Report: Medicaid Coverage of Telehealth Abortion Services in Six States (IL, MN, NM, NY, RI, WA)

Cat Duffy

Introduction

Telehealth medication abortion (TMAB) service delivery has expanded dramatically over the last several years, now accounting for roughly one fifth of all abortions in the United States.[1] Many have pointed to the potential of telehealth to reduce the ever-increasing travel and resource barriers facing abortion seekers after the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* in 2022. But this potential can only be actualized if telehealth service delivery is implemented equitably – and comprehensive insurance coverage of all telehealth modalities is a crucial factor in facilitating equitable access.

In 2022, the National Health Law Program published a comprehensive report analyzing the policies impacting coverage and reimbursement of TMAB in six states that use their own funding to provide abortion coverage for Medicaid enrollees. This report is the next installment in that series, examining the policies and regulations in a new set of six states: Illinois, Minnesota, New Mexico, New York, Rhode Island, and Washington. This issue brief will provide a thorough analysis of the major policies impacting coverage and reimbursement of TMAB, including detailing the major trends and highlighting policy barriers that impede comprehensive coverage and thus access to TMAB for Medicaid enrollees. It will conclude with a discussion of the importance of Medicaid coverage of TMAB and highlight forthcoming work.[2]

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[1] Soc'y of Family Planning, *#WeCount Report April 2022 to December 2023* (2024), https://doi.org/10.46621/970371hxrbsk.

[2] For the sake of space, this report will not include the comprehensive overview of the policy intersections between medication abortion, telehealth, and Medicaid coverage that was discussed extensively in the first report. For more information on these issues, *see*: Cat Duffy, Nat'l Health Law Prog., *Report: Progress and Gaps in Medicaid Coverage of Telehealth*

Methodology

State Selection

This report continues the work to build out a comprehensive landscape analysis of coverage and reimbursement of TMAB for Medicaid enrollees, focusing on Illinois, Minnesota, New Mexico, New York, Rhode Island, and Washington. These states represent an important subset of the 17 states that use their own funding to provide abortion coverage to Medicaid enrollees. Rhode Island is the newest state to implement coverage of abortion services for Medicaid enrollees, making it particularly ripe for analysis. Illinois and New Mexico have seen a tremendous increase in the demand for abortion services in the post-*Roe* era, as they both border states that have banned abortion services.[3] Similar to the first report, we chose these states to include as much geographic diversity in the states we examined as possible.

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.[4] 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 be

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Medication Abortion Services in Six States (2022), https://healthlaw.org/resource/report-progress-and-gaps-in-medicaid-coverage-of-telehealth-medication-abortion-services-in-six-states/.

[3] While patients traveling from out of state are ineligible for Medicaid coverage of abortion services, states that have comprehensive insurance coverage of abortion ensures that patients who live in Illinois or New Mexico can have their services covered by their health plan, as opposed to needing to rely on the limited resources of abortion funds. Studies following the implementation of Medicaid coverage in Illinois have shown that abortion funds are able to allocate more of their resources to out-of-state patients. *See* Am. Inst. for Rsch., *State Medicaid Coverage of Abortion Care: Impact on Clinics and Location Abortion Funds* (2023) https://www.air.org/sites/default/files/2023-01/Medicaid-Coverage-%232-State-Policy-Project-Jan-2023.pdf (last visited 06/25/2024).

[4] *See* Trisha Pasricha, Stat News, *State Medical Boards May be Roadblock to Wider Telemedicine Abortion* (2022), https://www.statnews.com/2022/10/07/telemedicine-abortion-roadblock-state-medical-boards/.

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, please contact Cat Duffy (duffy@healthlaw.org) as 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:

Modality coverage: We examined how each state defines telehealth and/or telemedicine, including what modalities are included, for the purposes of Medicaid coverage. Comprehensive coverage of all telehealth modalities, including audio-only and asynchronous care, is essential to equitable access.

Payment parity: This refers to the practice of reimbursing providers who deliver services via telehealth at the same rate and to the same extent as if they had seen the patient in person. 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.[5] We reviewed each state's payment parity policy and what modalities, if any, are reimbursed at parity.

Sites of care: We focused on how states define the originating site, which is the location of the patient at the time of services. Prior to the COVID-19 pandemic, many states did not define the originating site to include a patient's home or the patient's location generally.[6]

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[5] Yves-Yvette Young et al., *Contextualizing Medicaid reimbursement rates for abortion procedures*, 102 CONTRACEPTION 3, 195 (2020).
[6] Jenna Libersky et al., Mathematica, *Changes in Medicaid Telehealth Policies Due to COVID-19: Catalog Overview and Findings* (2020), https://www.macpac.gov/wp-content/uploads/2020/06/Changes-in-Medicaid-Telehealth-Policies-Due-to-COVID-19-Catalog-Overview-and-Findings.pdf.

Restrictions on the establishment of a patient-provider relationship: Prior to 2020, many states required an in-person interaction before a provider could deliver services to a patient via telehealth.[7] 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 blanket policies requiring an in-person interaction create medically unnecessary restrictions.[8] We examined whether each state has a policy regulating the creation of a patient-provider relationship via telehealth and whether it restricts the use of particular modalities.

Provider eligibility: We researched which types of providers may deliver services via telehealth, in particular focusing on whether or not the state Medicaid program prohibits the participation of virtual or out-of-state providers.

Reimbursement models: We investigated how each state reimburses providers for medication abortion services, including whether or not the states use the S0199 bundled payment code that allows providers to receive reimbursement for the comprehensive set of services associated with medication abortion. We also researched whether states make the use of the bundled payment contingent on the provision of particular services (*e.g.,* ultrasounds or follow up care) in order to receive full reimbursement.

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[7] *See*: John Glaser & Kyle Zebley, Harv. Bus. Rev., *It's Time to Cement Telehealth's Place in U.S. Health Care* (2023), https://hbr.org/2023/01/its-time-to-cement-telehealths-place-in-u-s-health-care; Jack Pitsor & Sydne Enlund, Nat'l Conf. of State Leg., *States Turn to Telehealth During the Pandemic* (2020), https://www.ncsl.org/research/health/states-turn-to-telehealth-during-the-pandemic-magazine2020.aspx.

[8] *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; 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.

The next section will detail the results for this state survey in those six categories and any notable barriers or gold standard policies.

Results: Trends and Gaps in State Medicaid TMAB Policies

Covered Modalities

All the states we researched provide coverage for telehealth service delivery in their Medicaid programs, although the scope of coverage for different modalities varies. All six states cover synchronous video, synchronous audio-only, and asynchronous store-and-forward modalities. Some states, such as New York, go beyond these three major categories and have created a series of other modality categories, including eVisits, Virtual Check-Ins, and more.[9]

Coverage Barrier: Temporary Policies

Many states across the country took action in the wake of the formal end of the COVID-19 public health emergency to make permanent the temporary telehealth flexibilities introduced during the height of the pandemic. Making these telehealth flexibilities into permanent policy is important to ensure stability for beneficiaries but also to formally signal that telehealth is an important, engrained part of our health care delivery system. However, from the states we examined, two states still have temporary coverage policies. Illinois established a broad Medicaid telehealth coverage policy during the public health emergency and issued a bulletin in May of 2023 to indefinitely extend these flexibilities until further notice.[10] While the current temporary policy is expansive, lack of a permanent Medicaid policy is a major barrier to the

[9] N.Y. State Dept. of Health, *Telehealth Policy Manual 2024-V1* (2024), https://www.health.ny.gov/health_care/medicaid/redesign/telehealth/docs/provider_manual.pdf (last visited 6/18/24).
[10] Ill. Admin. Code 89 § 140.403; Ill. Dept. of Healthcare & Family Services, *Continuation of Telehealth Flexibilities at COVID-10 Public Health Emergency End* (2023), https://hfs.illinois.gov/medicalproviders/notices/notice.prn230509b.html; Ill. Dept. of Healthcare & Family Services, *Telehealth Services Expansion Prompted by COVID-19* (2020), https://hfs.illinois.gov/medicalproviders/notices/notice.prn200320b.html.

use of telehealth for abortion care, as it would restrict the use of telehealth to a site-to-site model.[11]

In Minnesota, coverage of audio-only services only extends until July of 2025.[12] Minnesota's permanent law defines telehealth exclusively as a synchronous video interaction and explicitly excludes audio-only communications.[13]

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, who often have limited access to both broadband internet and abortion providers.[14] Furthermore, individuals with Medicaid coverage are overall more likely to lack reliable broadband services, which makes coverage of audio-only and asynchronous services important to ensuring access and not reinforcing existing digital inequities.[15]

Coverage Barrier: Narrow Modality Definitions

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[11] The site-to-site TMAB model has the provider and patient located at different clinical locations while using a secure video-conferencing platform for patient counseling, medication administration or dispensing, or to supervise drug ingestion. For more information on the spectrum of care associated with different medication abortion models, see: RHITES, *Medication Abortion Spectrum of Care* (2024), https://static1.squarespace.com/static/637e5bcdbfee712c3baf45b8/t/6643871390cace36d0c7228d/1715701523464/RHITES_Medication-Abortion-Spectrum-of-Care-Chart.pdf.

[12] Minn. Stat., Session Law Regular Session Chapter 70 (revising Minnesota Statute 62A.673, subdivision 2).

[13] Minn. Stat. § 256B.0625.

[14] *See* Juia Foutz et al., Kaiser Fam. Found., *The Role of Medicaid in Rural America* (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 (2020), https://www.healthaffairs.org/do/10.1377/forefront.20201026.515764/full/.

[15] Rob Houston & Matthew Ralls, Ctr for Health Care Strategies, *The Doctor Will Hear You Now: Audio-Only Telehealth and the Promise of Access, Equity, and Engagement in Medicaid* (2022), https://www.chcs.org/the-doctor-will-hear-you-now-audio-only-telehealth-and-the-promise-of-access-equity-and-engagement-in-medicaid/ (last visited 10/17/22).

In line with other research NHeLP has done on asynchronous TMAB, restrictive modality definitions emerged as a major barrier to comprehensive coverage when reviewing the policies in the six target states.[16] For example, New Mexico narrowly defines store-and-forward as the transfer of patient data "to allow a consulting provider to obtain information, analyze it, and report back to the referring physician providing the telemedicine consultation."[17] New York similarly limits the use of store-and-forward to provider consultations, defining it as "the asynchronous, electronic transmission of health information of a NYS Medicaid member… from a provider at an originating site to a telehealth provider at a distant site."[18] By arbitrarily limiting the use of asynchronous modalities exclusively to provider consultations, it effectively precludes asynchronous models of TMAB from coverage and consequently patient access.

While telehealth may combat some barriers facing abortion seekers, synchronous telehealth can still pose serious access obstacles, as it requires a device that can sustain a video or phone call, a safe place to conduct the call, and the ability to take the time to have a real-time interaction with a provider. Asynchronous TMAB can facilitate faster access to care, alleviate privacy and safety concerns, and maximize patient flexibility and choice.[19] Medicaid enrollees

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[16] Cat Duffy, *Asynchronous Telehealth Abortion Services for Medicaid Enrollees*, Nat'l Health Law Prog (2024), https://healthlaw.org/resource/asynchronous-telehealth-abortion-services-for-medicaid-enrollees/.
[17] N.M. Code R. § 8.310.2.12.
[18] N.Y. State Dept. of Health, *Telehealth Policy Manual* (2024), p. 7, https://www.health.ny.gov/health_care/medicaid/redesign/telehealth/docs/provider_manual.pdf (last visited 6/18/24).
[19] *See* Leah Koenig et al., *Patient Acceptability of Asynchronous vs Synchronous Telehealth Abortion Care: A Cohort Study of Telehealth Abortion Care Provided by Virtual Clinics in the United States*, 121 CONTRACEPTION, (2023), https://www.sciencedirect.com/science/article/abs/pii/S001078242300080X; 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; 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.

should have the ability to choose the service delivery model that best fits their needs and circumstances, without having to navigate medically unnecessary coverage restrictions.

Payment Parity

Similar to coverage parity, all the states we examined had payment parity for synchronous video telehealth service delivery but application of parity beyond that modality varied. This section will briefly outline each state's parity policy and highlight any restrictions we identified.

Illinois has the most specific and comprehensive payment parity language, instructing that "reimbursement for telehealth services will be made at the same rate paid for face-to-face services," and in order to be eligible for reimbursement, they must be delivered by:

- "interactive telecommunication system" (defined as synchronous video),
- "a telecommunication system" (defined as asynchronous store-and-forward), or
- "a communication system where information exchanged between the physician or other qualified health care practitioner and the patient during the course of the synchronous telehealth service is of an amount and nature that would be sufficient to meet the key components and requirements of the same service when rendered via face-to-face interaction." [20]

While Illinois has the most expansive and detailed parity language, this policy is a temporary flexibility that was established during the height of the COVID-19 pandemic and extended indefinitely until further notice.[21] As discussed in the previous section, it is important for states to make temporary flexibilities into permanent policy in order to erase any confusion around plan obligations to cover and pay for telehealth services. This is particularly true in the case of Illinois, as the state's pre-pandemic policies would significantly limit TMAB coverage.[22]

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[20] Ill. Admin. Code tit. 89, § 140.403(e)(5); Ill. Dept. of Healthcare and Family Services, *Continuation of Telehealth Flexibilities at COVID-10 Public Health Emergency End* (May 9, 2023), https://hfs.illinois.gov/medicalproviders/notices/notice.prn230509b.html; Ill. Dept. of Healthcare and Family Services, *Telehealth Services Expansion Prompted by COVID-19* (Mar. 20, 2020), https://hfs.illinois.gov/medicalproviders/notices/notice.prn200320b.html.
[21] Ill. Dept. of Healthcare and Family Services, *Continuation of Telehealth Flexibilities at COVID-10 Public Health Emergency End* (May 9, 2023), https://hfs.illinois.gov/medicalproviders/notices/notice.prn230509b.html.
[22] Ill. Admin. Code tit. 89, § 140.403.

Washington requires providers delivering services via telehealth to be reimbursed "the same amount of compensation" that would be paid "if the health care service was provided in person."[23] We interpret this as applying to all covered modalities, which are synchronous video, audio-only, and asynchronous store-and-forward. There is an exception for "hospitals, hospital systems, telemedicine companies," and provider groups of a specified size that allows them to "negotiate an amount of compensation for telemedicine services that differs from the amount of compensation for in-person services."[24]

Minnesota's law instructs that "services or consultations delivered through telehealth shall be paid at the full allowable rate."[25] It is unclear whether this implies parity with the rate paid for in-person services and we found no other clarifying guidance or bulletins. It also does not specify any modalities, so we interpret this language as applicable to all covered modalities, which are synchronous video, audio-only (until July of 2025), and asynchronous store-and-forward.

New York's parity policy is temporary and currently slated to remain in effect until April of 2026. It says "healthcare services delivered by means of telehealth are entitled to reimbursement on the same basis, at the same rate, and to the same extent" as when services are delivered in person. It covers both synchronous video and audio-only modalities but since the state restricts the use of asynchronous modalities to provider consultations, parity does not apply as there is no in-person equivalent.[26]

New Mexico's policy only applies to synchronous video, as it defines a telemedicine visit as a synchronous video interaction and clarifies that reimbursement for "telemedicine providers" is "made at the same rate as when the services provided are furnished without the use of a telecommunication system."[27] Furthermore, the provisions outlining payment for "telephone visits" and store-and-forward simply say services delivered through those modalities will be reimbursed, without any language specifying parity.

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[23] WA RCW 74.09.325(1)(b)(i).
[24] RCW 74.09.325(1)(b)(ii).
[25] Minn. Stat. § 256B.062 Subd. 3b(a) (2023)
[26] N.Y. State Dept. of Health, *Telehealth Policy Manual* (2024), p. 12, https://www.health.ny.gov/health_care/medicaid/redesign/telehealth/docs/provider_manual.pdf (last visited 6/18/24).
[27] N.M. Code R. §§ 8.310.2.12(M)(2)-(M)(3).

Rhode Island has one of the narrowest payment parity laws, as it specifies that it only applies to "in-network primary care providers, registered dietitian nutritionists, and behavioral health providers."[28] This would, in effect, exclude the vast majority of abortion providers, as only a very small percentage of primary care providers in the U.S. offer abortion services.[29]

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.[30] 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

Similar to our previous report, we found substantial progress in states expanding access to care via telehealth by redefining sites of care. While the exact language varied from state to state, all the Medicaid programs we looked at define the originating site as the location where the patient is located. This is a major improvement in Illinois, New York, and Rhode Island, which had restricted the sites of care prior to the COVID-19 inspired telehealth revolution.[31]

As we are four years into the mainstreaming of telehealth, this policy change might seem inconsequential. However, it is notable that all the states we examined defined the originating site as the patient's location, as opposed to specifying the patient's home or limiting it to a list of eligible locations. Defining the originating site to allow Medicaid beneficiaries to receive telehealth services from the location of their choice is the gold standard, as it maximizes flexibility, privacy, and patient choice. It allows patients who may lack the privacy or safety to access services from their home to have the ability to receive services from their car, work, or

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[28] R.I. Gen. Laws § 27-81-4.
[29] *See*: Diana Carvajal et al., Sci. Am., *Primary Care Providers Can Help Safeguard Abortion* (2022), https://www.scientificamerican.com/article/primary-care-providers-can-help-safeguard-abortion/.
[30] *See* Yves-Yvette Young et al., *Contextualizing Medicaid reimbursement rates for abortion procedures*, 102 CONTRACEPTION 3, 195 (2020).
[31] Jenna Libersky et al., Mathematica, *Changes in Medicaid Telehealth Policies Due to COVID-19: Catalog Overview and Findings* (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.

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.[32]

Establishing a Patient-Provider Relationship

Regulations on the use of telehealth for establishing a relationship with a new patient remain one of the most significant policies in shaping TMAB access. Due to abortion stigma and the siloization of this care in independent clinics, the vast majority of abortion seekers do not have a pre-existing relationship with an abortion provider. Therefore, any prohibition on the use of telehealth in establishing a patient-provider relationship effectively bans coverage of TMAB, except for those patients who happen to have a pre-existing relationship with an abortion provider.[33]

In our research, we found significant ambiguity in the policies regulating the formation of a patient-provider relationship in each state. Of the six states we examined, only one has an explicit Medicaid policy, three have general guidance from a medical or licensing board that would impact Medicaid providers, and two states' statutes and policies are completely silent on the issue. Overall, we believe all states likely allow at least some use of telehealth in establishing a new patient relationship, but some have specific modality restrictions, as we discuss in the next section.

States with Modality Restrictions

Only Washington has an explicit policy for Medicaid telehealth providers, but it speaks only to restricting the use of audio-only telehealth to certain scenarios. The state's provider manual instructs that "audio-only telemedicine requires an established relationship between the health care practitioner and the client," and that an established relationship is one in which the practitioner "has access to sufficient health care records to ensure safe, effective, and

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[32] 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.

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

appropriate care" and the client "has had, within the past three years, at least one in-person appointment, or at least one real-time interaction using both audio and video technology" with the provider or with a referring provider. [34] This effectively implements a requirement to have a synchronous video interaction in order to establish the patient-provider relationship.[35]

[34] Wash. State Health Care Authority, *Telemedicine Policy Billing Guide* (2024) p. 21, https://www.hca.wa.gov/assets/billers-and-providers/Telemedicine-policy-and-billing-20240606.pdf.

[35] Interestingly, the Washington Medical Commission issued guidance on this issue as well, indicating that "a valid practitioner-patient relationship may be established through telemedicine if the standard of care does not require an initial in-person encounter." Wash. Medical Commission, *Telemedicine Policy Statement POL2021-02* (2021) p. 4, https://wmc.wa.gov/sites/default/files/public/Telemedicine%20policy%2011%2019%2021.pdf.

On the other hand, New Mexico Medicaid has no explicit policy on this, but guidance from the New Mexico Medical Board prohibits prescribing, dispensing or administering drugs to new patients unless there is a synchronous video interaction.[36] In practice, this means only synchronous video calls can be used to establish a relationship with a new patient.

States Without (Explicit) Modality Restrictions

Both Rhode Island and Minnesota have general policies from professional boards that authorize the use of telehealth in creating a patient-provider relationship. The Rhode Island Board of Medical Licensure and Discipline defines a patient-provider relationship "as being clearly established when the physician agrees to undertake diagnosis and treatment of the patient and the patient agrees, whether or not there has been an in-person encounter."[37] In Minnesota, the Board of Medical Practice statute that governs the practice of telehealth simply states that "a physician-patient relationship may be established through telehealth."[38] It does not specify any modalities but Minnesota's definition of telehealth includes synchronous video, audio-only, and asynchronous store-and-forward technology.[39] It is important to note that the physician-specific language in these policies may create obstacles for advanced practice clinicians, who are authorized to provide abortion services in the state.

Neither New York nor Illinois Medicaid programs have a policy regulating the use of telehealth in the formation of a patient-provider relationship. Nor did we find any guidance from the state medical boards or other similar entities. Since there are no explicit prohibitions, we interpret this as allowing providers to establish a relationship via any covered telehealth modality.

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[36] N.M. Code R. § 16.10.8.
[37] Rhode Island Board of Medical Licensure and Discipline, *Guidelines for the Appropriate Use of Telemedicine and the Internet in Medical Practice*, https://health.ri.gov/publications/guidelines/provider/AppropriateUseOfTelemedicineAndTheInternetInMedicalPractice.pdf (last visited 06/20/2024).
[38] Minn. Stat. § 147.033 (2023).
[39] Minn. Dept. of Human Services, *Telehealth Services* (2023), https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-335178 (last visited 06/20/2024).

This research raises the question of what the ideal policy looks like. The rules around establishing a new patient relationship can be a fundamental barrier to coverage, particularly for abortion seekers.[40] This may mean that specific policy guidance that clarifies that providers may use any telehealth modality to establish a relationship with a new patient unless otherwise medically indicated could be preferable. Having explicit policy language in a provider manual or regulation is often extremely helpful in educating health plans about their obligations in covering TMAB, particularly when seeking to remedy erroneous denials. However, one could argue that general policies authorizing the use of telehealth (such as Minnesota's) might be superior, so long as the state has an expansive definition of telehealth. These general policies contain no restrictions thus one could and should read the law as authorizing the use of any modality included in the state's definition of telehealth.

Provider Eligibility

We found no telehealth specific restrictions on the types of providers who can deliver services and seek reimbursement, as every state allowed any properly licensed provider enrolled in the Medicaid program and acting within the scope of their license in that state to provide services via telehealth.

We also examined the rules around out-of-state providers since allowing providers to see patients across state lines can be an important mechanism for bolstering provider networks. This is particularly true for services facing increased demand and/or provider shortages, like abortion care. New York provides comprehensive information for out-of-state providers in its Telehealth Provider Manual, outlining that providers can be located anywhere in the U.S. or its territories and provide services to New York Medicaid members if they are enrolled in New York State Medicaid, licensed in New York, and if the "services are allowable."[41] New Mexico also addresses out-of-state providers specifically in its Administrative Code, detailing that:

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[40] 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. *See* Rachel Jones et al., Guttmacher Inst., *Abortion Incidence and Service Availability in the United States, 2017*, (2019), https://www.guttmacher.org/report/abortion-incidenceserviceavailability-us-2017.

[41] N.Y. State Dept. of Health, *Telehealth Policy Manual Version 2024-V1* (2024), p. 10, https://www.health.ny.gov/health_care/medicaid/redesign/telehealth/docs/provider_manual.pdf

> "[W]hen the originating-site is in New Mexico and the distant-site is outside New Mexico, the provider at the distant-site must be licensed for telemedicine to the extent required by New Mexico state law and regulations or meet federal requirements for providing services to IHS facilities or tribal contract facilities. Provision of telemedicine services does not require that a certified Medicaid healthcare provider be physically present with the MAP eligible recipient at the originating site unless the telemedicine consultant at the distant site deems it necessary."[42]

Both New York and Washington defined a distant site as located within the fifty states or U.S. territories, which should enable providers to see patients across state lines but would prohibit providers located outside of the U.S. from enrolling in Medicaid in those states.[43] None of the other states had policies or guidance that spoke to either authorizing or prohibiting out-of-state providers, which leaves their eligibility ambiguous, but at minimum we found no explicit obstacles.

A barrier that has emerged in states not examined in this report is a requirement for Medicaid providers to have a brick-and-mortar location, however, we found no evidence of this being a requirement in the six states featured in this issue brief.[44] As virtual providers become a bigger part of the abortion service delivery landscape, state agencies should ensure that their telehealth policies preserve Medicaid enrollees' ability to choose the service delivery model that best fits their needs – whether that is in-person or via telehealth.[45]

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[42] N.M. Code R. § 8.310.2.12(M)(1).
[43] N.Y. State Dept. of Health, *Telehealth Policy Manual Version 2024-V1* (2024), p. 10, https://www.health.ny.gov/health_care/medicaid/redesign/telehealth/docs/provider_manual.pdf; Wash. State Health Care Authority, *Telemedicine Policy Billing Guide* (2024) p. 18, https://www.hca.wa.gov/assets/billers-and-providers/Telemedicine-policy-and-billing-20240606.pdf.
[44] *See e.g.,* Cal. Code Regs. tit. 22, § 5100.60(c)(9); Conn. Medical Assistance Program, New Guidance for Services Rendered via Telehealth under the Connecticut Medical Assistance Program (CMAP) Provider Bulletin 2023-18 (2023), https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb23_18.pdf&URI=Bulletins/pb23_18.pdf.
[45] *See* Leah Koenig, Jennifer, Ko, & Ushman 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.

Reimbursement

In reviewing the billing and reimbursement policies in each state, we found that four states use the bundled payment code S0199 for medication abortion (Illinois, New Mexico, Rhode Island, and Washington).[46] Nevertheless, two of these states have restrictions that would limit reimbursement of TMAB.[47] New Mexico requires telehealth providers to use the 95 modifier, which reduces the reimbursement rate by over sixty five percent.[48] Washington prohibits the use of the bundled payment code if TMAB services are delivered via audio-only telemedicine or if the patient "does not receive ultrasound(s) and laboratory studies from the medical abortion provider."[49] Requiring the use of modifiers that substantially cut the reimbursement rate or effectively forcing an ultrasound and in-person interaction in order to receive full reimbursement may make it unsustainable for abortion providers to deliver services via telehealth. This is particularly true for providers that have a brick-and-mortar location in addition to offering telehealth services, as maintaining the security of these health centers can

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[46] Neither state uses the bundled payment code but New York issued billing guidance and Minnesota included abortion billing information in its provider manual. *See* N.Y. State Dept. of Health, New York State Medicaid Family Planning and Reproductive Health Services Frequently Asked Questions (2023) p. 10, https://www.emedny.org/ProviderManuals/communications/Family_Planing_Services_FAQS_2023.pdf; Minn. Dept. of Human Services, *Abortion Services* (2024), https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_137809 (last visited 06/21/2024).

[47] Ill. Dept. of Healthcare and Family Services, *Changes to Claim Submittal Process and Rates for Abortion Procedures Provider Notice* (2019), https://hfs.illinois.gov/medicalproviders/notices/notice.prn191101b.html; New Mexico Human Services Dept., *Changes to Claim Submittal Process and Rates for Abortion Procedures* (2022), https://www.hsd.state.nm.us/wp-content/uploads/22-07-Final-Supplemental-Guidance.pdf; Rhode Island Medicaid Program, *February 2024 Provider Update* (2024), p. 21 https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2024-02/pu373.pdf; Washington Apple Health, *Physician-Related Services/Health Care Professional Services Billing Guide* (2024), p. 240 https://www.hca.wa.gov/assets/billers-and-providers/Physician-related-services-bg-20240101.pdf.

[48] New Mexico Human Services Dept., *Changes to Claim Submittal Process and Rates for Abortion Procedures* (2022), https://www.hsd.state.nm.us/wp-content/uploads/22-07-Final-Supplemental-Guidance.pdf

[49] Washington Apple Health, *Physician-Related Services/Health Care Professional Services Billing Guide* (2024), p. 241 https://www.hca.wa.gov/assets/billers-and-providers/Physician-related-services-bg-20240101.pdf.

incur substantial costs. As explained in the payment parity section, these types of financial hits may be especially damaging to Medicaid providers, as research shows that Medicaid reimbursement rates are typically far below what it actually costs to provide abortion care.[50]

Recommendations

This report is the second installment in our landscape analysis of Medicaid coverage of telehealth medication abortion services and the policy trends and major access barriers we identified in this research closely track with the results of our first report. Thus, our recommendations for states seeking to improve comprehensive coverage of TMAB remain largely the same. The one main difference is that our recommendations now emphasize how each state's policies apply to different modalities.

When thinking of TMAB (and telehealth generally), the image that often comes to mind is a synchronous 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.[51] This trend also holds true for reproductive health care, as the number of telehealth abortion providers continues to grow, including those offering asynchronous care.[52] More attention must be paid to how state policies treat individual modalities and how definitions and policy language may create access barriers, even when that was not the original intention. As a result, our recommendations for policy improvements include:

1. **Allow providers to use telehealth to establish a new relationship with a patient, including via audio-only and asynchronous modalities.** States should eliminate any restrictions on modalities and instead allow the patient to choose their

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[50] Brittni Frederiksen & Alina Salganicoff, Kaiser Fam. Found., *Variability in Payment Rates for Abortion Services Under Medicaid* (2024), https://www.kff.org/medicaid/issue-brief/variability-in-payment-rates-for-abortion-services-under-medicaid/.
[51] 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).
[52] 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, & Ushman 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.

preferred service delivery model, so long as it meets the medically indicated standard of care.

2. **Provide sustainable reimbursement of all TMAB models.** States should provide full reimbursement to providers who use telehealth in delivering medication abortion care, without requiring an ultrasound or in-person interaction unless medically indicated.

3. **Eliminate modality-specific restrictions and instead provide comprehensive coverage for all telehealth modalities.** States should continue to expand Medicaid coverage of telehealth services and application of parity requirements to include all modalities, especially audio-only and asynchronous models. Coverage of all telehealth modalities maximizes patient choice and flexibility, empowering Medicaid enrollees to choose the modality that best fits their needs and circumstances. This can help address privacy concerns, potential technological barriers, and facilitate faster access to care.[53]

4. **Allow virtual-only and out-of-state providers to enroll as Medicaid providers.** The escalating abortion access crisis and subsequent strain on abortion provider capacity calls for states that cover abortions for Medicaid enrollees to consider how to bolster its provider network. Eliminating brick-and-mortar facility requirements (while still protecting access to in-person care) and streamlining enrollment processes for out-of-state providers could be important strategies in facilitating provider participation in Medicaid programs.

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[53] *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; 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; 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).

While there are a variety of improvements states could take to improve access to TMAB for Medicaid enrollees, we believe these four recommendations address the core issues in the TMAB coverage and reimbursement landscape.

Conclusion

This report is the second installment in our examination of the TMAB coverage and reimbursement landscape in the states that use their own funding to provide abortion coverage to Medicaid enrollees. Comprehensive coverage of TMAB can combat travel and resource obstacles, facilitate faster access to care, and address privacy concerns. The costs associated with seeking an abortion in the post-*Dobbs* landscape disproportionately harm people facing structural barriers to care, like Black, Indigenous, and other people of color, LGTBQ+ individuals, people living in rural areas, young people, individuals with disabilities, and those struggling to make ends meet. This research shows that 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. But gaps remain and the National Health Law Program will continue our research and advocacy to ensure that Medicaid enrollees have equitable access to all models of TMAB and in-person care.