Overdose Prevention Initiative

Telehealth in Transition:
What the January 30, 2026 Medicare Deadline Means for SUD Care and Overdose Prevention

Overview

Medicare telehealth policy shifted repeatedly during and after the COVID-19 public health emergency. Most temporary flexibilities now extend only through January 30, 2026; after that date, many non behavioral telehealth benefits will expire unless Congress acts (CMS, 2025). These provisions include limits on audio only visits, reduced billing eligibility for certain clinicians and narrowed authority for hospitals to deliver remote care in the home (CMS, 2025).

If Congress does not extend these flexibilities, Medicare beneficiaries will face a divided system. Behavioral health and SUD telehealth remain protected under permanent law, but the medical care that supports recovery becomes harder to reach. This imbalance will disrupt continuity of care, especially for older adults and rural residents.

Telehealth is central to SUD treatment. Evidence shows higher retention and lower overdose risk when buprenorphine is initiated via telehealth (Nguyen et al., 2023; Jones et al., 2023; Hailu et al., 2023). Treatment visits also shifted heavily to telehealth after COVID-era reforms and continued to grow (Lin et al., 2022).

Older adults face the greatest danger. Overdose deaths among adults 65 and older increased more than 9000 percent from 2000 to 2020 (HHS OIG, 2023). With nearly universal Medicare enrollment, any reduction in telehealth directly affects their access to treatment, chronic disease management and MOUD stability.

Policy Ask: Congress must extend Medicare's temporary non-mental telehealth flexibilities and protect access to MOUD and evidence based SUD services in all care settings to prevent treatment disruption and rising overdose risk.

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Background and Timeline of Federal Telehealth Rules

Before the COVID 19 Pandemic

- Medicare telehealth covered a limited set of services.
- Patients usually had to be at an approved "originating site" in a rural area such as a clinic or hospital, not at home (CCHP, 2025; KFF, 2024).
- Section 2001 of the SUPPORT for Patients and Communities Act began to remove these limits for SUD treatment and co occurring mental health conditions starting July 2019, eliminating the rural and site restrictions for those services (Congress, 2018).

During the COVID 19 Pandemic

Congress and CMS put in place broad emergency flexibilities:

- Allowed patients to receive many telehealth services from any location, including home
- Expanded which providers could bill for telehealth
- Allowed more use of audio only telehealth
- Let Federally Qualified Health Centers and Rural Health Clinics act as distant site providers for telehealth
- Relaxed DEA rules so clinicians could prescribe many controlled medications, including buprenorphine, without an in person visit, under temporary telemedicine flexibilities (DEA and HHS, 2024; SAMHSA, 2024).

After the COVID 19 Pandemic

Congress extended many Medicare telehealth flexibilities several times:

- The Consolidated Appropriations Act of 2021 permanently removed geographic and originating site restrictions for behavioral health telehealth services, including SUD treatment, so patients can receive these services from home in both rural and urban areas (CMS, 2025b; KFF, 2024).
- Later laws extended temporary Medicare telehealth flexibilities for non behavioral services through March 31, 2025 and then through September 30, 2025. (CCHP, 2025; Kiplinger, 2025).
- Congress extended these temporary flexibilities through a series of short-term laws, which created repeated policy cliffs that left health systems and beneficiaries uncertain about long-term access.

Where we are Today: The 2025 Shutdown and the New January 30, 2026 Deadline

- Many Medicare telehealth provisions lapsed on October 1, 2025 during a government funding impasse
- A continuing resolution later restored key telehealth provisions retroactively and extended them through January 30, 2026
- CMS updated its Telehealth FAQ for Calendar Year 2026 to clarify that
  - Through January 30, 2026, beneficiaries can receive Medicare telehealth services anywhere in the United States
  - Starting January 31, 2026, non-mental telehealth services revert to older geographic and site rules, while mental health telehealth keeps its permanent flexibilities (CMS, 2025a)

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Federal Administrative Actions on Telehealth for SUD and MOUD

- DEA and HHS issued a "Third Temporary Extension" of COVID-19 telemedicine flexibilities for controlled medications through December 31 2025
- In January 2025, DEA and HHS issued a final rule that makes permanent key telemedicine flexibilities for prescribing buprenorphine and other medications for opioid use disorder under defined safeguards (SAMHSA, 2025)

CMS (Medicare coverage)	DEA (controlled substances / MOUD prescribing)
• Sets Medicare telehealth coverage rules • Implements Congressional extensions • Permanent flexibilities apply only to behavioral health and SUD telehealth • Temporary non behavioral rules expire January 30, 2026	• Issued a Third Temporary Extension of telemedicine flexibilities through December 31, 2025 • On January 17, 2025, DEA and HHS issued a Final Buprenorphine Telemedicine Rule meant to take effect in February 2025 but delayed to December 31, 2025 (per the final rule's implementation notice) • On the same day DEA released the Special Registration Proposed Rule for controlled substances prescribing (still pending)
SAMHSA	**HRSA and HHS Guidance**
A 2024 rule made telehealth flexibilities permanent for opioid treatment programs (OTPs), allowing tele MOUD initiation and continuity inside OTPs	• HRSA classifies SUD treatment as telebehavioral health • HHS guidance confirms SUD telehealth may be delivered from home with fewer geographic limits (HHS, 2025a; 2025b)

Up to Jan 30, 2026

Medicare behavioral health and SUD telehealth

- Receive behavioral health and SUD treatment by telehealth from any location, including their home
- Use audio-video or audio-only technology when clinically appropriate
- See a wide range of behavioral health clinicians, including marriage and family therapists, mental health counselors and clinicians in FQHCs and RHCs (CMS, 2025a; CMS, 2025b; HHS, 2025)

These flexibilities rest on permanent changes in federal law for behavioral health and SUD. They do not end on January 30, 2026.

Medicare non-behavioral health and SUD telehealth

- Medicare covers many non-behavioral telehealth services wherever the patient is located, including home
- More types of practitioners, such as physical therapists and occupational therapists, may bill for telehealth
- Hospitals may bill for some services furnished remotely by hospital staff to patients in their homes
- Audio-only telehealth remains allowed for many services, including SUD and mental health care, when certain conditions are met

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What Changes on January 30, 2026 if Congress Does Not Act?

After January 30, 2026, non-mental telehealth will revert to older rules that require patients to be in a rural area and in a medical facility. This affects care for chronic conditions that directly shape overdose risk. Patients with SUD who need ongoing medical follow up may lose access to virtual visits that previously prevented treatment dropout.

The expiration of expanded practitioner eligibility means fewer clinicians will be able to provide telehealth-based follow up for conditions linked to relapse and overdose. This will increase wait times, raise clinician workload and widen gaps in care.

If Congress does not pass another extension or a permanent telehealth bill, on January 31, 2026 traditional Medicare will:

1. Restore pre-pandemic geographic and originating site restrictions for most non-mental telehealth services, so patients typically must be in a rural area and in an approved medical facility
2. Remove the temporary expansion that allows an extended list of practitioners, such as physical therapists and occupational therapists, to bill for telehealth
3. End hospital billing for some services delivered remotely by hospital staff to beneficiaries in their homes
4. Limit audio-only telehealth to mental health in more narrow circumstances, while audio only for many other services will no longer qualify as Medicare telehealth (CMS, 2025a; CCHP, 2025)

Important Exception:

Mental health and SUD telehealth keep their permanent flexibilities, including home as the originating site and removal of geographic restrictions, beyond January 30, 2026 (CMS, 2025a; CMS, 2025b).

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Type of Service	COVID-19 Public Health Emergency and current period through Jan 30, 2026	After Jan 30, 2026 if Congress does not act
SUD and mental health telehealth	Patients can be seen from home in any area, audio video or audio-only allowed, broad clinician types, FQHC and RHC can be distant sites	Same core flexibilities continue because they are permanent in law, subject to specific in person visit rules for mental health telehealth that restart after Jan 30 2026 (for new patients) (CMS, 2025a)
Non-mental telehealth (for example many medical specialties)	Patients can be seen from home in any area, broader service list and practitioner list, more audio-only, expanded hospital remote services	Most services again require rural location and an approved facility as originating site, narrower practitioner list, fewer audio only options, less hospital at home billing (CMS, 2025a; KFF, 2024)
MOUD prescribing via telemedicine	DEA temporary rule through Dec 31, 2025 allows telemedicine prescribing of many controlled substances, buprenorphine flexibilities in place	After Dec 31, 2025, general controlled substance flexibilities end unless new DEA rules are finalized, but buprenorphine telemedicine flexibilities continue under the DEA final rule (DEA and HHS, 2024; SAMHSA, 2025)

What do the Changes Mean for Patients Seeking SUD Treatment?

Although SUD-specific telehealth remains available, patients will face new barriers to the medical care that supports recovery. Medicare beneficiaries who relied on telehealth to manage chronic conditions will need to travel for in-person visits, which increases missed appointments and treatment interruptions.

Older adults will face the most significant burden. Adults 65 and older experienced a more than 9000 percent rise in overdose deaths from 2000 to 2020, driven by prescription opioids, synthetic opioids and polysubstance use (HHS OIG, 2023). Restricting non-mental telehealth will reduce their ability to stabilize chronic illness, maintain MOUD treatment and prevent medical complications that increase overdose risk.

Patients who begin telehealth SUD treatment after January 30, 2026 may encounter new in-person visit requirements for some mental health services, which can delay treatment starts for those with mobility or transportation barriers.

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Because mental health and SUD telehealth flexibilities are permanent, Medicare patients can still:

- Start and continue SUD treatment by telehealth from home
- Receive counseling and many recovery support visits by video or audio-only, when clinically appropriate
- Access buprenorphine by telemedicine under the DEA final rule, without always needing an in person visit first (SAMHSA, 2025)

However, the January 30, 2026 date still affects patients:

- Patients with complex conditions may lose non-mental telehealth options that help manage co-occurring physical illnesses, such as pain, heart disease, or diabetes, which influence relapse and overdose risk
- Patients in non-rural areas may once again need to travel to a facility for many types of medical telehealth that are not classified as mental health
- Confusion about what remains covered can discourage people from seeking or continuing care

Evidence shows that telehealth SUD treatment improves retention and may decrease overdose risk, especially for buprenorphine.

A large study found that telehealth initiation of buprenorphine was tied to lower rates of nonfatal opioid overdose and better engagement (Nguyen et al., 2023). CDC reported that expanded OUD telehealth during the pandemic was associated with a lower risk of fatal overdose among Medicare beneficiaries (CMS and CDC, 2023). Additional research found tele-MOUD to be a comparable alternative to in-person care and equally effective at supporting treatment quality (Hailu et al., 2023). National treatment data show buprenorphine visits continued to rise after COVID telehealth reforms, with care shifting significantly toward telehealth rather than falling back to in-person only services (Lin et al., 2022).

Any new barrier that makes patients unsure about coverage can undercut gains in engagement, retention and overdose prevention.

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What do the Changes Mean for Providers Delivering Telehealth or MOUD?

Loss of non-mental telehealth limits will deepen workforce strain. Clinicians will need to shift more appointments back to in-person care, increasing workload in a system already experiencing mental health shortages.

Rural and aging communities will feel the greatest impact. Providers in these regions rely on telehealth to monitor chronic illness, coordinate care and maintain MOUD treatment plans. Without federal action, more patients will cycle between in-person and telehealth requirements, creating administrative burden and reducing retention.

Providers managing older adults with OUD will need to incorporate more in-person chronic disease visits, increasing transportation barriers and raising the risk of treatment dropout.

Through January 30, 2026:

- Mental health and SUD clinicians can continue to use telehealth from home or clinics, including audio only when needed
- A wide range of clinicians can bill Medicare for telehealth, and FQHC and RHC providers can serve as distant sites for many services (CMS, 2025a; CMS, 2025e)

For MOUD:

- Clinicians can rely on the DEA buprenorphine telemedicine final rule, which secures a long term pathway for remote buprenorphine prescribing under clear standards (SAMHSA, 2025).
- For other controlled medications related to co occurring conditions, clinicians still face uncertainty after December 31, 2025 unless DEA adopts additional permanent rules

After January 30, 2026 with no new law:

- Mental health and SUD telehealth remain available, but clinicians must follow new in person visit timing rules for telemental health, such as an in person visit within six months for new patients starting after that date and at least every 12 months, with some exceptions (CMS, 2025a)
- Non-mental clinicians will face tighter limits on telehealth billing, especially for patients not in rural areas
- Some clinicians who gained telehealth billing rights during the PHE will no longer be eligible to bill Medicare telehealth codes
- Hospital teams that support SUD care, such as pharmacists or social workers providing remote follow up for medical conditions, may lose hospital at home telehealth billing options

Community-Based & Rural Programs

What do the Changes Mean for Community and Rural Health Programs?

Rural programs already face limited clinician availability and long travel distances. When non-mental telehealth coverage expires, programs will lose the ability to stabilize co-occurring medical conditions virtually, which is a core component of preventing overdose among rural older adults. Research shows telehealth supports rural SUD treatment access and may reduce disparities (Walker et al., 2025; Rural Health Information Hub, 2024).

Community programs will need to coordinate more in-person medical visits for patients with limited mobility. This will reduce the effectiveness of integrated models that combine SUD, mental health and chronic disease management under one telehealth umbrella.

Because SUD telehealth flexibilities are permanent, rural programs can still:

- Offer SUD and mental health visits from home or community sites
- Use audio-only visits when broadband is limited
- Integrate tele-MOUD into mobile clinics, community centers, and harm reduction programs

However, the loss of broader non-mental telehealth flexibilities after January 30, 2026 can:

- Limit telehealth for other chronic conditions that influence overdose risk, such as liver disease, HIV, and chronic pain
- Reduce the ability of small rural hospitals to bill for remote services delivered by staff to patients at home, which weakens integrated care models
- Increase administrative complexity as programs must track which services are still covered as telehealth and which now require in person visits

Employers and Workforce Health

What do the Changes Mean for Employers Using Telehealth in Workforce Health?

Workers with SUD often rely on telehealth to attend follow up appointments without missing work. If broader Medicare telehealth flexibilities end, commercial insurers may also tighten their coverage, reducing employer-based telehealth availability.

Employers increasingly support older workers managing chronic pain, disability or long-term recovery. Medicare telehealth limits can disrupt continuity for workers transitioning onto Medicare or for caregiving employees who rely on telehealth to manage family health needs.

The workforce impact is largest in industries with high injury rates and high opioid exposure, including construction, transportation and agriculture. Telehealth limits reduce the tools employers use to stabilize workers' health, maintain MOUD engagement and prevent overdose.

If Medicare lets non-mental telehealth flexibilities expire:

- Some commercial and Medicare Advantage plans may narrow non-mental telehealth offerings or adopt more complex prior authorization rules
- Onsite or near site clinics that serve older workers or workers on Medicare may need to shift from telehealth back to in person visits for many non-mental services
- Employers trying to integrate SUD support with primary care and chronic disease management through telehealth could face more fragmented coverage

For overdose prevention on the job, the risk is that workers have telehealth access for SUD and mental health, but less support for the medical issues, pain care, or follow-up visits that help them stay in treatment and remain employed and able to work.

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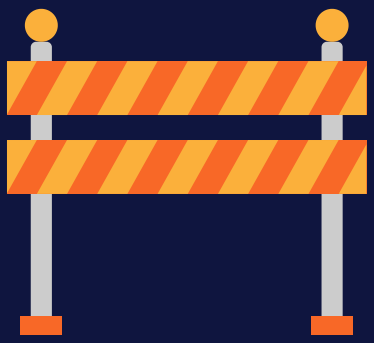

Key Barriers and Accessibility Concerns

Access barriers will be highest for older Americans, rural residents, people with disabilities and those with fixed incomes. The 9000 percent increase in overdose deaths among older adults shows that this group cannot absorb additional barriers to telehealth.

Limiting non mental telehealth will deepen disparities for patients who depend on virtual care to manage mobility issues, multiple chronic conditions and transportation barriers. These factors contribute directly to overdose risk when treatment disruptions occur.

Even with permanent mental health telehealth flexibilities, several barriers remain:

Technology access and digital literacy

Many rural and low income patients lack reliable internet or devices. Studies show that lack of cell phone or broadband access reduces SUD telehealth engagement in rural communities (Button et al., 2022).

Racial and ethnic disparities

New research finds disparities in SUD telehealth use among Medicaid patients and persistent differences by race, ethnicity, and payer type (Walker et al., 2025; Choi et al., 2025).

Coverage and payment complexity

Different rules for Medicare, Medicare Advantage, Medicaid, and commercial plans make it difficult for patients and providers to know what is covered. Confusion grew during the October 2025 shutdown when claims were held and later made retroactive only after CMS guidance (Fierce Healthcare, 2025; CMS, 2025d).

Workforce limits

Nearly one in five US counties has no opioid treatment program or buprenorphine prescriber, so telehealth becomes a lifeline, especially for Medicare and Medicaid populations (Axios, 2024).

Risk of a telehealth "cliff"

Repeated short term extensions create uncertainty, which can discourage health systems and community programs from investing in stable telehealth infrastructure that supports SUD treatment and recovery (Mintz, 2025).

What You Can Do: Actions for Policymakers, Health Systems and Partners

The expiration of Medicare's broader telehealth flexibilities after January 30, 2026 creates a two-tiered system. Mental health and SUD telehealth remain protected, but the medical care that supports long-term recovery becomes harder to access. This increases treatment dropout and the likelihood of unmanaged medical complications, which raises overdose risk.

For older adults experiencing the fastest growth in overdose deaths, any reduction in telehealth access creates substantial danger. Medicare plays the most significant role in their care, and limiting telehealth will weaken prevention efforts for the population most in need of stable access.

The evidence is clear:

- Telehealth for OUD, especially tele-MOUD, supports treatment retention and may reduce overdose risk
- Studies of Medicaid and Medicare populations show higher retention in buprenorphine treatment and lower rates of nonfatal overdose among people who start treatment via telehealth compared with in person only care (Nguyen et al., 2023; Hammerslag et al., 2023; CDC, 2023)

Given this evidence, allowing a partial telehealth cliff after January 30, 2026 would:

- Undermine integrated care for people with SUD and co-occurring physical conditions
- Increase barriers for older adults and rural residents who rely on telehealth for transportation or mobility reasons
- Add confusion for providers and patients at a time when trust and continuity matter for overdose prevention

Keeping mental health telehealth strong is necessary but not sufficient. Overdose prevention requires stable access to mental health SUD care, medications and the broader medical services that help people stay alive, housed and employed.

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Policymakers

Pass federal legislation that:
- Makes permanent Medicare telehealth flexibilities for non behavioral services, including home as originating site for appropriate services
- Aligns telehealth coverage and in person visit requirements across behavioral and physical health when clinically appropriate
- Codifies audio only coverage for SUD and key chronic conditions when broadband or device access is limited
- Protect behavioral telehealth while expanding telehealth access for chronic disease management. Older adults depend on both. Limiting medical telehealth narrows overdose prevention at the very moment older adult deaths are accelerating

Direct CMS and HHS to:
- Issue clear, plain language guidance for patients, providers, and community organizations on what happens after January 30 2026
- Standardize telehealth coding and coverage rules for SUD and co occurring conditions across Medicare, Medicaid guidance, and marketplace plans

Instruct DEA to:
- Finalize comprehensive telemedicine rules for controlled medications that honor the buprenorphine model, with safeguards and reduced paperwork for patients who already demonstrate stability in treatment

Health Systems/ Providers

Build and maintain tele-SUD programs that
- Use video when possible but offer audio only as a backup for people without broadband
- Integrate SUD treatment, mental health care, and primary care in shared telehealth workflows
- Track retention and overdose outcomes to show impact and support advocacy

Map the January 30, 2026 risk points:
- Identify which services and clinician types will lose telehealth coverage if Congress does not act
- Identify Medicare patients with chronic comorbidities who rely on non-behavioral telehealth and proactively transition them into care plans before January 30, 2026. This is especially critical for older adults starting or maintaining MOUD
- Prioritize high risk populations such as older adults with OUD, people leaving hospitals or jails, and rural patients

Train staff and patients
- Provide simple education on how Medicare SUD and behavioral telehealth will continue
- Clarify where in person visits will become necessary again and plan for transportation and scheduling barriers

Advocates/Community Partners

Use evidence from CDC, NIDA, and peer reviewed studies to show that telehealth MOUD and SUD care improve retention and reduce overdose risk (Nguyen *et al.*, 2023; CDC, 2023; Hailu *et al.*, 2023).

Center the voices of people in recovery
- Document how telehealth reduced missed visits, travel costs, and work disruptions
- Highlight impacts for rural residents, older adults, and people with disabilities
- Educate Congress on the 9000 percent increase in overdose deaths among older Americans and show how Medicare telehealth limits directly worsen outcomes for this group. Connect telehealth access to overdose prevention for seniors, rural residents and people with disabilities

Press for clear, bipartisan messaging that
- Telehealth is not a luxury, it is basic infrastructure for overdose prevention and recovery
- The January 30, 2026 deadline is a policy choice, not an inevitability

Moving Forward

Medicare's temporary telehealth flexibilities expire on January 30 2026, creating a divided system in which behavioral health and SUD telehealth will remain available but the medical care that supports recovery becomes harder to reach. This change threatens treatment continuity for older adults, rural residents and people managing chronic illness alongside SUD or OUD. The evidence is clear that telehealth for MOUD improves retention and lowers overdose risk, and treatment visits continue to shift toward telehealth rather than back to in-person care. To prevent disruptions in care and rising overdose risk, Congress should extend Medicare's temporary non behavioral telehealth flexibilities and protect access to MOUD and evidence-based SUD services in all settings. This brief outlines how the current policies developed, what will change if Congress does not act, the implications for patients and providers and the steps policymakers can take now to strengthen access, stability and progress in overdose prevention.

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Global Health Advocacy Incubator
Changing Policies to Save Lives

This document was prepared by the Global Health Advocacy Incubator Overdose Prevention Initiative, for more information visit advocacyincubator.org.

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