

State Medicaid Coverage of Abortion Care: Lessons Learned and Recommendations

To learn about the impacts on prices, patients, and procedures in states permitting or discontinuing the use of state Medicaid funds for abortion care, researchers at the American Institutes for Research[®] (AIR[®]) gathered data from clinics and local abortion funds in three states: two, Illinois and Maine, that initiated state Medicaid coverage of abortion care; and one, West Virginia, that discontinued state Medicaid coverage of abortion care. The lessons learned in this document summarize factors that helped or hindered clinics' and funds' ability to prepare for and navigate changes in state Medicaid policy regarding abortion care coverage. Exemplars from the study are provided, as appropriate, for additional detail or context. The document then provides recommendations for stakeholders in states that are likely to experience shifts in Medicaid policy.



Implementation of State Medicaid Coverage of Abortion: Facilitators and Challenges

Facilitators That Eased Implementation of State Medicaid Coverage of Abortion Care

+ *Building on existing support and strengthening organizational relationships*

Example: In Illinois, clinicians emphasized the importance of building on existing support from the American Civil Liberties Union (ACLU) during the introduction of the legislation to initiate coverage in Illinois. Accentuating the value of relationship building, the ACLU built a coalition of providers and advocates to support Medicaid coverage, additional reproductive health policy changes, and efforts to repeal parental notification.

+ *Clinics' experience billing state Medicaid for other services*

Example: Clinics that had experience billing Medicaid (e.g., for family planning services, ultrasounds) before the policy shift had an easier time adjusting to the transition toward Medicaid coverage of abortion.

+ *Ability to prescreen and qualify eligible patients for state Medicaid coverage through presumptive eligibility.*

Example: Maine and Illinois ultimately enabled presumptive eligibility for Medicaid coverage for eligible patients. In Maine, clinics could prescreen and qualify patients in real time. In Illinois, clinic staff noted that before presumptive eligibility, coverage decisions took up to a week, and after presumptive eligibility, coverage decisions could be made within in a day.

Challenges That Complicated Implementation of State Medicaid Coverage of Abortion Care

- ✘ *Some clinics experienced unanticipated financial challenges, at least initially, due to shifts in payer sources and their respective reimbursement rates.*

Example: Some clinics experienced an initial decrease in the volume of patients paying out-of-pocket, resulting in an initial decrease in overall clinic funding that was not anticipated. This financial impact was mitigated with increases in the Medicaid reimbursement rates in both states and an increase in procedures provided to out-of-state patients in Illinois.

- ✘ *Administrative processes central to Medicaid billing and operations were not always adequately planned for at the state or clinic level.*

Example: In Illinois, an archaic paper-based billing process for all Medicaid claims was cumbersome and complicated billing for abortion care for several months. It took a long time for claims to be processed, and for clinics to be reimbursed.

Example: In Maine, clinicians providing family planning and abortion care services needed to be credentialed for both in order to bill Medicaid. Ensuring that clinicians were credentialed for both, so they could bill Medicaid, was a challenge.

- ✘ *A shift occurred regarding those who most needed financial assistance for abortion procedures in Illinois and Maine.*

Example: Local abortion funds saw an increased need for financial assistance among people who did not qualify for state Medicaid (income just above the limit or out-of-state), had insurance that did not cover abortion care, had insurance with high deductibles, or had no insurance.



Discontinuation of Medicaid Coverage of Abortion

Facilitators That Mitigated Patient Cost Burden and Clinic Financial Risk in Discontinuation of State Medicaid Coverage of Abortion Care

- ✚ *The shift from state Medicaid coverage to other sources of payment helped clinics to remain open.*

Example: After the policy shift, the volume of abortions decreased, however, total funds paid for both medication and surgical abortions was more than was reimbursed for procedures under Medicaid rates. These funds came from national and local fund financial support, internal funding sources, and out-of-pocket payments from patients who were no longer Medicaid-eligible.

- ✚ *Increased fundraising and philanthropy enabled the clinics to remain open.*

Example: Concerned about clinic's ability to remain open in West Virginia, the philanthropic community stepped up efforts to raise funds to support clinic operations and patients.

✦ ***A more streamlined approach to distributing financial assistance simplified the process of getting funds into the hands of patients needing assistance.***

Example: Clinic staff from West Virginia noted that in 2020, during the COVID-19 pandemic, they received a set amount (block grant) monthly to support patients needing funding assistance. The financial support assistance still specified a set amount per patient, but funds were sent to the clinic once monthly, which allowed the clinics to plan and helped minimize staff burden.

✦ ***After the policy shift, local abortion fund support and collaboration increased to address patient financial need.***

Example: Local abortion fund representatives from West Virginia noted an increase in funds disbursed after the policy shift. They also indicated that the lack of state Medicaid funding for abortion care resulted in increased communication between the fund and patients to ensure patients had the funding support they needed.

Challenges Exacerbating the Burden on Clinics, Patients, or Funds After Discontinuation of State Medicaid Coverage of Abortion Care

✦ ***Misinformation about the status of abortion rights at the time of the policy shift required staff time to resolve misperceptions.***

Example: When the policy shift first took effect, many patients believed that abortion services were no longer available in West Virginia. Local fund and clinic staff had to inform patients that abortion services were still available from the clinic.

✦ ***Activity among opponents of abortion access increased around the passage of the legislation, adding to staff workload and complicating workflows.***

Example: West Virginia saw an increase in protest activity and in the number of fake appointments being made, which made it challenging to schedule real patients.



Recommendations to Stakeholders Preparing for a Change in Their State Medicaid Program's Coverage of Abortion

In the current landscape, other states are likely to experience shifts in state Medicaid policy (either implementing or discontinuing coverage). Findings from this study suggest four areas of preparation for abortion care stakeholders who anticipate a change in state Medicaid policy for abortion care coverage.

- ✓ **Partnerships and collaborations with decision makers:** Stakeholders anticipating or experiencing a shift in policy to **implement** state Medicaid coverage for abortion care should engage with those who will be making decisions about the timing, rollout, processes, and administration of the new program to facilitate a smooth process as well as equitable reimbursement rates.

- ✓ **Preparation and alignment of necessary billing, enrollment, and reimbursement processes:** Stakeholders planning the systems and programs that will *implement* state Medicaid coverage for abortion care should consider the early challenges faced by Illinois and Maine regarding complicated or outdated state Medicaid billing processes, patient enrollment challenges, and reimbursement processes that may carry over to the new program.
- ✓ **Reimbursement rates and financial sustainability:** Stakeholders planning programs that will *implement* state Medicaid coverage for abortion care, as well as stakeholders in states *anticipating a discontinuation* of state Medicaid’s abortion care coverage should anticipate the fiscal impacts of having a different payer mix involved in reimbursement. This could include ensuring fair reimbursement rates in a newly implemented service benefit, preparing for the fiscal impact of previous patients who self-pay moving onto (for an implementing state) or off (for a discontinuing state) Medicaid, or considering the need to broaden services to better support sustainability in the event that Medicaid coverage for abortion either goes away or affects revenue through insufficient reimbursement.
- ✓ **Coordination between providers and local and national abortion funds who provide financial and other supports to patients:** Each of the participating states in this study (i.e., *implementing* and *discontinuing* Medicaid payment for abortion care) saw changes in the kinds of patients who needed assistance after the policy shift, or in the kinds of support that were needed by patients after the policy shift. Coordination among clinics and local abortion funds, and local abortion funds’ collaboration with national organizations or other funders, will help ensure that the impacts of the policy shift create an opportunity to support more patients in new ways, rather than create more financial burden for certain groups of patients (e.g., out-of-state, privately insured).

Please visit the project page to explore relevant findings and additional materials:

