



REPORT

Progress and Gaps in Medicaid Coverage of Telehealth Medication Abortion Services in Six States



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Dana Northcraft (RHITES),
Fabiola Carrión, and Manatt Health.**

Author: Cat Duffy



Introduction

The COVID-19 pandemic inadvertently resulted in a revolution in health care service delivery, as mandatory quarantines and social distancing requirements caused health care providers and patients to rely on telehealth in lieu of face-to-face interactions on an unprecedented scale. As millions of Americans depended on telehealth to obtain care, states across the country took action to expand telehealth access by improving insurance coverage, including coverage mandates, payment parity requirements, and other changes to remove barriers to telehealth service delivery.

The revolution in telehealth and insurance coverage (in conjunction with key changes in federal and state policy) holds immense potential for expanding abortion access by eliminating or greatly reducing costs often associated with seeking an abortion. These costs can include significant travel distances, transportation and lodging expenses, child care, lost wages, and more. The new access opportunities created by telehealth service delivery are paramount now that the Supreme Court ruling in *Dobbs v Jackson Women's Health Organization* has overturned *Roe v. Wade* and eliminated the constitutional right to abortion. This ruling has opened the floodgates to extreme bans and restrictions, further gutting abortion access across the United States and overburdening provider networks that were already stretched thin. While telehealth delivery of medication abortion cannot remedy the abortion access crisis, it can help reduce barriers and improve access to care, particularly for those in rural areas, people with low incomes, and other populations that face systemic barriers to care.

This issue brief examines the Medicaid telehealth coverage policies in six key states (Alaska, Connecticut, Hawaii, Maine, Montana, Oregon) as case studies for understanding how the Medicaid telehealth coverage landscape has changed and hopefully improved access to medication abortion. It first provides an overview of relevant policies and issues including background on medication abortion, models of telehealth service delivery and their benefits, state and federal barriers to telehealth medication abortion (TMAB), and Medicaid coverage of abortion and telehealth. It then explains the methodology used in the research phase of this project, including an explanation of how states were selected, what materials and data sources were examined, and the policies identified for investigation. The issue brief provides an analysis of the major trends in Medicaid TMAB coverage, including areas of improvement and remaining gaps, before presenting a series of general recommendations states could pursue in order to further improve Medicaid coverage of telehealth delivery of medication abortion services. It concludes with a discussion of Medicaid TMAB coverage as a health

equity issue in the post-*Dobbs* world and opportunities for further expanding access to medication abortion via telehealth.

While we believe this report provides a comprehensive overview of the Medicaid telehealth for medication abortion care coverage landscape, we also know that there are often differences between what a statute says and how it is implemented on the ground. If you have observed significant discrepancies with information we present in this report, please reach out to Cat Duffy (duffy@healthlaw.org) as NHeLP would be very interested in working with advocates to remedy any coverage gaps that have arisen.¹

Medication Abortion, Telehealth, and Medicaid: Understanding the Basics

Medication Abortion and Telehealth: An Overview

MEDICATION ABORTION: A SAFE AND COMMON INTERVENTION

Medication abortion (MAB) involves taking two medications, first one dose of mifepristone, which blocks progesterone, a hormone needed to maintain a pregnancy, followed by a dose of misoprostol. This dose is taken roughly 24-48 hours later and causes the uterus to empty.² Medication abortion is extremely safe and common and its use has increased quickly since the U.S. Food and Drug Administration (FDA) approved mifepristone in 2000. 2020 marked the first time that medication abortion accounted for over half of all abortions obtained in the United States – a trend that is likely to continue, particularly given the shifts in telehealth service delivery.³ Studies, including one from the National Academies of Science, Engineering, and Medicine, have shown that medication abortion is incredibly safe and highly effective, with a success rate of over 95 percent.⁴

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- 1 The National Health Law Program (NHeLP) is a public interest law firm that protects and expands the health care rights of people with low incomes and other underserved communities. We believe that access to reproductive and sexual health care is critical to a person's overall well-being and health, including equitable abortion access. We apply a reproductive justice framework in our advocacy and analysis, exposing and fighting the systems of oppression that affect a person's ability to make health decisions about their body, sexuality, health, and reproductive future. You can learn more about NHeLP and our equity stance here: <https://healthlaw.org/equity-stance/>.
 - 2 See Am. C. Obstet. & Gynecol., *Clinical Guidance Practice Bulletin, Medication Abortion Up to 70 Days of Gestation* (Oct. 2020), <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-of-gestation> (last visited Oct. 5, 2022).
 - 3 Rachel Jones et al., *Medication Abortion Now Accounts for More Than Half of All US Abortions*, Guttmacher Inst. (Feb. 2022), <https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions>.
 - 4 See Nat. Acad. Sci., Engineering & Med., *The Safety and Quality of Abortion Care in the United States*, <https://www.nap.edu/read/24950/chapter/4> (last visited Oct. 5, 2022). See also, ANSIRH, *Safety and Effectiveness of First-Trimester Medication Abortion in the United States* (Aug. 2016), <https://www.ansirh.org/sites/default/files/publications/files/medication-abortion-safety.pdf> (last visited Oct. 5, 2022).

TELEHEALTH MEDICATION ABORTION SERVICE DELIVERY MODELS

Telehealth medication abortion (TMAB) generally refers to the use of telehealth for some or all of the interactions between a provider and a patient for abortion care. Prior to the pandemic, abortion providers primarily used a site-to-site TMAB model, where the provider and patient were located at different clinical locations while using a secure video-conferencing platform for patient counseling, medication administration or dispensing, or to supervise medication consumption, depending on the state's restrictions and due to federal restrictions that were in place at the time.⁵ Direct-to-patient TMAB uses synchronous or asynchronous telehealth platforms for patient screening and counseling and mail delivery for sending the medication abortion pills to the patient directly. While both of these models can involve sending the patient to a local health care provider to obtain any clinically indicated lab tests or ultrasonography, a myriad of studies have examined the direct-to-patient model and found it to be extremely safe and effective.⁶

BENEFITS OF USING TELEHEALTH IN MEDICATION ABORTION CARE

Telehealth delivery of abortion services has many benefits, for both individual patient experience and abortion access as a whole. Expanded use of TMAB can help to shore up

- 5 The Gynuity TelAbortion study was the only exception to this prior to the pandemic. The TelAbortion study uses a direct-to-patient TMAB model, which uses synchronous video conferencing for patient counseling and mail delivery for sending patients the mifepristone and misoprostol. See Medical Abortion, Gynuity Health Proj., <https://gynuity.org/programs/medical-abortion> (last visited Oct. 5, 2022).
- 6 See Ushma Upadhyay et al., *Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study*, 182 JAMA INT. MED. 5 (2022), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2790319>; Courtney Kerestes et al., *Provision of Medication Abortion in Hawai'i During COVID-19: Practical Experience with Multiple Care Delivery Models*, 104 CONTRACEPTION 1 (2021), [https://www.contraceptionjournal.org/article/S0010-7824\(21\)00097-4/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(21)00097-4/fulltext); Ushma Upadhyay et al., *Safety and Efficacy of Telehealth Medication Abortions in the US During the COVID-19 Pandemic*, 4 JAMA NETWORK OPEN 8 (2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2783451?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=082421.

Modality Definitions

Synchronous Video Interactions

This modality uses a secure live video platform for interactions between a patient and a provider. It represents the most commonly covered modality and often what people think of when considering telehealth service delivery.

Synchronous Audio-Only Interactions

This modality uses real-time audio-only interactions between a patient and provider (such as telephone calls using a secure audio conferencing platform). Coverage of this modality is essential for people who have limited access to broadband which makes video interactions inaccessible.

Store-And-Forward (Asynchronous)

This is a type of health care delivery that allows patients to use pictures, dynamic intake forms, direct messaging, and more to receive care in non-real-time interactions.

Remote Patient Monitoring

This modality uses telehealth technologies to collect medical data, such as vital signs and blood pressure, from a patient in order to electronically transmit that information to providers to assist treatment.

access gaps. Even prior to *Dobbs* and the subsequent closure of over 60 abortion providing health centers, data showed that eighty-nine percent of counties in the United States did not have an abortion provider.⁷ In the South and Midwest, over fifty percent of women lived in a county with no health center that offered abortion services.⁸ People living in rural areas often face long travel distances to the nearest abortion provider, increasing the time and resources necessary to access care.⁹ Telehealth service delivery can expand access and reduce the barriers for people living in rural areas or in areas with no abortion provider by eliminating the need for in-person interaction with a provider. Even if lab tests or ultrasounds are clinically indicated, a hybrid model of telehealth could be used to allow patients to obtain those services at a local health center as opposed to traveling to the abortion provider. The elimination of the need to travel potentially hundreds of miles to the nearest abortion provider could help people who have limited mobility or live in areas with minimal or no public transportation.

Expanded use of telehealth can reduce delays and improve access to early abortion care.¹⁰ Timely access to care is essential because, while abortion is extremely safe at any point during pregnancy, abortion care becomes more expensive and more complicated as a patient gets further into their pregnancy.¹¹ It also increases the likelihood that they may run into a state's gestational age limit. Telehealth models that utilize a history-based screening in lieu of laboratory testing or ultrasonography not only reduce travel times for patients but can expand the provider network to include those who may want to provide abortion services but do not

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- 7 Marielle Kirstein et al., *100 Days Post-Roe: At Least 66 Clinics Across 15 US States Have Stopped Offering Abortion Care*, Guttmacher Inst. (Oct. 2022), <https://www.guttmacher.org/2022/10/100-days-post-roe-least-66-clinics-across-15-us-states-have-stopped-offering-abortion-care> (last accessed 10/17/22); Rachel Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, Guttmacher Inst. (Sept. 2019), <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>.
- 8 NHeLP recognizes that in addition to cis-women, trans, intersex, genderfluid, and gender nonconforming individuals may experience pregnancy, and that all people have reproductive health needs. In this issue brief and throughout our policy advocacy, education, and litigation, we use the words “woman” or “women” to conform with statutory or regulatory language or when needed to accurately reflect the scope of research that focuses solely on women. See Rachel Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, Guttmacher Inst. (Sept. 2019), <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>.
- 9 Jonathan Bearak et al., *Disparities and Change Over Time in Distance Women Would Need to Travel to Have an Abortion in the USA: A Spatial Analysis*, 2 THE LANCET 11, (Nov. 2017), [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(17\)30158-5/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(17)30158-5/fulltext); Ushma Upadhyay et al., *Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study*, 182 JAMA INT. MED. 5 (2022), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2790319>.
- 10 See Am. C. Obstet. & Gynecol., *Clinical Guidance Practice Bulletin, Medication Abortion Up to 70 Days of Gestation* (Oct. 2020), <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-of-gestation> (last visited Oct. 5, 2022).
- 11 Ushma Upadhyay et al., *Trends In Self-Pay Charges And Insurance Acceptance For Abortion In The United States, 2017–20*, 41 HEALTH AFFAIRS 4 (April 2022), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01528>.

have access to ultrasound technology, like primary care clinicians.¹² Furthermore, allowing patients to obtain care in their home or any other place of their choice can help resolve privacy concerns, as traveling to a health center or a provider's office can expose people to anti-abortion protestors and stigma they may face outside of these locations.

TELEHEALTH EQUITY CONCERNS

While telehealth holds the potential to improve access for people who face structural barriers to care, it is important to note that it is not a panacea and has the potential to exacerbate other existing inequities unless expanded within a health equity framework. For example, data on telehealth utilization has shown that there are significant demographic differences in terms of audio vs video telehealth use, with Latine, Asian, and Black individuals, people without a high school diploma, and adults over 65 having the lowest rates of video telehealth usage.¹³ Coverage policies that require the use of live video in service delivery can make telehealth inaccessible for people with limited access to broadband and devices. This disproportionately impacts communities of color that face chronic underinvestment as the result of digital redlining.¹⁴ Insufficient support for interpretation services or education on how to use telehealth platforms can compound access barriers for people with limited English proficiency or low digital literacy. Telehealth may open new opportunities for expanding access to health care, including abortion services, but these policies must be crafted intentionally to ensure equitable access.¹⁵

Obstacles to TMAB Expansion

STATE BARRIERS: LEGISLATIVE RESTRICTIONS ON TMAB

These evolutions in TMAB service delivery present an exciting opportunity for expanding abortion access, but state-level abortion restrictions create significant hurdles, depending on the state. Nineteen states have enacted laws that prohibit telehealth abortion service delivery, either explicitly banning the use of telehealth in abortion services or doing so implicitly by

12 Ushma Upadhyay et al., *Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study*, 182 JAMA INT. MED. 5 (2022), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2790319>; Elizabeth Raymond et al., *Commentary: No-test Medication Abortion: A Sample Protocol for Increasing Access During a Pandemic and Beyond*, 101 CONTRACEPTION 6 (2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7161512/>.

13 Madjid Kirimi et al., *National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services*, ASPE Office of Health Policy Issue Brief, (Feb. 2022), <https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf>.

14 See Terri-Ann Thompson, Dana Northcraft & Fabiola Carrión, *Addressing Structural Inequities, a Necessary Step Toward Ensuring Equitable Access to Telehealth for Medication Abortion Care During and Post COVID-19*, 3 FRONTIERS IN GLOBAL WOMEN'S HEALTH (2022), <https://www.frontiersin.org/articles/10.3389/fgwh.2022.805767/full>.

15 If you are interested in learning more about the intersection of telehealth, reproductive health care, and health equity, please refer to the work being done by RHITES (Reproductive Health Initiative for Telehealth Equity & Solutions) at <https://www.rhites.org>.

requiring the provider to be physically in the presence of the patient.¹⁶ Outside of these bans, there are many types of policies that can create barriers to the use of telehealth in medication abortion care, ranging from telehealth regulations around scope of practice, and payment parity to abortion restrictions on eligible providers, clinic requirements, and more.

State policies to restrict access to medication abortion have increased dramatically over the last two state legislative sessions, as hostile state legislatures have introduced a slew of different restrictions, including mail delivery bans, complete medication abortion bans, and more.¹⁷ In 2021 alone, six states banned mail delivery of medication abortion and four states enacted gestational age limits (between seven and ten weeks depending on the state), in addition to other assorted restrictions. We expect to see a continuation of these trends in the 2023 state legislative session, as anti-abortion state legislators, emboldened by the *Dobbs* decision, will likely introduce new bans and restrictions to further eliminate access.

FEDERAL BARRIERS: THE FDA MIFEPRISTONE REMS

Federal policy has also historically constrained access to medication abortion via telehealth. The FDA implemented a Risk Evaluation and Mitigation Strategy (REMS) – a drug safety program only implemented for “certain medications with serious safety concerns” – for Mifeprex (the brand name version of mifepristone) in 2011. The initial mifepristone REMS included a series of onerous and medically unnecessary restrictions, including instituting an in-person dispensing requirement (although the FDA allowed the drug to be administered at home), requiring providers to become certified by submitting a Prescriber Agreement Form to the drug’s distributor, and requiring patients to do wet signatures and providers to maintain the FDA-approved Patient Agreement Form.¹⁸

The mifepristone REMS effectively banned the use of direct-to-patient telehealth in service delivery for years until the COVID-19 pandemic. While other health care providers could shift interactions with their patients to telehealth platforms from the beginning of the pandemic, the REMS made it impossible for abortion providers to utilize telehealth to minimize in-person

16 Guttmacher Inst., *Medication Abortion*, (as of Sept. 1, 2022), <https://www.guttmacher.org/state-policy/explore/medication-abortion> (last accessed 10/14/22).

17 See Elizabeth Nash, *State Policy Trends 2021: The Worst Year for Abortion Rights in Almost Half a Century*, Guttmacher Inst. (Dec. 2021), <https://www.guttmacher.org/article/2021/12/state-policy-trends-2021-worst-year-abortion-rights-almost-half-century>; Elizabeth Nash et al., *2022 State Legislative Sessions: Abortion Bans and Restrictions on Medication Abortion Dominate*, Guttmacher Inst. (Mar. 2022), <https://www.guttmacher.org/article/2022/03/2022-state-legislative-sessions-abortion-bans-and-restrictions-medication-abortion>.

18 For clarity, this issue brief exclusively uses the terminology “mifepristone REMS,” although the initial REMS program was approved exclusively for Mifeprex, the name brand version of mifepristone manufactured by Danco Laboratories. In 2019, the FDA established one shared system REMS for mifepristone products, to include both Mifeprex and the generic version, mifepristone. See Food & Drug Admin., *Questions and Answers on Mifeprex*, <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex> (last visited Oct. 14, 2022); Food & Drug Admin., *Risk Evaluation and Mitigation Strategies, REMS*, <https://www.fda.gov/drugs/drug-safety-and-availability/risk-evaluation-and-mitigation-strategies-rems> (last visited Oct 5. 2022).

interactions to protect patients' health and preserve then-limited personal protective equipment. As a result, the American College of Obstetricians and Gynecologists (ACOG) brought a lawsuit to challenge the mifepristone REMS, which succeeded in obtaining a preliminary injunction to block enforcement of the in-person dispensing requirement in July 2020.¹⁹ This injunction permitted abortion providers to use telehealth for medication abortion service delivery (as allowed by state law) until it was lifted by the Supreme Court in the beginning of 2021.

The FDA sent a letter to ACOG in April 2021 announcing that it was temporarily suspending enforcement of the in-person dispensing requirement and would allow mail delivery of mifepristone for the duration of the public health emergency.²⁰ In December 2021, the FDA announced permanent changes to the REMS, including removing the in-person dispensing restriction and allowing all pharmacists to dispense mifepristone if they become certified. The permanent lifting of the in-person dispensing requirement removes a major federal barrier to telehealth delivery of abortion services. The FDA has yet to issue final guidance on the new retail pharmacist certification process, but opening the door to pharmacist dispensing (and prescribing) could bolster provider networks in abortion access deserts.²¹ Overall, the new flexibilities afforded by these changes to the mifepristone REMS open the door to significant expansions in access to medication abortion via telehealth.

Medicaid Coverage of Abortion and Telehealth

Insurance coverage of abortion services is essential to ensure equitable access, but a federal congressional budget rider called the Hyde Amendment limits the use of federal funding to only cases of rape, incest, and life endangerment. The Hyde Amendment functions as a de facto abortion ban for Medicaid beneficiaries, unless they live in one of the 16 states that use state funds to cover abortions in all instances for residents enrolled in Medicaid. In states that do not provide this coverage, Medicaid enrollees seeking an abortion are forced to pay out-

19 A judge for the U.S. District Court for the District Court of Maryland granted the preliminary injunction against the FDA's enforcement of the in-person dispensing requirement, ruling that the mifepristone REMS placed an undue burden on patients' constitutional right to abortion and put the health and economic stability of both patients and health care workers at risk. This injunction remained in effect until January 12, 2021, when the Supreme Court stayed the injunction at the request of the Trump administration. See *Am. C. of Obstetricians & Gynecologists et al. v. U.S. Food & Drug Admin.*, No. 90 (D. Md. Jul. 13, 2020) (order granting preliminary injunction); *Food & Drug Admin. v. College of Obstetricians & Gynecologists et al.*, No. 20A34 (592 U.S. Jan. 12, 2021) (order granting application for stay).

20 Food & Drug Admin, Letter to ACOG and SMFM on Updates to Mifepristone REMS, (Apr. 2021), <https://www.aclu.org/letter/fda-response-acog-april-2021>.

21 See Liz McCaman Taylor & Cathren Cohen, *Medicaid Coverage of Advanced Practice Prescribing for Reproductive & Sexual Health Medications*, Nat'l Health Law Prog. (May 2022), <https://healthlaw.org/wp-content/uploads/2022/05/Medicaid-SOP-RSH.pdf>; Shelly Kaller et al., *Pharmacists' Knowledge, Perspectives, and Experiences with Mifepristone Dispensing for Medication Abortion*, 61 J. Am. PHARM. ASSOC. (2021), [https://www.japha.org/article/S1544-3191\(21\)00285-5/pdf](https://www.japha.org/article/S1544-3191(21)00285-5/pdf); Daniel Grossman & Philip Goldstone, *Mifepristone by Prescription: A Dream in the United States but Reality in Australia*, 92 CONTRACEPTION 3 (2015), 186-189.

of-pocket, with the average costs ranging from \$500 to well over \$1000.²² This kind of out-of-pocket cost can be catastrophic for people with low incomes or may force people to spend time collecting the money they need to pay for their care, pushing them further into their pregnancy and escalating the costs.²³

While federal law limits Medicaid abortion coverage overall, the Medicaid Act does not differentiate between medication or procedural abortions for coverage purposes.²⁴ In fact, it requires states to cover all outpatient drugs from any manufacturer participating in the Medicaid Drug Rebate Program, since all 50 states and territories have chosen to participate in the optional prescription drug benefit.²⁵ Danco Laboratories and GenBioPro, the manufacturers of mifepristone, each have a Medicaid rebate agreement in place, which means all states must cover mifepristone.²⁶

The COVID-19 pandemic spurred a dramatic increase in the use of telehealth in the United States, a trend that holds true for individuals enrolled in Medicaid. A Government Accountability Office (GAO) study of changes in telehealth utilization at the beginning of the pandemic found an exponential increase in the number of Medicaid beneficiaries that used telehealth to receive some form of care.²⁷ Similarly, a 2021 national survey found that telehealth utilization was highest for the Medicaid subgroup, however, racial disparities in utilization rates persist.²⁸ In response to the service delivery shifts, the Centers for Medicare

22 Ushma Upadhyay et al., *Trends In Self-Pay Charges And Insurance Acceptance For Abortion In The United States, 2017–20*, 41 HEALTH AFFAIRS 4 (2022), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01528>.

23 See Carmela Zuniga et al., *Abortion as a Catastrophic Health Expenditure in the United States*, 30 WOMEN'S HEALTH ISSUES 6, (2020), 416-425. <https://www.sciencedirect.com/science/article/abs/pii/S1049386720300669>

24 While federal law requires state Medicaid programs to cover medication abortion, a 2019 GAO report found numerous violations, as 13 states and the District of Columbia reported that they did not cover mifepristone. In response, the National Health Law Program partnered with state advocates to send letters to all states that were out of compliance. See Fabiola Carrión, *When States Fail to Cover Abortions under Medicaid, NHeLP Steps In*, Nat'l Health Law Prog. (Dec. 5, 2019), <https://healthlaw.org/when-states-fail-to-cover-abortions-under-medicaid-nhelp-steps-in/>; U.S. Gov't Accountability Off. (GAO), GAO-19-159, CMS Action Needed to Ensure Compliance with Abortion Coverage Requirements 15–26 (2019).

25 Generally, states must cover outpatient prescription drugs made by a manufacturer with a rebate agreement in place as long as the drugs are used for a medically accepted indication; 42 U.S.C. § 1396r-8(d).

26 See, HCFA, Dear State Medicaid Director Letter (Mar. 30, 2001), <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd033001.pdf> (informing states that the manufacturer of Mifeprex has entered into a rebate agreement with the federal government, and as a result, states must cover the drug); CMS, Drug Products in the Medicaid Drug Rebate Program, (Aug. 2022), <https://data.medicaid.gov/dataset/0ad65fe5-3ad3-5d79-a3f9-7893ded7963a> (last visited 10/31/22).

27 U.S. Gov't Accountability Off. (GAO), *CMS Should Assess Effect of Increased Telehealth Use on Beneficiaries' Quality of Care* (Mar. 2022), <https://www.gao.gov/products/gao-22-104700>.

28 Madjid Kirimi et al., *National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services*, ASPE Office of Health Policy Issue Brief (Feb. 2022), <https://aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf>.

and Medicaid Services (CMS) issued guidance to states to facilitate “efforts to expand the use of telehealth services in Medicaid programs” and emphasized the significant flexibilities afforded to states in determining coverage.²⁹ Many states did enact a series of policy changes – some temporary, some permanent – in order to facilitate telehealth coverage in Medicaid and this report will examine how those changes impact medication abortion service delivery coverage and analyze remaining gaps that must be addressed in order to ensure telehealth is utilized to its full potential.

Methodology

State Selection

This project examined the policies impacting coverage of telehealth and abortion services in the Medicaid programs in six key states: Alaska, Connecticut, Hawaii, Maine, Montana, and Oregon. We limited the pool of eligible states for selection to the 16 states that cover abortions for Medicaid beneficiaries with state funds. Within that subset, those states are largely located on either coast and generally support reproductive freedom. Within those 16 states, we chose these six to maximize both the geographic and political diversity to develop a more holistic and comprehensive view of the Medicaid telehealth coverage landscape. For example, while a court ruling compels the Montana Medicaid program to provide abortion coverage, post-*Dobbs* access analyses predict that Montana will be one of the states that will restrict abortion access in the next year.³⁰ As non-contiguous states, Hawaii and Alaska both introduce unique access challenges that potentially make telehealth service delivery a vital strategy for overcoming geographic isolation and provider shortages.

Within these six states, we conducted an in-depth analysis of all relevant state statutes, regulations, and court rulings that impact either abortion or telehealth policy in the state. We also examined state Medicaid agency materials, including provider manuals, fee schedules, bulletins, and other guidance issued by state agencies, since these materials can provide critical insight into policy implementation. When relevant, we also examined policies and guidance issued from other non-Medicaid entities that impact the regulation of telehealth, such as state medical boards.³¹ While we strove to capture a comprehensive understanding of the TMAB coverage landscape, we recognize that there is often a difference in what a statute or regulation says and how it is actually interpreted or implemented on the ground. This could

29 See CMS, State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth (COVID-19 Version), <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf> (last visited 10/17/22).

30 *Jeanette R. v Ellery*, No. BDV-94-811 (Mont. Dist. Ct. filed June 1, 1994); Elizabeth Nash & Lauren Cross, *26 States Are Certain or Likely to Ban Abortion Without Roe: Here's Which Ones and Why*, Guttmacher Inst. (Oct. 2021), <https://www.guttmacher.org/article/2021/10/26-states-are-certain-or-likely-ban-abortion-without-roe-heres-which-ones-and-why> (last visited 10/17/22).

31 See Trisha Pasricha, *State medical boards may be roadblock to wider telemedicine abortion*, Stat News, (Oct. 7, 2022), <https://www.statnews.com/2022/10/07/telemedicine-abortion-roadblock-state-medical-boards/>.

be true for the states we examined, as there were instances where some states' telehealth policies were silent on certain issues or had broad definitions that could be interpreted in a variety of ways that may impact insurance coverage. If there are significant discrepancies with the trends we describe in this report, NHeLP would be very interested in working with advocates to remedy any coverage issues that have arisen.

Policy Categories

In order to ensure a thorough understanding of the policy landscape impacting telehealth service delivery of medication abortion for Medicaid beneficiaries, we examined six key policy arenas that are major factors in impacting coverage: how telehealth and different modalities are defined for coverage purposes, payment parity requirements, sites of care, establishing a patient-provider relationship for the purposes of telehealth reimbursement, eligible Medicaid providers, and reimbursement models.

TELEHEALTH DEFINITIONS AND COVERED MODALITIES

We examined how each state defined telehealth and/or telemedicine, including what modalities were included, for the purposes of Medicaid coverage. The COVID-19 pandemic caused many states to reconsider how they defined telehealth, in particular whether or not they considered the audio-only modality to be a covered service.³² Coverage of audio-only is vital for equitable access, as Medicaid enrollees often lack reliable broadband services.³³

Payment Parity

Many states established payment parity for telehealth services within their Medicaid programs during the COVID-19 pandemic, meaning that the Medicaid agency would reimburse providers who deliver services via telehealth at the same rate as providers who saw patients in person for those same services. Ensuring telehealth providers receive equivalent reimbursement is crucial to facilitate telehealth service delivery. This is particularly true for abortion services, where providers already face low reimbursement rates.³⁴ We investigated each state's payment parity policy and what modalities, if any, are reimbursed at parity.

Sites of Care

One major shift resulting from policy changes in response to the COVID-19 pandemic revolved around how states defined originating sites (where the patient is located during the time of service) and distant sites (where the provider is located during the time of service).

32 Kathleen Gifford et al., *States Respond to COVID-19 Challenges but Also Take Advantage of New Opportunities to Address Long-Standing Issues: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2021 and 2022*, Kaiser Family Found. (Oct. 2021), <https://www.kff.org/report-section/states-respond-to-covid-19-challenges-but-also-take-advantage-of-new-opportunities-to-address-long-standing-issues-benefits-and-telehealth/>.

33 Rob Houston & Matthew Ralls, *The Doctor Will Hear You Now: Audio-Only Telehealth and the Promise of Access, Equity, and Engagement in Medicaid*, Center for Health Care Strategies (Mar. 2022), <https://www.chcs.org/the-doctor-will-hear-you-now-audio-only-telehealth-and-the-promise-of-access-equity-and-engagement-in-medicaid/>.

34 Yves-Yvette Young et al., *Contextualizing Medicaid reimbursement rates for abortion procedures*, 102 CONTRACEPTION 3, 195 (2020).

Prior to the pandemic, many states did not define an originating site to include a patient's home or the patient's location generally.³⁵

Establishing a Patient-Provider Relationship

One common policy prior to the COVID-19 pandemic that impeded TMAB delivery in particular was the requirement that providers must see a patient in-person in order to establish a patient-provider relationship prior to delivering services via telehealth.³⁶ Studies of the direct-to-patient TMAB model show that fully remote models using a history-based screening are extremely safe and effective, indicating that policies requiring an in-person interaction function as medically unnecessary barriers.³⁷

Any in-person requirement would present a barrier to telehealth abortion providers that do not have a brick-and-mortar facility in a state from seeking reimbursement for services, meaning the patient would be forced to pay out-of-pocket or the provider would have to absorb the cost. Additionally, abortion stigma has resulted in the siloing of this care, which means many patients seeking an abortion are unlikely to have a pre-existing relationship with an abortion provider.

Eligible Providers

During the COVID-19 pandemic, states made a series of changes (some temporary, some permanent) to policies that determined what providers could participate in a state's Medicaid program and deliver services via telehealth.³⁸ We examined what types of providers are authorized to provide telehealth services in a state's Medicaid program and if a state imposed any restrictions on non-physician providers who may provide abortion services, like nurse practitioners, midwives, physician assistants, etc. Furthermore, we reviewed whether or not the state had an explicit policy allowing out-of-state providers to furnish services to Medicaid enrollees.

35 Jenna Libersky et al., *Changes in Medicaid Telehealth Policies Due to COVID-19: Catalog Overview and Findings*, Mathematica (Jun. 2020), <https://www.macpac.gov/wp-content/uploads/2020/06/Changes-in-Medicaid-Telehealth-Policies-Due-to-COVID-19-Catalog-Overview-and-Findings.pdf>.

36 Jack Pitsor & Sydne Enlund, *States Turn to Telehealth During the Pandemic*, Nat'l Conf. of State Leg. (Oct. 2020), <https://www.ncsl.org/research/health/states-turn-to-telehealth-during-the-pandemic-magazine2020.aspx>

37 See Ushma Upadhyay et al., *Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study*, 182 JAMA INT. MED. 5 (2022), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2790319>; Ushma Upadhyay et al., *Safety and Efficacy of Telehealth Medication Abortions in the US During the COVID-19 Pandemic*, 4 JAMA NETWORK OPEN 8 (2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2783451?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=082421; Courtney Kerestes et al., *Provision of Medication Abortion in Hawai'i During COVID-19: Practical Experience with Multiple Care Delivery Models*, 104 CONTRACEPTION 1 (2021), [https://www.contraceptionjournal.org/article/S0010-7824\(21\)00097-4/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(21)00097-4/fulltext); Elizabeth Raymond et al., *TelAbortion: evaluation of a direct to patient telemedicine abortion service in the United States*, 100 CONTRACEPTION 3 (2019), p 173-177.

38 Madeline Guth & Elizabeth Hinton, *State Efforts to Expand Medicaid Coverage & Access to Telehealth in Response to COVID-19*, Kaiser Family Found. (June 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/state-efforts-to-expand-medicare-coverage-access-to-telehealth-in-response-to-covid-19/>.

Reimbursement Models

We examined how each state approaches reimbursement for medication abortion. We were interested in whether or not states use the S0199 bundled payment code that allows providers to receive reimbursement for the comprehensive set of services associated with medication abortion. In particular, we investigated whether states made bundled payment contingent on the provision of particular services, including whether or not providers must perform an ultrasound in order to use the bundled code.

Results: Trends and Gaps in State Telehealth Policies

Covered Modalities and Payment Parity

States made major improvements in Medicaid telehealth coverage, expanding the types of covered modalities and establishing payment parity for telehealth services. Five of the six states we examined included coverage for both live video and audio-only synchronous modalities. The notable exception was Hawaii, where Medicaid coverage of telehealth does not include audio-only services despite the unique access challenges facing the remote island state.

We also examined each state's payment parity policies for covered telehealth services, because mandating coverage of a particular modality does not necessarily require payers to reimburse providers at the same rate as they would for services provided in person. Every state included in this analysis established payment parity for telehealth delivery of services in Medicaid, typically using policy language that reimbursement for services delivered via telehealth should be "equivalent" or "to the same extent" and rate as services provided "in person" or "face-to-face." Five of the six states we examined applied these parity requirements to both live video and audio-only modalities.

Three states (AK, CT, OR) also indicated that payment parity requirements would apply to at least one asynchronous modality, including store-and-forward and/or remote patient monitoring. However, it is unclear how these rates are established since no in-person equivalent exists for these services.

Prior to the pandemic, only a limited number of states had payment parity requirements, meaning providers who did offer services via telehealth were often reimbursed at lower

Overall, the results of our comprehensive survey of the TMAB coverage and reimbursement landscapes in the six target states revealed a lot of positive policy changes that improved Medicaid coverage of telehealth service delivery. However, there still exists substantial room for improvement in ensuring equitable access to TMAB through comprehensive Medicaid coverage, but the dimensions of improvement varied between states.

rates.³⁹ Payment parity requirements are uniquely important for Medicaid abortion providers, as those providers already face unsustainable reimbursement rates that often do not cover the cost of care.⁴⁰ If states allow payers to reimburse telehealth service delivery at lower rates, it creates a disincentive for abortion providers, who already often receive insufficient reimbursement, to provide services via telehealth.

Sites of Care

States made significant improvements in expanding access to care via telehealth by redefining sites of care. All states now allow patients to receive telehealth services in their home. This represents a major advancement in Alaska, Connecticut, and Maine, which previously restricted the sites of care to providers' offices.⁴¹ Allowing patients to receive telehealth services in their home is crucial for direct-to-patient models of TMAB and eliminating the need to travel to a clinical location can alleviate privacy and safety concerns stemming from stigma associated with seeing an abortion provider.⁴²

Four states (AK, CT, HI, ME) went further to broadly define the originating site as the place where the patient is located.⁴³ Allowing Medicaid beneficiaries to receive telehealth services from the location of their choice is the gold standard, as it maximizes flexibility, privacy, and patient choice. In this model, patients who may lack the privacy or safety to access services from their home have the ability to receive services from their car, work, or other private location. It may also facilitate faster access to care by allowing patients to schedule the earliest available appointment, which, for example, might be during a work break.⁴⁴

Sites of Care

- **Originating Site**
the location of the patient
- **Distant Site**
the location of the provider

39 Gabriela Weigel et al., *Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond*, Kaiser Family Found. (May 2020), <https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/>.

40 See Yves-Yvette Young et al., *Contextualizing Medicaid reimbursement rates for abortion procedures*, 102 *CONTRACEPTION* 3, 195 (2020).

41 Jenna Libersky et al., *Changes in Medicaid Telehealth Policies Due to COVID-19: Catalog Overview and Findings*, Mathematica (Jun. 2020), <https://www.macpac.gov/wp-content/uploads/2020/06/Changes-in-Medicaid-Telehealth-Policies-Due-to-COVID-19-Catalog-Overview-and-Findings.pdf>.

42 Katherine Ehrenreich & Daniel Grossman, *Women's Experiences Using Telemedicine to Attend Abortion Information Visits in Utah: A Qualitative Study*, 29 *WOMEN'S HEALTH ISSUES* 5, (Sept.-Oct. 2019) 407-413, <https://www.sciencedirect.com/science/article/pii/S104938671830598X>.

43 We found no definition for an originating site in Oregon, but telehealth regulations declare that a patient "may be located in the community, or in a health care setting." At minimum this includes the patient's home but likely can be interpreted broadly as the location of the patient, but there is ambiguity around what constitutes "the community." Or. Admin. R. 410-120-1990.

44 Katherine Ehrenreich & Daniel Grossman, *Women's Experiences Using Telemedicine to Attend Abortion Information Visits in Utah: A Qualitative Study*, 29 *WOMEN'S HEALTH ISSUES* 5, (Sept.-Oct. 2019) 407-413, <https://www.sciencedirect.com/science/article/pii/S104938671830598X>.

Establishing a Patient-Provider Relationship

Prior to the COVID-19 pandemic, many states required an in-person interaction to establish a patient-provider relationship before a provider could use telehealth to deliver services. Data shows that the majority of abortions (sixty percent) provided in the United States occur in specialized clinics that focus on abortion care – only five percent occurred in hospitals or private physicians’ offices.⁴⁵ Therefore, such a requirement effectively bans telehealth for medication abortion care except for those patients who happened to have a pre-existing relationship with an abortion provider.⁴⁶

Oregon and Hawaii were the only states to have explicit Medicaid policies that allow providers to use telehealth to establish a patient-provider relationship, which we have interpreted to authorize the use of all covered modalities in each state.⁴⁷ However, Hawaii’s statutory language is specific to physicians, which may create obstacles for advanced practice clinicians (APCs) who are authorized provide abortion services in the state.

In Alaska, Maine, and Montana, we found no Medicaid policy on the use of telehealth for establishing a patient-provider relationship. Nevertheless we did find guidance from either the state’s medical board or professional licensing board that outlined the conditions under which telehealth may be used to establish a patient-provider relationship.⁴⁸ In all three states, however, this guidance was specific to physicians, which may create obstacles for expanding TMAB access in Maine and Montana, as both states authorize APCs to provide medication abortion.⁴⁹ In Alaska, APCs are currently allowed to provide medication abortion thanks to a court ruling in 2021, however, the state’s medical board guidance on telehealth includes explicit restrictions on the ability of physician assistants to prescribe, dispense, or furnish prescription medication, requiring either an in-person examination or a pre-existing patient

45 Rachel Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, Guttmacher Inst. (Sept. 2019), <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>.

46 Jack Pitsor & Sydne Enlund, *States Turn to Telehealth During the Pandemic*, Nat’l Conference of State Leg. (Oct. 2020), <https://www.ncsl.org/research/health/states-turn-to-telehealth-during-the-pandemic-magazine2020.aspx>.

47 In Oregon, telehealth providers “shall provide services via telehealth” including “establishing or maintaining an appropriate provider-patient relationship,” Or. Admin. R. 410-120-1990; In Hawaii, “the physician-patient relationship may be established via a telehealth interaction,” which is defined as including the four major telehealth modalities: live video consultation, store-and-forward, remote patient monitoring, and mobile health, Haw. Rev. Stat. § 453-1.3.

48 See Alaska St. Med. Board, *Telemedicine Policies and Procedures (Jan. 2011)*, https://www.commerce.alaska.gov/web/portals/5/pub/MED_Guide_Telemedicine.pdf (last visited 10/5/22); 02 ME Code Rules § 373-6-3, <https://regulations.justia.com/states/maine/02/373/chapter-6/section-373-6-3/>; Mont. Admin. R. 24.156.813, <https://rules.mt.gov/gateway/RuleNo.asp?RN=24%2E156%2E813>.

49 See Guttmacher Institute, *Medication Abortion*, (as of Sept. 1, 2022), <https://www.guttmacher.org/state-policy/explore/medication-abortion> (last accessed 10/14/22).

relationship.⁵⁰ Given the degree to which a prohibition on using telehealth to establish a provider relationship could hinder the provision of TMAB, more clarity is needed from state Medicaid agencies in this arena.

Eligible Providers

In contrast to the ambiguity surrounding establishing a patient-provider relationship, state Medicaid policies clearly outlined the requirements for the types of providers who can use telehealth and seek reimbursement for those services. We found no telehealth specific restrictions on the types of providers who can deliver services and seek reimbursement, as every state allowed any provider enrolled in the Medicaid program and acting within the scope of their license in that state to provide services via telehealth.⁵¹

In analyzing Medicaid telehealth provider rules, we encountered an issue in Oregon that may introduce complications for non-brick-and-mortar abortion providers that exclusively use telemedicine. Oregon's rules require that "providers who offer telemedicine or telehealth delivery of services shall also offer in-person services," in addition to the state's other eligibility requirements.⁵² This rule effectively prohibits virtual-only TMAB providers from seeking reimbursement for services delivered to Medicaid enrollees. At NHeLP, we believe that all patients should have the right to choose between receiving care in person or via telehealth and that neither form of service delivery should be sacrificed in favor of the other.⁵³ However, given the current moment and ever worsening abortion access crisis, it seems important to consider how to craft policies that protect a patient's right to choose their own form of care without inadvertently prohibiting telehealth providers from being able to provide abortion services.

50 In Alaska, advanced practice clinicians are currently allowed to provide medication abortion care, thanks to a preliminary injunction issued by a state Superior Court in Alaska that is blocking enforcement of the state's physician-only law while litigation moves forward. However, this could change depending on the outcome of the lawsuit. *Planned Parenthood Great Northwest, Hawaii, Alaska, Indiana, Kentucky v. State of Alaska, et al.*, Case No 3AN-19-11710CI; Alaska St. Med. Board, *Telemedicine Policies and Procedures* (Jan. 2011), https://www.commerce.alaska.gov/web/portals/5/pub/MED_Guide_Telemedicine.pdf (last visited 10/5/22).

51 Alaska Admin. Code tit. 7, § 110.620; House Bill No. 5596, Pub. Act No. 21-9 (Conn. 2021); Haw. Rev. Stat § 346-59.1; Maine Dept. Health Human Services, *Chapter I - Section 4: Telehealth Services*, <https://www.maine.gov/sos/cec/rules/10/ch101.htm> (last visited 10/5/22); Mont. Code Ann. § 53-6-122; Or. Admin. R. 410-120-1990.

52 Or. Admin. R. 410-120-1990.

53 Nat. Health Law Prog., *Medicaid Principles on Telehealth*, (May 11, 2020), <https://healthlaw.org/wp-content/uploads/2020/05/Medicaid-Telehealth-Principles-FINAL.FORMATTED.pdf>.

Out of State Providers

During the COVID-19 pandemic, all 50 states used flexibilities afforded by Section 1135 waivers to allow out-of-state providers to see patients in one state so long as they were providing services within the scope of their license from another state.⁵⁴ Allowing providers to see patients across state lines represents an important mechanism for bolstering provider networks, particularly for services facing provider shortages, like abortion care.

Montana led the field on this issue as its Medicaid Provider Manual explicitly includes guidance for these providers, describing the licensing and Medicaid enrollment requirements for “out of state distance providers” under its Telemedicine Chapter.⁵⁵ It imposes no other restrictions on out-of-state providers outside of the standard eligibility requirements it maintains for in-state providers. Given Montana’s size and the rural nature of large swaths of the state, it makes sense that the Medicaid agency would seek to maximize its provider network. Oregon allows providers located within 75 miles of the state’s border to be considered as “providing in-state services,” however, this is not specific to telehealth service delivery.⁵⁶ Connecticut allows a “telehealth provider” to furnish services “from any location” so long as they are “appropriately licensed,” enrolled in the Connecticut Medicaid program, and maintain required professional liability insurance.⁵⁷ However, this policy will expire July 2023 unless new legislation is enacted. No other state considered for this brief has an explicit policy on out-of-state providers and we found no major restrictions in any state that would serve as a barrier.

Reimbursement

In reviewing the billing and reimbursement guidance in each state, only one state (Oregon) had public guidance on the use of the S0199 bundled payment code for medication abortions.⁵⁸ In Hawaii, the fee-for-service guidance and fee schedule provided the CPT codes for each service associated with a medication abortion that should be submitted, with no mention of a bundled payment code. In four states (Alaska, Connecticut, Maine, Montana), we found no clear billing guidance for providers when seeking reimbursement for medication abortion care.

54 Jenna Libersky et al., *Changes in Medicaid Telehealth Policies Due to COVID-19: Catalog Overview and Findings*, Mathematica, June 4, 2020, <https://www.macpac.gov/wp-content/uploads/2020/06/Changes-in-Medicaid-Telehealth-Policies-Due-to-COVID-19-Catalog-Overview-and-Findings.pdf>.

55 Mont. Dept. Pub. Health Hum. Services, *General Information for Providers Manual* (February 2020), <https://medicaidprovider.mt.gov/manuals/generalinformationforprovidersmanual#604026797-telemedicine> (last visited 10/19/22).

56 Or. Admin. R. 410-120-1180.

57 HB 5596, Public Act No 21-9, (Conn. 2021).

58 Or. Admin. R. 410-130-0562.

Recommendations

States have made significant progress in improving Medicaid coverage of telehealth services since the outbreak of the COVID-19 pandemic. While we only examined the policy landscape in six key states, we believe the trends identified in this report likely extend to other states that cover all abortions for Medicaid enrollees. While significant progress has been made in facilitating access to TMAB, this section provides general recommendations for policy changes and clarifications states could pursue in order to further improve coverage and access to medication abortion for Medicaid enrollees.

Allow providers to use telehealth to establish a relationship with a new patient

State Medicaid agencies should issue guidance to clearly state that in instances where the standard of care does not require an in-person interaction, a patient-provider relationship can be established via telehealth. This policy should apply to all covered provider types, including but not limited to physicians, nurse practitioners, midwives, physician assistants, and other advanced practice clinicians. Similarly, the best version of this policy will allow the patient-provider relationship to be established via any telehealth modality, unless there is a medical reason to require a particular type of interaction.

This approach to regulating the establishment of a patient-provider relationship is particularly important for telehealth delivery of medication abortion services for two reasons. First, many states (including five of the six states we examined) allow advanced practice clinicians (APCs) to provide medication abortion care, which studies show to be extremely safe.⁵⁹ Additionally, studies show that the direct-to-patient model is just as safe and effective as care delivered with an in-person interaction between a provider and a patient.⁶⁰ APC provision of abortion services is an essential part of the solution to the ongoing abortion provider shortage, which

59 Lauren Porsch et al., *Advanced practice clinicians and medication abortion safety: A 10-year Retrospective Review*, 101 *CONTRACEPTION* 5 (May 2020), [https://www.contraceptionjournal.org/article/S0010-7824\(20\)30119-0/pdf#relatedArticles](https://www.contraceptionjournal.org/article/S0010-7824(20)30119-0/pdf#relatedArticles); Tracy Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 *AM. J. PUB. HEALTH* 3 (Feb. 2013), <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2012.301159>.

60 Ushma Upadhyay et al., *Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study*, 182 *JAMA INT. MED.* 5 (2022), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2790319>; Ushma Upadhyay et al., *Safety and Efficacy of Telehealth Medication Abortions in the US During the COVID-19 Pandemic*, 4 *JAMA NETWORK OPEN* 8 (2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2783451?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=082421; Courtney Kerestes et al., *Provision of Medication Abortion in Hawai'i During COVID-19: Practical Experience with Multiple Care Delivery Models*, 104 *CONTRACEPTION* 1 (2021), [https://www.contraceptionjournal.org/article/S0010-7824\(21\)00097-4/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(21)00097-4/fulltext); Elizabeth Raymond et al., *TelAbortion: Evaluation of a direct to patient telemedicine abortion service in the United States*, 100 *CONTRACEPTION* 3 (2019), p 173-177.

has escalated as a result of *Roe* being overturned.⁶¹ Restricting reimbursement for telehealth interactions to physicians or imposing prior in-person interactions for non-physician providers creates medically unnecessary barriers to TMAB that complicate an already fraught abortion access landscape.

Second, as a result of the siloing and stigmatization of abortion in the broader health care system, many patients have no pre-existing relationship with an abortion provider when seeking care for the first time. This is especially true given that the majority of abortions are provided at health centers that focus on abortion and reproductive health care.⁶² Any regulation that requires an in-person interaction prior to the use of telehealth in the delivery of care effectively bans direct-to-patient models of TMAB and nullifies the benefits of telehealth in eliminating travel barriers and costs.

Issue comprehensive guidance on reimbursement for medication abortion services delivered via telehealth

State Medicaid agencies should issue guidance on billing procedures for medication abortion care delivered via telehealth to align state reimbursement policies with the most updated FDA guidelines. New guidance is essential, as the rules around both medication abortion provision and telehealth have changed dramatically thanks to the swift state-level policy changes brought on by the COVID-19 pandemic and the FDA's permanent changes to the mifepristone REMS. Abortion providers who are stretched to capacity in the post-*Dobbs* world do not have the time or resources necessary to decode federal and state policy changes on their own.

New guidance should clarify that state Medicaid agencies will provide full reimbursement to providers who use telehealth in delivering medication abortion care, without requiring an ultrasound or in-person interaction unless medically indicated. Providers should be the ones determining the best standard of care for their patients, including what the pre- and post-care protocols should entail – not Medicaid agencies or politicians. In states that use the bundled payment code, the new guidance should clarify that providers should use the S0199 code for all medication abortions and will receive full reimbursement, so long as providers use a clinically appropriate method to determine gestational age and use evidence-based methods to assess termination of pregnancy. Maintaining the full bundled payment while providing flexibility within the bundle of services facilitates direct-to-patient models of TMAB while ensuring providers can continue to cover the costs of providing abortions.

61 See Garnet Henderson, *There's an Abortion Provider Shortage Across the U.S. Here's How We Address It*, Elle (Nov. 18, 2021), <https://www.elle.com/culture/career-politics/a38257180/abortion-provider-shortage-how-to-fix/>; Marielle Kirstein et al., *100 Days Post-Roe: At Least 66 Clinics Across 15 US States Have Stopped Offering Abortion Care*, Guttmacher Inst. (Oct. 2022), <https://www.guttmacher.org/2022/10/100-days-post-roe-least-66-clinics-across-15-us-states-have-stopped-offering-abortion-care>.

62 Rachel Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, Guttmacher Inst. (Sept. 2019), <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>.

Regardless of whether or not states use the bundled payment code, all states should issue bulletins and update their Medicaid manuals in order to inform providers and patients that they will cover medication abortion that is delivered or mailed, including through mail-order pharmacies and include reimbursement for the mailing of such medications. Ensuring coverage and reimbursement of these new delivery models is essential to facilitate the sustainability of this type of care and maximize the potential gains in abortion accessibility.

Finally, state Medicaid agencies should clarify how payment parity policies apply to asynchronous modalities, like store-and-forward or remote patient monitoring, that have no in-person equivalent to use as a baseline for reimbursement. While every state we examined instituted payment parity for telehealth services, the policy language often just required payment at the same rate as the same services provided face-to-face, leaving significant ambiguity to how this applies to asynchronous models.

Provide coverage for all telehealth modalities, especially audio-only and asynchronous care

While states have achieved major improvements in Medicaid telehealth modality coverage, gaps still remain, even within the six states we examined. States should continue to expand Medicaid coverage of telehealth services and apply parity requirements to include all modalities, especially audio-only and asynchronous models. Comprehensive coverage of the full spectrum of telehealth modalities is crucial to unlocking the full potential of telehealth to expand abortion access and to maximize patient choice.

Medicaid enrollees should be able to choose their preferred format for receiving care, whether that is in person or via telehealth. Similarly, patients that choose telehealth service delivery should be able to choose the modality that best fits their needs and circumstances, without worrying about whether or not their insurance covers it. Full coverage of all modalities is pivotal to ensure the full benefits of telehealth are actualized, including the potential to eliminate (or greatly reduce) distance and resource barriers.

Medicaid coverage and reimbursement of the full range of modalities, including audio-only and asynchronous models, is essential to ensure equitable telehealth access. Medicaid covers one out of every four people living in rural areas, which often has limited access to both broadband internet and abortion providers.⁶³ Furthermore, individuals with Medicaid coverage are overall more likely to lack reliable broadband services, which makes coverage of audio-only services important to ensuring access and to avoid reinforcing existing digital inequities.⁶⁴

63 See Juia Foutz et al., *The Role of Medicaid in Rural America*, Kaiser Family Found. (Apr. 25, 2017), <https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/>; Mark Dornauer & Robert Bryce, *Too Many Rural Americans Are Living In the Digital Dark. The Problem Demands A New Deal Solution*, HEALTH AFFAIRS (Oct. 28, 2020), <https://www.healthaffairs.org/doi/10.1377/forefront.20201026.515764/full/>.

64 Rob Houston & Matthew Ralls, *The Doctor Will Hear You Now: Audio-Only Telehealth and the Promise of Access, Equity, and Engagement in Medicaid*, Center for Health Care Strategies (Mar. 2022), <https://www.chcs.org/the-doctor-will-hear-you-now-audio-only-telehealth-and-the-promise-of-access-equity-and-engagement-in-medicaid/>.

Allow out-of-state providers to deliver care via telehealth and consider expedited credentialing systems to facilitate participation

While many states loosened requirements during the height of COVID-19 to allow out-of-state clinicians to provide care to Medicaid enrollees, many of those flexibilities have been rescinded. The escalating abortion access crisis and subsequent strain on abortion provider capacity calls for states that cover abortion for Medicaid enrollees to consider how to bolster its provider network. One important strategy could facilitate out-of-state provider participation in a state's Medicaid program to deliver care via telehealth.

States should consider issuing guidance to clarify the out-of-state provider processes for obtaining state licensing and enrolling in the Medicaid program. Clear guidance that demystifies the enrollment process could help to incentivize provider enrollment, particularly in access states that may have better reimbursement rates. States could also consider creating an expedited application process for out-of-state providers to reduce the administrative burden while still ensuring providers are acting within their scope of practice.⁶⁵

As state after state has banned abortion in the wake of *Dobbs*, provider networks have struggled to meet the demand for services in states that have seen an influx of out-of-state patients. This has caused wait times and delays in access to care for state residents and out-of-state patients alike.⁶⁶ Telehealth service delivery opens the door to new, innovative solutions but states need to facilitate out-of-state provider participation in their Medicaid program. Expansion of the Medicaid abortion provider network can reduce delays and facilitate access to care for the Medicaid population and open up capacity for non-Medicaid providers to see out-of-state patients.

Conclusion

Comprehensive coverage of telehealth medication abortion service delivery should be considered as one of various approaches for combating abortion access disparities and health inequities. TMAB can alleviate the costs associated with seeking abortion care, including long travel distances, lodging and transportation costs, child care arrangements, and potential lost wages. These costs disproportionately harm people facing structural barriers to care, like Black, Indigenous, and other people of color, people living in rural areas, young adults, people with disabilities, and those struggling to make ends meet. While telehealth is no panacea, Medicaid enrollees seeking medication abortion can gain from the

65 California's newly enacted Assembly Bill No. 657 provides a good example of this type of expedited licensure process. See AB No. 657, (Cal. 2021).

66 See Claire Cleveland, *Out-of-state patients seeking abortions arrive in Colorado in record numbers*, CPR News (October 2022), <https://www.cpr.org/2022/10/17/out-of-state-patients-seeking-abortion-arrive-in-colorado-in-record-numbers/>.

opportunities that telehealth has offered to millions of U.S. residents during the public health emergency and will continue to do so after the pandemic ends.

Medicaid coverage of TMAB has improved significantly, as states have established more robust coverage of the full spectrum of telehealth modalities, enhanced telehealth payment parity policies, and removed some restrictions around sites of care and patient-provider relationships. As states grapple with the fallout from the *Dobbs* decision, we hope to see continued improvement in TMAB coverage and would encourage states to update their Medicaid telehealth coverage policies to bring them in line with the most updated FDA guidelines. This will be particularly true once the FDA announces the final guidelines for the mifepristone REMS and the certification process for retail pharmacists seeking authorization to dispense mifepristone. CMS can play a vital role in encouraging states to take action to update and improve their telehealth coverage policies and payment methods to facilitate pharmacist dispensing of medication abortion as allowed by the new mifepristone REMS. The improvements in the Medicaid TMAB coverage landscape explored in this report are encouraging, but more work remains to ensure states enact equitable telehealth policies that leverage the innovative potential of new service delivery models without inadvertently exacerbating existing health inequities.