State Telehealth Laws and Reimbursement Policies

At-A-Glance

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Center for Connected Health Policy
THE NATIONAL TELEHEALTH POLICY RESOURCE CENTER

Since the onset of the pandemic, Medicaid programs nationwide have steadily moved from temporary measures toward more permanent, structured telehealth policies. Recent trends reflect steady growth in reimbursement, targeted expansions in cross-state licensure, and the development of professional practice standards that introduce guardrails to ensure quality and accountability.

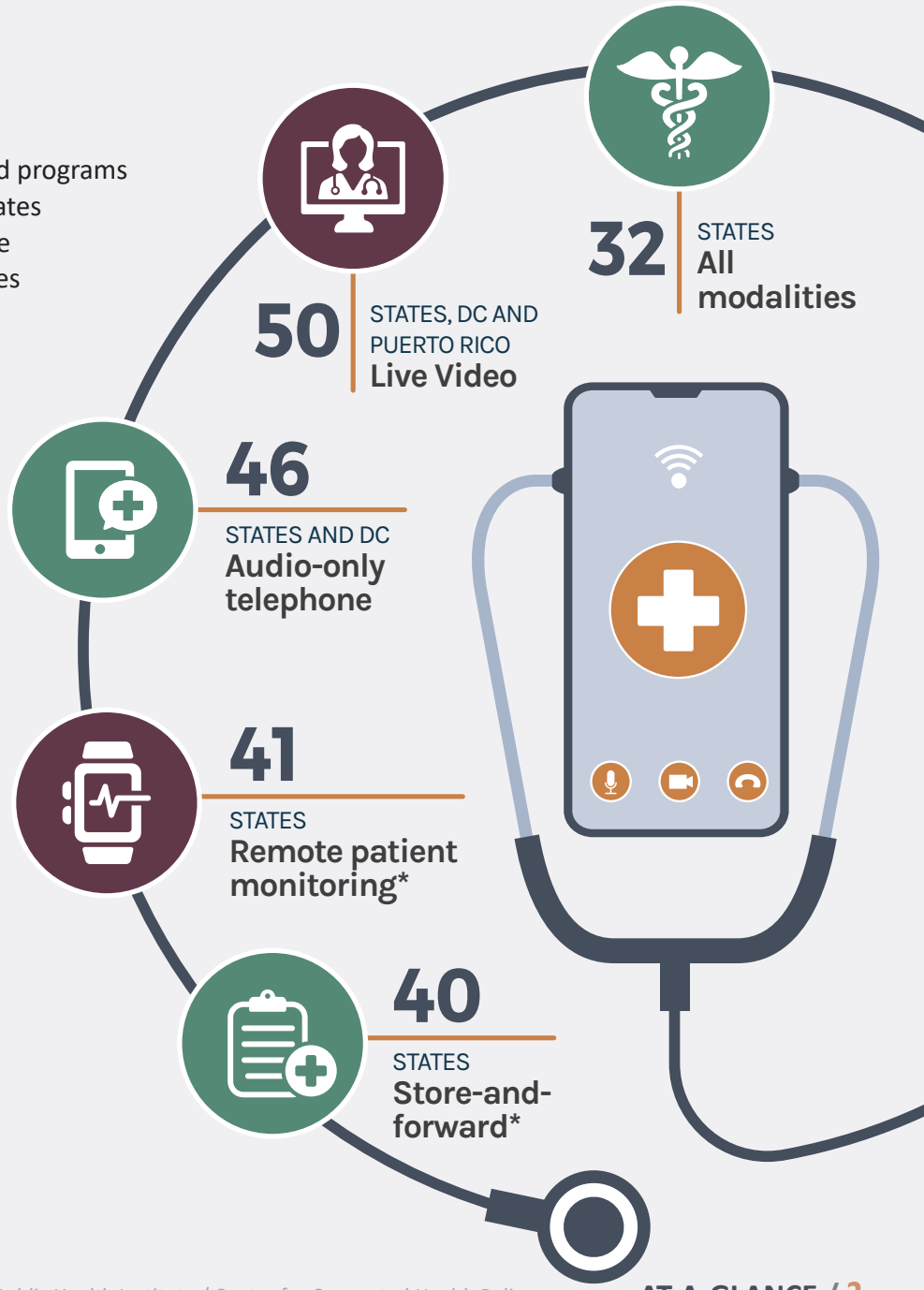
The Report's Methodology

- State reviews for this edition took place between late May and early September 2025, and the summary also incorporates updates that have occurred since the publication of CCHP's last annual State Telehealth Policy Summary in November 2024.
- CCHP considers a state to be reimbursing for Medicaid telehealth only when official Medicaid documentation confirms payment for a specific modality. A statutory mandate on its own is not sufficient.
- Sources consulted include state statutes, administrative codes, Medicaid provider manuals, and other official Medicaid communications such as newsletters, announcements, bulletins, and updates. Medicaid fee schedules were not systematically searched for specific codes for this report.
- States are listed as reimbursing for a modality or site even if coverage is narrow or highly limited. Readers should always refer to individual state policies for detailed requirements.
- For licensure policies, CCHP's review focused on telehealth-related provisions. However, if broader licensing exceptions were identified during the search, those were noted as licensing exceptions. To be counted as a telehealth-specific license or registration, the law or rule had to explicitly reference telehealth or remote care.

CCHP

Medicaid Reimbursement

Live video remains the most widely reimbursed form of telehealth across Medicaid programs nationwide, with nearly universal coverage apart from the Virgin Islands. While states continue to differ in the details of their requirements—such as which providers are eligible, what services qualify, and where patients must be located—recent updates reflect a clear trend toward greater flexibility. Many states have expanded the types of providers who can deliver care, clarified how telehealth applies in managed care, and broadened the range of services eligible for reimbursement. Behavioral health, oral health, maternal care, and school-based telehealth have been particular areas of growth, alongside increased recognition of provider-to-provider tools like eConsults and technologies such as remote patient monitoring. In addition, some states have moved to make audio-only coverage permanent, while others are refining administrative and billing standards to ensure that telehealth services meet confidentiality, quality, and accountability standards.



Audio-only

Audio-only telehealth has emerged as one of the fastest growing areas of Medicaid reimbursement following the pandemic. Coverage, however, is often structured with limits—such as restricting use to established patients, allowing it only for certain conditions like behavioral health, or reimbursing a defined set of codes that mirror Medicare's list.

Home as Originating Site

Some Medicaid programs allow reimbursement for telehealth delivered in a patient's home when billed with Place of Service Code 10, which designates home-based telehealth services.

The home is recognized as an eligible originating site in 48 states and the District of Columbia.

**Some states that are included in the counts above reimburse this modality solely as part of Communication Technology-Based Services (CTBS), which have their own separate codes and reimbursement rates.*

Private Payer Laws

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STATES AND PUERTO RICO
Have explicit payment parity

Forty-four states, the District of Columbia, Puerto Rico and the Virgin Islands have a private payer law that addresses telehealth reimbursement. Private payer telehealth laws continue to evolve, with many states refining requirements to promote equitable coverage and reimbursement. Recent updates have largely focused on strengthening or extending existing provisions, whether by removing sunset clauses, expanding parity requirements, or clarifying coverage standards. Collectively, these changes reflect a broader effort to ensure telehealth remains a lasting and flexible option across the payer landscape.

Professional Board Standards

As states continue to refine Medicaid and private payer telehealth policies, many are also turning to licensing boards and health agencies to establish professional practice standards. These rules are designed to ensure that care delivered virtually maintains the same levels of safety, quality, and accountability as in-person services, while often tailoring requirements to specific professions. A consistent theme across these standards is that providers must be licensed in the state where the patient is located, reinforcing state authority while supporting cross-state consistency.

In addition, states are embedding expectations around technology, confidentiality, and informed consent to safeguard patients while supporting effective care. These rules often address issues such as secure platforms, documentation requirements, and the need for valid provider-patient relationships before initiating telehealth encounters.

Prescribing

A growing area of attention in telehealth policy is around prescribing medications, particularly controlled substances. States vary in how they balance timely access to care with safeguards to prevent misuse, often setting conditions around patient-provider relationships, visit requirements, or the types of medications that may be prescribed remotely. While approaches by each state may differ, the overall trend reflects an effort to integrate telehealth into prescribing practices in a way that supports both access and safety.

Note: Providers must also comply with federal limits on prescribing controlled substances.

EXAMPLE:

PENNSYLVANIA now permits initial opioid treatment program exams for medications like buprenorphine to be conducted via telehealth, provided an in-person follow-up occurs within 14 days.

Consent

Forty-five states, DC, and Puerto Rico include some sort of consent requirement in their statutes, administrative code, and/or Medicaid policies. Consent requirements for telehealth vary, with some states mandating written consent and others permitting verbal consent. In many cases, laws are unclear about how often providers must obtain consent specific to telehealth, and requirements can also differ across payers and provider types.

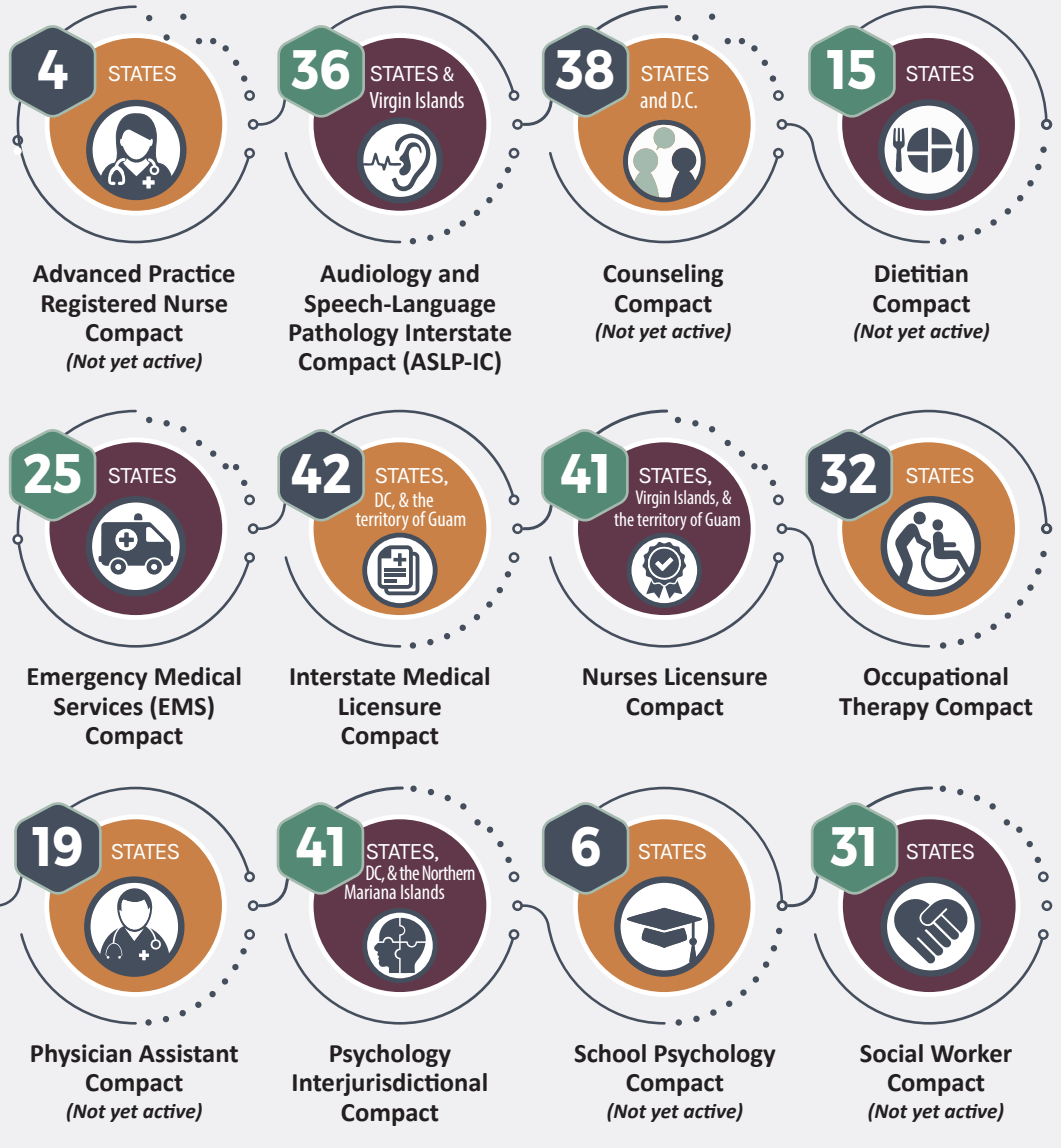
Licensure

Thirty-eight states, as well as DC and Puerto Rico offer some type of limited exception to in-state licensing requirements. Many states now allow some form of flexibility, often permitting out-of-state providers to consult with or operate under the supervision of an in-state professional, or provide services they have a previous relationship with for a limited amount of time.

CCHP also found that **eighteen states as well as the Virgin Islands and Puerto Rico** have telehealth-specific special registration or licensure processes that are available as an alternative to full in-state licensure. These models range from comprehensive telemedicine licenses to temporary permits or streamlined registration systems. Their growth over the last few years illustrates how states are working to expand access to telehealth services while maintaining oversight and safeguards to ensure accountability and quality.

Adoption of Interstate Compacts continues to be common for states.

The Compact Numbers:



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