



Asynchronous Telehealth Abortion Services for Medicaid Enrollees

[Cat Duffy](#)

Introduction

Medicaid coverage of telehealth has changed dramatically over the last several years. In response to the COVID-19 pandemic, many states introduced flexibilities tied to the public health emergency (PHE) to facilitate the use of telehealth service delivery in Medicaid. The revolution in telehealth also extends to the sexual and reproductive health care sphere, as advocates have turned to telehealth as a potential mechanism for combating the escalating abortion access crisis in the post-*Dobbs v. Jackson Women’s Health Organization* landscape. Telehealth medication abortion (TMAB) service delivery has increased greatly, including the expansion of asynchronous service delivery models.¹ While telehealth is no panacea, when implemented equitably it can help reduce the time and resources barriers individuals seeking abortions may encounter – and insurance coverage is one of the most important factors in facilitating equitable access.

This issue brief focuses on outlining the current coverage and reimbursement landscape for asynchronous TMAB, providing a chart of the current policies in the seventeen states that use state funding for abortion coverage for Medicaid enrollees and analyzing the trends across states. This brief is intended to be an educational resource – significant information gaps around asynchronous TMAB exist, as most people commonly understand “telehealth” to be a synchronous interaction between a provider and a patient. This brief will walk through what

¹ Soc. Family Planning, *#WeCount Report April 2022 to December 2022* (Apr. 2023), <https://doi.org/10.46621/143729dhcsyz>; Am. Telemedicine Assoc., *Asynchronous Telehealth: Improving Access, Empowering Patients, and Reducing Costs*, <https://www.americantelemed.org/wp-content/uploads/2021/01/Asynchronous-Telehealth-Improving-Access-Empowering-Patients-and-Reducing-Costs-CLEAN.pdf> (last visited October 19, 2023).

asynchronous service delivery of medication abortion looks like, the potential benefits of this model in addressing major access barriers (particularly for people with low-incomes), and a brief overview of specific policy barriers we identified during the research for this brief.

Methodology

In order to accurately understand Medicaid coverage and reimbursement landscape for asynchronous TMAB, we looked at the policies and laws in all seventeen states that use state funding for abortion coverage for Medicaid enrollees. We examined all relevant state statutes and regulations impacting Medicaid coverage of telehealth (and abortion, when relevant). This process included reviewing state Medicaid agency materials, such as provider manuals, bulletins, and other guidance issued by state agencies, since these materials can provide critical insight into policy implementation. When pertinent, we also examined policies and guidance issued from other non-Medicaid entities that impact the regulation of telehealth, such as state medical boards.

In addition to the following brief, we created a chart that provides an overview of the policies in each state. This includes how each state defines asynchronous care or store-and-forward services, whether or not the state's Medicaid program covers asynchronous care, if a state's payment parity law applies to asynchronous modalities, and whether or not a patient-provider relationship can be established via asynchronous telehealth. The chart includes links to the relevant policies and laws that were up to date at the time of publication.

Please note, this issue brief does not constitute legal advice nor can we guarantee that the laws and policies have not changed since publication since they have been rapidly evolving. The chart we have created is based on our interpretation of policies and statutes in states that are often vague and subject to interpretation. While we aim to provide a comprehensive understanding of the asynchronous 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. If there are discrepancies in the information provided here, please contact Cat Duffy (duffy@healthlaw.org).

Asynchronous TMAB: An Overview

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. Direct-to-patient TMAB is a form of telehealth service delivery where the provider and patient use telehealth for the patient's intake, informed consent, and counseling interactions and abortion pills are then

mailed directly to the patient.² Data shows TMAB is extremely safe and effective and it can alleviate the costs associated with seeking abortion care, including long travel distances, lodging and transportation costs, child care arrangements, and potential lost wages.³

There are two main categories of telehealth modalities: synchronous and asynchronous. Synchronous care uses secure audio-video or audio-only platforms that allow real-time interaction between patients and providers. Asynchronous care (also called “store-and-forward”) uses a combination of dynamic intake forms, direct messaging, and secure HIPAA compliant applications to transfer pictures, medical history, consent forms, and other patient information or questions to facilitate non-live interactions between a patient and a provider.⁴ Generally, a patient sends information and care requests to a provider that is then ‘stored’ until the provider has the opportunity to review it and respond.

² There are also other service delivery models, including pharmacist-dispensed medication where a patient has a telehealth encounter with the clinician who then sends the prescription to a local pharmacy for the patient to pick up. There’s also site-to-site TMAB where the provider and patient are located at different clinical sites – this was most common prior to the COVID-19 pandemic. For an overview of the spectrum of care associated with medication abortion *see*: RHITES, Medication Abortion Spectrum of Care, https://static1.squarespace.com/static/637e5bcdbfee712c3baf45b8/t/659fe2a04ce65b0c83875b15/1704977056417/RHITES+Medication+Abortion+Spectrum+of+Care+Chart_v3.pdf (last visited, Jan. 18, 2024).

³ For data on the safety of TMAB *see*: Ushma Upadhyay, Leah Koenig, & Karen Meckstroth, *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; Ushma Upadhyay et al., *Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study*, JAMA INTERNAL MED. (2022), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2790319>; on reducing travel barriers, *see*: Leah Koenig et al., *The Role of Telehealth in Promoting Equitable Abortion Access in the United States: Spatial Analysis*, 9 JMIR PUBLIC HEALTH SURVEILL. 1 (2023), <https://publichealth.jmir.org/2023/1/e45671>.

⁴ For additional background information on store-and-forward services, *see*: Ctr. Connected Health Pol., *Key Components of Telehealth: Store-and-Forward*, <https://www.cchpca.org/what-is-telehealth/?category=store-and-forward> (last visited Dec. 1, 2023).

When thinking of TMAB (and telehealth generally), the image that often comes to mind is a synchronous audio-video interaction between a patient and provider. But the use of asynchronous telehealth has grown, particularly in the wake of the COVID-19 pandemic, and is used by telehealth providers across the country in a variety of fields.⁵ This trend also holds true for reproductive health care, as the number of telehealth abortion providers continues to grow, including those offering asynchronous care.⁶

Asynchronous TMAB typically involves a comprehensive patient questionnaire designed to assess a patient's suitability for TMAB, including determining the estimated gestational age, obtaining the patient's medical history, and screening for any risk factors like ectopic pregnancy.⁷ A provider then reviews the patient's information and determines whether or not the patient is eligible for telehealth service delivery or if they need to be referred for in person care or an ultrasound when medically indicated. After completing intake (including any required informed consent), the provider sends the patient informational materials, including guidance about treatment and follow-up care. Finally, the provider either mails the medication abortion pills to the patient or sends the medication abortion prescription to a certified pharmacist for mail delivery. Asynchronous TMAB is unique because it facilitates interaction between the provider and the patient during the abortion process, as most virtual providers offer a messaging portal or hotline that patients can use to ask questions or get more information.

⁵ Am. Telemedicine Assoc., *Asynchronous Telehealth: Improving Access, Empowering Patients, and Reducing Costs*, <https://www.americantelemed.org/wp-content/uploads/2021/01/Asynchronous-Telehealth-Improving-Access-Empowering-Patients-and-Reducing-Costs-CLEAN.pdf> (last visited October 19, 2023).

⁶ This includes both brick-and-mortar facilities that also offer telehealth services and completely virtual providers that do not have a physical location. For an overview of the current telehealth abortion provider landscape, see: Leah Koenig, Jennifer, Ko, & Ushma Upadhyay, Virtual clinic telehealth abortion services in the United States one year after Dobbs: A landscape review, JMIR PREPRINTS, <https://preprints.jmir.org/preprint/50749> (last visited Jan. 19, 2023).

⁷ For more insight into asynchronous TMAB delivery model, see Hey Jane, *Clinical White Paper: Safe, effective and in-demand: An asynchronous telehealth abortion model for a new era of care*, https://assets-global.website-files.com/5f29ca1c3156ae2435b7a35f/65088da1ac583354e4e4583c_Hey%20Jane%20Clinical%20White%20Paper%20-%202023.pdf (last visited Oct. 11, 2023).

Benefits of Asynchronous TMAB

While much has been made of the potential for telehealth to reduce abortion access barriers, comprehensive coverage of the full range of telehealth modalities is crucial to capitalize on this potential. While telehealth generally may combat distance barriers, synchronous telehealth models can still pose major obstacles to accessing care, particularly for people with low-incomes or those who already face structural barriers to accessing care.

Synchronous video interactions with a provider require that a patient has reliable access to broadband, a device that can sustain a video call, a safe place to conduct the call, and the ability to take time out of their day to have a real-time interaction. These technological requirements can be significant barriers for many people, as 2019 data showed that 25 million Americans lacked reliable internet access and 14 million did not own a video-capable device (e.g., a laptop, smartphone, etc.).⁸ Scholars have rightly noted that inequitable implementation of telehealth service delivery can actually worsen pre-existing health disparities, as people who lack reliable broadband or have low tech literacy are more likely to have low incomes and/or lower levels of education.⁹ Comprehensive coverage of audio-only service delivery can alleviate some of these issues, but may not address the time and space constraints patients may face in trying to coordinate a synchronous interaction.

Beyond technological barriers, the stigma surrounding abortion may make a real-time interaction with a provider impossible for some. Generally, research has shown that patients

⁸ Krutika Amin et al., How might internet connectivity affect health care access? Peterson-KFF Health System Tracker (2020), <https://www.healthsystemtracker.org/chart-collection/how-might-internet-connectivity-affect-health-care-access/#Share%20of%20population%20with%20no%20internet%20access%20at%20home,%20202019>.

⁹ See 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); Michelle Katzow, Caren Steinway, Sophia Jan, *Telemedicine and Health Disparities During COVID-19*, 146 *PEDIATRICS* 2 (2020), <https://publications.aap.org/pediatrics/article/146/2/e20201586/36919/Telemedicine-and-Health-Disparities-During-COVID>; Pew Research Center, *Internet/Broadband Fact Sheet* (2021), <https://www.pewresearch.org/internet/fact-sheet/internet-broadband/?tabId=tab-e60540d5-6342-47eb-835d-21b1c0a5e37b> (last visited Oct. 20, 2023).

prioritize privacy when seeking abortion services and several studies show patients believe telehealth offers an enhanced level of privacy versus obtaining care in person.¹⁰ Abortion stigma motivates some patients to opt for telehealth in order to avoid entering abortion clinics for fear of being identified, particularly for those living in small or rural communities.¹¹ Asynchronous TMAB offers a greater level of privacy for patients by not requiring a real-time video or audio call that could be overheard, which is essential for patients who may lack the privacy or safety to access synchronous services. Abortion stigma is not limited to protestors outside health centers – patients may have partners, roommates, or family members who are unsupportive or even abusive. Asynchronous service delivery can facilitate “honest and discrete” interactions with providers without anxiety, which is vital for abortion seekers who face an increasingly criminalized landscape.¹²

Furthermore, asynchronous TMAB may facilitate faster access to services by removing resource and logistical barriers to accessing care. When seeking asynchronous care, patients do not need to balance their schedule against a provider’s in order to schedule an appointment and can instead initiate care when they have the time to do so.¹³ This flexibility is vital for

¹⁰ See 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); Courtney Kerestes et al., *Person-centered, high-quality care from a distance: A qualitative study of patient experiences of TelAbortion, a model for direct-to-patient medication abortion by mail in the United States*, 54 *PERSPECT. SEX. REPROD. HEALTH* 4 (2022), 177-187; 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, (2019) 407-413, <https://www.sciencedirect.com/science/article/pii/S104938671830598X>.

¹¹ Courtney Kerestes et al., *Person-centered, high-quality care from a distance: A qualitative study of patient experiences of TelAbortion, a model for direct-to-patient medication abortion by mail in the United States*, 54 *PERSPECT. SEX. REPROD. HEALTH* 4 (2022), 177-187.

¹² See Am. Telemedicine Assoc., *Asynchronous Telehealth: Improving Access, Empowering Patients, and Reducing Costs*, <https://www.americantelemed.org/wp-content/uploads/2021/01/Asynchronous-Telehealth-Improving-Access-Empowering-Patients-and-Reducing-Costs-CLEAN.pdf> (last visited October 19, 2023).

¹³ For more information on how asynchronous care can assist providers in meeting patients where they’re at, see Am. Telemedicine Assoc., *Asynchronous Telehealth: Improving Access, Empowering Patients, and Reducing Costs*, <https://www.americantelemed.org/wp-content/uploads/2021/01/Asynchronous-Telehealth-Improving-Access-Empowering-Patients-and-Reducing-Costs-CLEAN.pdf> (last visited October 19, 2023).

people working full time who may not have paid time off or the ability to take time off period and can instead complete intake forms or respond to provider questions during a lunch break or simply on their own time.¹⁴ 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.¹⁵ It also increases the likelihood that they may run into a state's gestational age limit.

Finally, asynchronous TMAB offers a method of receiving care that maximizes patient flexibility and choice. Patients that seek in-person services or synchronous care generally have one interaction with the provider prior to the medication abortion, meaning patients must come prepared with all their questions and concerns. As noted earlier, asynchronous care is unique in that patients may connect with their provider during the abortion process via asynchronous chat or messaging options. While patients receiving care via other modalities could certainly call their provider or health center if they have questions, this type of interaction is not built into the care model and patients may worry about incurring additional costs. Preliminary data shows that asynchronous patients report higher rates of feeling cared for than those who receive synchronous care and the sustained interaction facilitated by asynchronous chat may be one explanation for this result.¹⁶

Barriers to Medicaid Coverage of Asynchronous Care

While state Medicaid agencies have made notable progress in updating and improving coverage of synchronous telehealth, coverage of asynchronous care lags notably behind in several dimensions. No virtual abortion providers accept Medicaid currently, which is a huge barrier to equitable abortion access. While many factors go into whether or not an abortion provider enrolls in Medicaid, policy has a huge impact on telehealth service delivery and can make it impossible for certain telehealth providers to enroll. This section will provide an overview of some of the trends we found in the landscape analysis of the seventeen states that use state funding to provide abortion coverage for Medicaid enrollees.

¹⁴ Abigail Aiken & Ushma Upadhyay, *The future of medication abortion in a post-Roe world*, *BMJ* (2022), <https://www.bmj.com/content/377/bmj.o1393>.

¹⁵ 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>.

¹⁶ Leah Koenig et al., *Patient Acceptability of Telehealth Medication Abortion Care in the United States, 2021–2022: A Cohort Study*, *AM. J. PUB. HEALTH* (2024), <https://doi.org/10.2105/AJPH.2023.307437>.

Vague or Limiting Definitions of Asynchronous Care

While not every state had an explicit definition of asynchronous or store-and-forward modalities, most states define it as the transmission of a patient's medical information — such as digital images, documents, and pre-recorded videos — from an originating site to the provider at the distant site. However, several states (Alaska, New Mexico, New York, Vermont) defined asynchronous care exclusively as interactions or consultations between providers. This narrow definition precludes any coverage for asynchronous TMAB, as it explicitly does not cover the transfer of data from a patient to a provider.

Some states that restrict their definition of asynchronous care to provider consultations had other telehealth categories of care that could theoretically include TMAB (e.g., “e-Visits” in New York or “patient-initiated online digital services” in Alaska) but the definitions often contained other restrictions, like limiting it to established patients (AK) or non-urgent services, that would be barriers to TMAB coverage.

As telehealth service delivery models continue to evolve, state Medicaid agencies must update their policies to ensure Medicaid enrollees have equitable access to all telehealth modalities. To that end, states should explicitly include asynchronous modalities in their definition of telehealth and clearly define asynchronous care (or store-and-forward) to include patient-initiated interactions with providers.

Restrictions on Formation of the Patient-Provider Relationship

Regulations around the formation of a patient-provider relationship can be major barriers for telehealth abortion providers generally, regardless of the modality. 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, which means many patients seeking an abortion are unlikely to have a pre-existing relationship with an abortion provider.¹⁷

¹⁷ 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-serviceavailability-us-2017>.

Only five states had an explicit Medicaid policy on the formation of a patient-provider relationship via telehealth. Two states (California and Maine) restrict the use of telehealth with new patients to synchronous interactions. Hawaii, Massachusetts, and Oregon all had general policies outlining requirements for providers using telehealth to establish a patient relationship but none of these policies were modality specific. Since there are no explicit barriers or prohibitions, we interpret the policies in these states as allowing providers to establish a relationship via asynchronous care (although Hawaii's language is specific to physicians which if interpreted narrowly by the agency could be a barrier for advanced practice clinicians).

The remaining twelve states had no Medicaid policy on this issue but 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. These policies were typically about telehealth generally and included no modality restrictions.

These restrictions are a major barrier for abortion providers since due to 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.¹⁸ Any regulation that requires an in-person or synchronous interaction effectively bans asynchronous models of TMAB. 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.

Gaps in Coverage and Payment Parity

While the last few years have seen immense improvement in coverage and payment parity for synchronous telehealth services, the application of these policies to asynchronous care lags significantly. While the majority of states do provide Medicaid coverage of asynchronous care, over a quarter either do not cover it or impose significant limitations. The only state to explicitly not cover asynchronous care is Connecticut. Four states (Alaska, New Mexico, New York, Vermont) limit coverage to asynchronous interactions between providers and Maine limits coverage to established patients. These restrictions essentially prohibit coverage of asynchronous TMAB for Medicaid enrollees. Furthermore, California prohibits coverage of

¹⁸ 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-serviceavailability-us-2017>.

“patient-initiated” consultations and explicitly excludes coverage of asynchronous care delivered via mobile phone applications.

In addition to the states that restrict coverage of asynchronous care, Hawaii limits application of payment parity to synchronous telehealth exclusively and Rhode Island limits payment parity for asynchronous care to a particular subset of providers that would exclude most abortion providers.

In total, this means nearly half of the seventeen states that use state funding to provide abortion coverage for Medicaid enrollees either likely do not cover asynchronous TMAB or reimburse providers significantly less than in-person abortion care. 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. States should issue new guidance clarifying their coverage and payment policies to ensure Medicaid enrollees have access to their preferred modality, whether that is in-person, synchronous, or asynchronous telehealth.

Conclusion

We have seen tremendous strides in improving coverage and reimbursement of telehealth abortion services in the last few years. Comprehensive coverage of abortion for Medicaid enrollees is one of the most important factors in building an equitable abortion access landscape, as it improves access and distribution of abortion fund resources to low-income and underserved populations. Telehealth service delivery has a crucial role to play in the post-Dobbs landscape and asynchronous TMAB offers unique benefits to patients that may face structural barriers to accessing care, whether they lack reliable broadband for a synchronous video call or the time or space to safely have a real-time interaction with a provider. This issue brief provides an overview of what asynchronous TMAB looks like, the benefits of this delivery model, and a brief overview of some key policy barriers to equitable coverage and reimbursement. Significant 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.