	Tympanometry and reflex threshold measurements	CMS code, PHE code
92552	Pure tone audiometry air	CMS code, PHE code
92553	Audiometry air & bone	CMS code, PHE code
92555	Speech threshold audiometry	CMS code, PHE code
92556	Speech audiometry complete	CMS code, PHE code
92557	Comprehensive hearing test	CMS code, PHE code
92563	Tone decay hearing test	CMS code, PHE code
92565	Stenger test pure tone	CMS code, PHE code
92567	Tympanometry (impedance testing)	CMS code, PHE code
92568	Acoustic reflex testing, threshold	CMS code, PHE code
92570	Acoustic immittance testing	CMS code, PHE code
92587	Evoked auditory test limited	CMS code, PHE code
92588	Evoked auditory test complete	CMS code, PHE code
92607	Evaluation for prescription for speech device, 1 hour	CMS code, PHE code
92608	Evaluation for prescription for speech device, additional 30 minutes	CMS code, PHE code
92609	Use of speech device service	CMS code, PHE code
92610	Evaluate swallowing function	CMS code, PHE code
92625	Tinnitus assessment	CMS code, PHE code
92626	Evaluation of auditory rehabilitation status first hour	CMS code, PHE code
92627	Evaluation of auditory rehabilitation status; each additional 15 minutes	CMS code, PHE code
96105	Assessment of aphasia	CMS code, PHE code
96125	Standardized cognitive performance testing by qualified health care professional	CMS code, PHE code
97129	Therapeutic interventions that focus on cognitive function, initial 15 minutes	CMS code, PHE code
97130	Therapeutic interventions that focus on cognitive function, each additional 15 minutes	CMS code, PHE code
99446	Telephone or internet assessment and management service provided by consultative physician with verbal and written report, 5-10 minutes of medical consultative discussion and review	Telehealth by definition, Telecommunications code
99447	Telephone or internet assessment and management service provided by consultative physician with verbal and written report, 11-20 minutes of medical consultative discussion and review	Telehealth by definition, Telecommunications code
99448	Telephone or internet assessment and management service provided by consultative physician with verbal and written report, 21-30 minutes of medical consultative discussion and review	Telehealth by definition, Telecommunications code
99449	Telephone or internet assessment and management service provided by consultative physician, 31 minutes or	Telehealth by definition, Telecommunications code

	more of medical consultative discussion and review	
99451	Telephone or internet assessment and management service provided by consultative physician with written report, 5 minutes or more of medical consultative discussion and review	Telehealth by definition, Telecommunications code
99452	Telephone or internet referral service, 30 minutes	Telehealth by definition, Telecommunications code
99478	Subsequent intensive care of recovering low birth weight infant, per day	CMS code, PHE code, Institutional code
G0071	Virtual Communication Services for FQHCs and RHCs	Telehealth by definition, FQHC/RHC-specific code
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	CMS code
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes	CMS code
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hour	CMS code
G0296	Counseling visit to discuss need for lung cancer screening using low dose CT scan (service is for eligibility determination and shared decision making)	CMS code
G0316	Prolonged hospital inpatient or observation care	CMS code, Institutional code
G0317	Prolonged nursing facility evaluation and management service	CMS code, Institutional code
G0318	Prolonged home or residence evaluation and management	CMS code
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit), and brief intervention 15 to 30 minutes	CMS code, Behavioral health code
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit), and intervention, greater than 30 minutes	CMS code, Behavioral health code
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth	CMS code, Telehealth by definition, Institutional code
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth	CMS code, Telehealth by definition, Institutional code
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35	CMS code, Telehealth by definition, Institutional code

	minutes communicating with the patient via telehealth	
G0410	Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes	CMS code, PHE code, Institutional code, Behavioral health code
G0420	Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour	CMS code
G0421	Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour	CMS code
G0422	Intensive cardiac rehabilitation with or without continuous ECG monitoring with exercise	CMS code, PHE code
G0423	Intensive cardiac rehabilitation with or without continuous ECG monitoring without exercise	CMS code, PHE code
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth	CMS code, Telehealth by definition, Institutional code
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth	CMS code, Telehealth by definition, Institutional code
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth	CMS code, Telehealth by definition, Institutional code
G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	CMS code
G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes	CMS code
G0438	Annual wellness visit; includes a personalized prevention plan of service, initial visit	CMS code
G0439	Annual wellness visit, includes a personalized prevention plan of service, subsequent visit	CMS code
G0442	Annual alcohol misuse screening, 15 minutes	CMS code
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	CMS code, Behavioral health code
G0444	Annual depression screening, 15 minutes	CMS code
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed	CMS code

G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	CMS code
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	CMS code
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	CMS code, Telehealth by definition, Institutional code
G0466	FQHC visit new patient	FQHC/RHC-specific code
G0467	FQHC visit, established pt	FQHC/RHC-specific code
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)	CMS code
G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	CMS code, Telehealth by definition, Institutional code
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	CMS code, Telehealth by definition, Institutional code
G0511	Chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner, 20 minutes or more	Behavioral health code, FQHC/RHC-specific code
G0512	Collaborative care model (COCM) services by an RHC or FQHC practitioner, 60 minutes or more	Behavioral health code, FQHC/RHC-specific code
G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 3	CMS code
G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each ad	CMS code
G2010	Remote evaluation of recorded video and/or images submitted by an established patient	Telehealth by definition, Telecommunications code
G2012	Brief communication technology-based service by a physician or other qualified health care professional	Telehealth by definition, Telecommunications code
G2025	Distant site telehealth services (for FQHCs and RHCs)	Telehealth by definition, FQHC/RHC-specific code
G2061	Qualified nonphysician healthcare professional online assessment and management service for an established patient, 5-10 minutes	Telehealth by definition, Telecommunications code

G2062	Qualified nonphysician healthcare professional online assessment and management service for an established patient, 11-20 minutes	Telehealth by definition, Telecommunications code
G2063	Qualified nonphysician healthcare professional online assessment and management service for an established patient, 21+ minutes	Telehealth by definition, Telecommunications code
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month	CMS code, Behavioral health code
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month	CMS code, Behavioral health code
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separate)	CMS code, Behavioral health code
G2211	Complex E/M visit add on	CMS code
G2212	Prolonged office or other outpatient evaluation and management service	CMS code, PHE code
G3002	Chronic pain management and treatment, monthly bundle	CMS code
G3003	Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month	CMS code
G9685	Physician service or other qualified health care professional for the evaluation and management of a beneficiary's acute change in condition in a nursing facility. this service is for a demonstration	CMS code, PHE code, Institutional code
Q3014	Telehealth facility fee	Telehealth by definition
S9152	Speech therapy, re-evaluation	CMS code, PHE code

* Applicable Category definitions:

CMS codes are those included on the CMS list of telehealth services payable under the Medicare Physician Fee Schedule.

PHE codes refer to services that were eligible for Medicare payment when delivered via telehealth during the COVID-19 public health emergency.

Behavioral health codes refer to services for diagnosis and management of mental health conditions and substance use disorders.

Institutional codes refer to services delivered in inpatient or other institutional settings, including nursing facilities.

Telehealth by definition refers to services that can be delivered by telehealth only.

Telecommunications are services that do not meet CMS' definition of a telehealth visit but are delivered virtually, such as virtual check-ins.

FQHC/RHC-specific codes refer to codes that can only be billed by federally qualified health centers and rural health centers.

Appendix D. Evaluation & Management Codes for In-person Ambulatory Visits

HCPCS Code	Description
90785	Interactive complexity
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes
90833	Psychotherapy, 30 minutes
90834	Psychotherapy, 45 minutes
90836	Psychotherapy, 45 minutes
90837	Psychotherapy, 60 minutes
90838	Psychotherapy, 60 minutes
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis
90845	Psychoanalysis
90846	Family psychotherapy, 50 minutes
90847	Family psychotherapy including patient, 50 minutes
90853	Group psychotherapy
90875	Individual psychophysiological therapy incorporating biofeedback training with psychotherapy, 30 minutes
92002	Eye and medical examination for diagnosis and treatment, new patient
92004	Eye and medical examination for diagnosis and treatment, new patient, 1 or more visits
92012	Eye and medical examination for diagnosis and treatment, established patient
92014	Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits
94005	Evaluation of home ventilator management care plan, 30 minutes or more
99201	New patient office or other outpatient visit, typically 10 minutes
99202	New patient office or other outpatient visit, typically 20 minutes
99203	New patient office or other outpatient visit, typically 30 minutes
99204	New patient office or other outpatient visit, typically 45 minutes
99205	New patient office or other outpatient visit, typically 60 minutes
99211	Established patient office or other outpatient visit, typically 5 minutes
99212	Established patient office or other outpatient visit, typically 10 minutes
99213	Established patient office or other outpatient visit, typically 15 minutes
99214	Established patient office or other outpatient, visit typically 25 minutes
99215	Established patient office or other outpatient, visit typically 40 minutes
99324	New patient assisted living visit, typically 20 minutes
99325	New patient assisted living visit, typically 30 minutes
99326	New patient assisted living visit, typically 45 minutes
99327	New patient assisted living visit, typically 60 minutes
99328	New patient assisted living visit, typically 75 minutes
99334	Established patient assisted living visit, typically 15 minutes
99335	Established patient assisted living visit, typically 25 minutes
99336	Established patient assisted living visit, typically 40 minutes
99337	Established patient assisted living visit, typically 60 minutes
99341	New patient home visit, typically 20 minutes
99342	New patient home visit, typically 30 minutes
99343	New patient home visit, typically 45 minutes
99344	New patient home visit, typically 60 minutes
99345	New patient home visit, typically 75 minutes

99347	Established patient home visit, typically 15 minutes
99348	Established patient home visit, typically 25 minutes
99349	Established patient home visit, typically 40 minutes
99350	Established patient home visit, typically 60 minutes
99354	Prolonged office or other outpatient service first hour
99355	Prolonged office or other outpatient service each 30 minutes beyond first hour
99495	Transitional care management services, moderately complexity, requiring face-to-face visits within 14 days of discharge
99496	Transitional care management services, highly complexity, requiring face-to-face visits within 7 days of discharge
G0420	Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour
G0421	Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour
G0438	Annual wellness visit; includes a personalized prevention plan of service, initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service, subsequent visit
G0466	FQHC visit, new patient
G0467	FQHC visit, established patient
G0511	Chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner, 20 minutes or more
G0512	Collaborative care model (COCM) services by an RHC or FQHC practitioner, 60 minutes or more

Appendix E. Statute Language

SEC. 50324. PROVIDING ACCOUNTABLE CARE ORGANIZATIONS THE ABILITY TO EXPAND THE USE OF TELEHEALTH.

(a) In General.--Section 1899 of the Social Security Act (42 U.S.C. 1395jjj) is amended by adding at the end the following new subsection:

``(l) Providing ACOs the Ability To Expand the Use of Telehealth Services.--

``(1) In general.--In the case of telehealth services for which payment would otherwise be made under this title furnished on or after January 1, 2020, for purposes of this subsection only, the following shall apply with respect to such services furnished by a physician or practitioner participating in an applicable ACO (as defined in paragraph (2)) to a Medicare fee-for-service beneficiary assigned to the applicable ACO:

``(A) Inclusion of home as originating site.--Subject to paragraph (3), the home of a beneficiary shall be treated as an originating site described in section 1834(m)(4)(C)(ii).

``(B) No application of geographic limitation.--The geographic limitation under section 1834(m)(4)(C)(i) shall not apply with respect to an originating site described in section 1834(m)(4)(C)(ii) (including the home of a beneficiary under subparagraph (A)), subject to State licensing requirements.

``(2) Definitions.--In this subsection:

``(A) Applicable ACO.--The term `applicable ACO means an ACO participating in a model tested or expanded under section 1115A or under this section--

``(i) that operates under a two-sided model--

``(I) described in section 425.600(a) of title 42, Code of Federal Regulations; or

``(II) tested or expanded under section 1115A; and

``(ii) for which Medicare fee-for-service beneficiaries are assigned to the ACO using a prospective assignment method, as determined appropriate by the Secretary.

``(B) Home.--The term `home' means, with respect to a Medicare fee-for-service beneficiary, the place of residence used as the home of the beneficiary.

``(3) <<NOTE: Applicability.>> Telehealth services received in the home.--In the case of telehealth services described in paragraph (1) where the home of a Medicare fee-for-service beneficiary is the originating site, the following shall apply:

``(A) No facility fee.--There shall be no facility fee paid to the originating site under section 1834(m)(2)(B).

``(B) Exclusion of certain services.--No payment may be made for such services that are inappropriate to furnish in the home setting such as services that are typically furnished in inpatient settings such as a hospital.''.

(b) Study and Report.--

(1) Study.--

(A) In general.-- <<NOTE: 42 USC 1395jjj note.>> The Secretary of Health and Human Services (in this subsection referred to as the ``Secretary'') shall conduct a study on the implementation of section 1899(l) of the Social Security Act, as added by subsection (a). <<NOTE: Analysis.>> Such study shall include an analysis of the utilization of, and expenditures for, telehealth services under such section.

(B) Collection of data.--The Secretary may collect such data as the Secretary determines necessary to carry out the study under this paragraph.

(2) <<NOTE: Recommendations. 42 USC 1395jjj note.>> Report.--Not later than January 1, 2026, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.