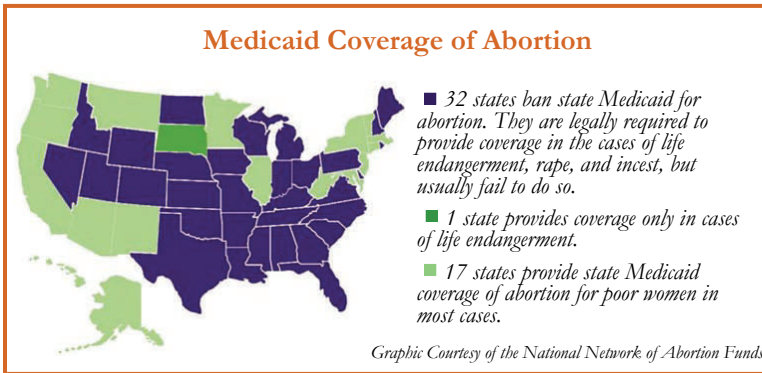


State Level Research Brief

Public Funding for Abortion: Pennsylvania

Background

The Hyde Amendment, first approved by Congress in 1976, limits women's access to comprehensive reproductive health care by prohibiting federal Medicaid funding for abortion except when a woman is pregnant as a result of rape or incest or when her pregnancy endangers her life. States have the option to cover abortion care using state funds in broader circumstances, but only 17 currently do. Since 1985, federal funding for abortion has been available in Pennsylvania only in the limited exceptions outlined by the Hyde Amendment. According to reports provided by Medicaid to the Guttmacher Institute, the number of federally funded abortions in Pennsylvania has remained at or around zero since 1985 except for one small spike in 1994 when 37 federally funded abortions were reported.¹⁻⁷



A few years ago, advocates conducted a series of activities aimed at improving Medicaid coverage of abortion in cases of rape, incest, or life endangerment of the woman. Beginning in 2001, the Women's Law Project, the Women's Medical Fund, and CHOICE worked together, with the support of the National Institute for Reproductive Health, on a statewide program of activities designed to document and address barriers to abortion funding in qualifying cases for low-income women in Pennsylvania. These organizations interviewed providers to understand reimbursement problems, met with representatives from managed care organizations (MCOs) to review policies, changed state certification requirement forms to make them easier to understand, created educational materials for women, advocates, and providers explaining Medicaid policies, and reached out to a wide coalition of advocates to build support. Due to these activities, the Pennsylvania Department of Public Welfare issued a medical assistance bulletin outlining for health care providers and state MCOs the appropriate procedures for obtaining Medicaid coverage for an abortion, as well as the circumstances under which an abortion can be covered in the state.⁸ These improvements built on a legal victory from 1995, when the Women's Law Project and the Center for Reproductive Rights won a legal challenge to remove two onerous requirements for receiving Medicaid funding for abortion: First, a woman is no longer required to report a rape to the police to obtain Medicaid coverage for an abortion if a physician indicates that she was psychologically or physically unable to file a report. Second, in cases of life endangerment, only one physician (instead of two) is required to certify that an abortion is necessary to avert the death of a woman.

Study Description

Ibis Reproductive Health documented the experiences of abortion providers seeking Medicaid reimbursement for abortions provided in cases of rape, incest, or life endangerment of the woman, circumstances that should qualify for Medicaid coverage under the Hyde Amendment. From 2007 to 2010, we conducted over 60 in-depth telephone interviews with abortion providers in 15 states (Arizona, Florida, Idaho, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, New York, Oregon, Pennsylvania, Rhode Island, Wisconsin, and Wyoming). We asked each provider to identify the person most knowledgeable about Medicaid funding in their facility and interviewed physicians, physician assistants, clinic directors, managers, nurses, counselors, and financial administrators.^{9,10}

Findings

We interviewed nine providers across the state of Pennsylvania between November 2007 and January 2008. Interviewees worked in abortion practices that varied in size, services offered, and annual case load; the practices provided an average of 2,295 abortions annually (range 250-5,433). Participants' educational background, age, and years of service in the provision of abortion care also varied; the average age of the participants was 37 years and they all had at least five years of experience in the field.

Providers estimated that, in the year prior to the interview, over 350 claims that they submitted to Medicaid for abortion services in Hyde-qualifying cases were successfully reimbursed, a number strikingly different from the estimates provided by Medicaid to the Guttmacher Institute. As a group, Pennsylvania providers reported receiving funding from Medicaid for a far greater number and proportion of claims than providers working in most other states in our study. The only providers that had more success receiving reimbursement for claims were located in two states where state funding is available for all or most abortions, not just those that meet the federal criteria for Medicaid funding. Many providers in Pennsylvania attributed their success to the statewide intervention described above. However, providers also reported that not all of their claims were reimbursed, citing almost 50 cases in which claims were denied, and they reported multiple obstacles to obtaining Medicaid reimbursement even when their efforts were ultimately successful. Three primary obstacles to obtaining Medicaid reimbursement were reported, including unclear and burdensome paperwork requirements, inconsistent support from Medicaid staff about how to file claims for qualifying abortions, and inadequate financial compensation from Medicaid. Many providers have developed strategies to overcome these barriers to Medicaid reimbursement for qualifying abortions.

Finding 1: The 2001 state-level intervention improved access to reimbursement for many providers

Several providers credited the state-level program of activities with improving the reimbursement process for providers and access to abortion funding for patients. As one provider said, “In our state...the abortion providers collectively had some help with clarification of forms and clarification of patient’s rights. And through that in the past couple years, I feel that our protocols are clearer. And patients’ rights are clearer.”

Providers also said that as a result of the efforts to improve Medicaid funding, they felt better educated about their responsibilities when applying for funding and that this alleviated many concerns about their legal accountability in determining whether the patient was in fact a victim of rape. One provider also explained that her clinic is no longer “jumping through hurdles” when working with Medicaid and that it is now easier for them to access funding for patients in qualifying cases.

“[Since the intervention] we’re not jumping through hurdles, or having to convince anybody in Medicaid to fund this abortion.”

Finding 2: Medicaid paperwork requirements are unclear, variable, and burdensome

Though providers reported relative ease with obtaining pre-authorization for procedures, many reported confusion about what certification forms were required in order to be reimbursed post-procedure. Confusion appeared to increase when applying for reimbursement from one of the many state MCOs that are a part of Pennsylvania Medicaid, particularly for abortions for pregnancies resulting from rape or incest.

Some providers were more familiar with the paperwork required to file a claim than others. Some reported that two certification forms, the MA3 and the MA368, were required, in addition to the provider’s claim form, for receiving funding, and others reported that just the MA3 and a claim form were required. Most providers indicated that “straight Medicaid” no longer requires the submission of a police report in order for an abortion to be reimbursed, though some providers reported that some MCOs continued to require police reports, despite the court order that eliminated this requirement for women unable to report the crime.

Many providers described challenges in submitting certification requirement forms for Medicaid reimbursement due to the different claims-processing requirements of the various Medicaid MCOs. As one provider explained, “Pennsylvania had one system of medical assistance, and then it broke down into a number of sub-providers throughout the state. And each of those sub-providers had different kinds of regulations for whether or not they would accept...the forms that we submitted to them for reimbursement. And it became even more of a nightmare.”

Procedures differed most around filing claims for rape or incest cases. One provider described the varying procedures for filing certification requirement forms in cases of rape with the multiple MCOs in her area: “One of them requires a police report to pay for pregnancies that are the result of the rape. One of the medical assistance providers requires a police report and that the date of the rape and the date on the ultrasound match.... One of them just requires those forms [the MA3 and MA368] and nothing else.... One requires the forms, plus a letter from me stating that the patient’s been counseled.”

Some providers required their patients to have a physician who does not work at the abortion clinic sign the required forms in order to protect the clinic’s physicians. However, they stated that this can be problematic as many physicians who do not work in abortion care “just refuse to sign the forms because they don’t want to; because they don’t believe in abortion.” Some providers reported that even though a police report is not required by all of Pennsylvania Medicaid’s MCOs, they preferred having the police report to protect the physician and the clinic from liability in cases of false rape claims. As one provider explained, “I’m just distrustful of the state’s ability to protect our physicians, to protect our patients, and maybe not just ability—their interest in doing so.”

Frustrated with the overall claims process, some providers have given up on filing for reimbursement from Medicaid all together. As one provider explained, “It was nearly impossible for us to ever procure reimbursement. We would file over and over and over again, and have the forms either be lost, or they were rejected, and so we would reapply, and not hear anything, and then they would tell us that time was up, that there wasn’t anything that we could do about it, and it was a nightmare.”

Finding 3: Medicaid employees provide inconsistent billing support

Some providers reported that the billing process, though paper heavy, was facilitated by positive relationships with dedicated Medicaid personnel. As one provider said, “We’ll have an assigned rep, or someone that will call, who will see it through,” and other providers explained that over time they built rapport with staff at some of the MCOs. However, providers reported they could not rely on finding supportive staff at all MCOs in the state. As one said, “[MCO]’s been pretty good lately and they’ve had pretty consistent staff, which I think helps a lot, because when we call, we can say, ‘Hey [staff name], did you get that letter?’ We know the people there, and have spoken to them; it’s been the same woman, literally, for the five years I’ve been here... At [MCO] and [MCO], it’s a different person every time we pick up the phone.” Another provider illustrated the impact of losing a dedicated and helpful Medicaid staff person: “I called them [Medicaid], and I said, ‘Listen, we have these claims. We really need to get them paid. How do we do it?’ And she talked me through the entire form, and how it should be filled out, and what I’d need to put in each box in order to get the claim paid. And that was very helpful. But, she’s no longer there, and when we try and get someone like that to help us [now] it doesn’t work.”

A few providers also expressed difficulty working with Medicaid staff to resolve rejections: “The countless re-submissions; they’ll have 10 or 12 different codes as to why it [was] rejected. And it just doesn’t make sense...the rejection codes are difficult to interpret and when you get someone on the phone, they’re not helpful. They don’t tell you how you can resubmit it, or what information we need on the claim in order to resubmit it so it’ll be approved.”

Finding 4: Financial compensation from Medicaid is low and slow

Inadequate reimbursement from Medicaid was reported as a significant barrier by all interviewees. Some providers were unsure of the Medicaid reimbursement rate for abortion procedures. As one said, “I don’t even know what the reimbursement rate would be now, but, I remember at a time, it was so little, that it wasn’t worth it.” Other providers reported standard Medicaid rates for abortion that ranged from \$102 to \$450. Some indicated that the rate varied depending on gestational age, while others said it did not. Although the exact rate of reimbursement was not clear, many of the providers indicated that it was lower than the already reduced clinic fee for abortion. In spite of these barriers, none of the providers reported that the Medicaid reimbursement rate dissuaded them from submitting Medicaid claims or accepting Medicaid patients.

Most providers noted inconsistencies in the amount of time it took for claims to be reimbursed. These ranged from within a month to over a year and most were unable to recall an experience in which a case was reimbursed quickly. Providers described being confronted with numerous bureaucratic and administrative roadblocks and recalled many instances in which reimbursements were delayed because claims were repeatedly denied and re-submitted for seemingly arbitrary reasons.

Summary

These findings show that the current Medicaid system is not consistently meeting the needs of low-income women in Pennsylvania; all but one provider in this study indicated that current funding procedures in the state impede access to abortion for Medicaid recipients seeking services. The majority of providers reported experiencing barriers when submitting claims for funding. Several providers reported challenges navigating the inconsistent reporting requirements of the various state MCOs, particularly in knowing whether or not an MCO required a police report to obtain funding, when legally the requirement should not be in place if a woman is physically or psychologically unable to report the rape. Though many of the providers we spoke with had developed positive and helpful relationships with Medicaid employees, assistance provided via Medicaid MCOs was inconsistent and often unpredictable, leaving some providers to make best guesses about the appropriate way to submit claims. Additionally, reimbursement for abortion services is low and slow to process. For some providers the combination of these

Finding 5: When Medicaid fails, providers take creative measures to get reimbursed

Frustrated by Medicaid’s lack of consistent payments, some providers have taken creative and assertive measures to receive reimbursement. One provider successfully sent her unpaid claims to a collection agency: “We did end up sending a lot of the claims to a collection agency because we’d had enough. And we got word from the collection agency a week or two ago that the Department of Health would be sending us payment.” Another provider successfully issued an ultimatum to Medicaid after months of non-payment by telling the Medicaid MCO, “We’re not seeing any more of your patients until you pay on these claims... And eventually that would get someone to take action on their end, and get enough of the claims paid that we would start seeing the patients again.” Two providers mentioned directly involving recipients in pursuing reimbursement by having them contact their Medicaid MCO directly and demanding coverage for their procedures. One provider recalled saying to patients, “‘Call your insurance company. You are the consumer and you need to advocate for yourself, and ask your insurance company why they’re not covering this.’ Because sometimes the patients themselves were able to get a little bit further than we were, by literally calling customer service, and saying, ‘I have this form, and you’re supposed to cover it, and why aren’t you?’”

Additionally, many providers reported they reduce their fees by an average of \$50 for Medicaid recipients who are ultimately unable to get funding and that they rely heavily on abortion funds, grassroots and often volunteer-led organizations that raise money to directly help women cover the cost of an abortion.

challenges led to giving up on seeking Medicaid dollars altogether, spending inordinate amounts of staff time to obtain funding, reducing their fees, or turning to abortion funds for support.

Our results are consistent with earlier findings that prompted the coalition of advocates to conduct the 2001 program of activities to streamline funding procedures for abortion care. This earlier research identified several barriers to obtaining federal funding for abortion in qualifying cases. These barriers included confusing Medicaid reimbursement forms, physician refusal to sign the reimbursement forms, lack of knowledgeable and trained staff at Medicaid MCOs, and abortion providers not contracting with various managed care plans.¹¹

Though some challenges remain, it appears that the advocates’ efforts helped to remove or mitigate many of the barriers to accessing Medicaid funding. This is in spite of the fact that the success of the intervention is not reflected in the number of federally funded abortions reported by Medicaid. (We speculate that the number of federally funded abortions



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reported by Medicaid to the Guttmacher Institute may be different than the number estimated by providers due to potential differences in the timeframes in which the data was collected and/or inaccuracies in Medicaid's recordkeeping or providers' recollections of cases.) According to providers' reports, the funding system for abortion in Pennsylvania appears to be running more smoothly than the systems of most of the other states where we conducted interviews. The work of state-level providers and advocates to improve access to funding appears to be a key factor in the relative success of the system. Providers throughout the state noted that the revised Medicaid certification requirement forms are much clearer than before, making the process of filling out and submitting them much easier. Additionally, though providers reported that they experienced challenges with some MCOs, no provider reported refusing to contract with any managed care plans or declining to see a patient enrolled in one. In fact, most providers reported great success in working with at least one local MCO. The intervention to improve the system also appears to have contributed to increasing providers' sense of empowerment and their belief in their clients' entitlement to Medicaid funding.

It should be noted that because we interviewed only a sample of the abortion providers working in Pennsylvania, the experiences of all providers may not be represented in these findings. The experiences of some providers may also be different from those represented here because of the apparent differences in how providers and local Medicaid offices interpret and apply the law.

Next Steps

Lessons learned about the successes and remaining challenges for Pennsylvania providers can provide important feedback about ways to improve access to abortion funding for women who are legally entitled to it in Pennsylvania and can help advocates in other states develop strategies to improve access to federal funding and state funding when available. Though Pennsylvania's funding system seems to have improved greatly over time, providers also reported a number of ways in which access to funding could continue to be streamlined.

Most providers reported they believed Pennsylvania Medicaid should cover abortion under all circumstances and supported any advocacy efforts that would push the state in that direction. However, many felt that changing the law so that state Medicaid funds can be used to cover abortion under a wider range of circumstances would be extremely challenging. As one provider said, "It won't happen in Pennsylvania, but I can dream! ... We have legislation that still allows for these

other barriers such as the informed consent and 24-hour waiting period, and parental consent laws. I guess [we are in] one of the stricter states in the country." Believing that securing Medicaid funding for abortion in a broader range of circumstances was a long-term goal, providers suggested two other ways for improving the processing of claims in the interim: 1) Assign a dedicated Medicaid staff person to work with abortion providers, and 2) Shift the burden of getting claims reimbursed to Medicaid by reducing the amount of follow up required by providers, and by ensuring that rejection codes are clear and that Medicaid staff are helpful and proactive in reimbursing claims.

We also suggest the need for further education of both providers and Medicaid staff about how to submit claims for funding in qualifying cases to the various MCOs in the state. As managed care organizations have continued to proliferate in Pennsylvania, working towards uniform reporting and funding requirements among MCOs may significantly reduce the confusion some providers experienced and ultimately improve the chances of receiving funding from Medicaid. Efforts should be undertaken to inform MCOs that they cannot legally require a police report when a women is seeking an abortion due to a rape if she is physically or psychologically unable to report it. Actions to ensure that MCOs change their procedures accordingly are also needed. It is also clear that the Medicaid reimbursement rates for abortion services needs to be raised to make applying for funding "worth it." Finally, future efforts may be able to draw on the experiences and strategies of savvy and active providers who identified ways to push back against an unresponsive system, including by sending Medicaid bills to a collection agency and refusing to see clients of non-paying managed care organizations.

Medicaid policies and procedures that unjustly deny access to Medicaid funding for abortion care cannot be ignored. Providers reported that overturning the Hyde Amendment is critical to improving access to funding for women on Medicaid. While we work toward that goal, Medicaid must be held accountable to fund abortion for women who meet the current criteria for federal funding, in cases of rape, incest, and life endangerment. Continued efforts to expand public funding for low-income women are needed to ensure equitable access to abortion services for all women in the US.



Ibis Reproductive Health aims to improve women's reproductive autonomy, choices, and health worldwide.

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- Gold RB and Macias J, Public funding for contraceptive, sterilization and abortion services, 1985, *Fam Plann Perspect*, 1986, 18(6):259-264.
- Gold RB and Guardado S, Public funding of contraceptive, sterilization and abortion services, 1987, *Fam Plann Perspect*, 1988, 20(5):228-233.
- Gold RB and Daley D, Public funding for contraceptive, sterilization and abortion services, fiscal year 1990, *Fam Plann Perspect*, 1991, 23(5):204-211.
- Daley D and Gold RB, Public funding for contraceptive, sterilization and abortion services, fiscal year 1992, *Fam Plann Perspect*, 1993, 25(6):244-51.
- Sollom T, Gold RB and Saul R, Public funding for contraceptive, sterilization and abortion services, 1994, *Fam Plann Perspect*, 1996, 28(4):166-73.
- Sonfield A and Gold R, Public funding for contraceptive, sterilization and abortion services, FY 1980-2001, New York: The Alan Guttmacher Institute, 2005.
- Sonfield A, Alrich C and Gold RB, Public funding for family planning, sterilization and abortion services, FY 1980-2006, *Occasional Report*, New York: The Alan Guttmacher Institute, 2008, No. 38.
- Commonwealth of Pennsylvania Department of Public Welfare, *Medical Assistance Bulletin #99-06-15*, Nov. 28, 2006.
- Kacanek D, Dennis A, Miller K and Blanchard K, Medicaid funding for abortion: Providers' experiences with cases involving rape, incest and life endangerment, *Perspect Sex Reprod Health*, 2010, 42(2):79-86.
- Dennis A, Blanchard K and Córdova D, Strategies for securing funding for abortion under the Hyde Amendment: A multi-state study of abortion providers' experiences managing Medicaid, *Am J Public Health*, 2011 (forthcoming).
- Horsley S, *Takin' it to the states: A toolkit for expanding abortion access and reproductive justice in your state*, Boston: The National Network of Abortion Funds, 2008.