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Original Research Article

Lessons learned: Illinois providers' perspectives on implementation of Medicaid coverage for abortion ☆,☆☆

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ABSTRACT

Objective: On January 1, 2018, Illinois became the first Midwestern state to cover abortion care for Medicaid enrollees. This study describes state implementation of the policy, the impact on abortion providers, and lessons learned.

Study Design: We documented abortion providers' perspectives on the service delivery consequences of Medicaid coverage for abortion in Illinois. We conducted in-depth interviews with clinicians and administrators ($N = 23$) from 15 Illinois clinics, including clinics that provided other services and those primarily providing abortion. We conducted interviews in person or by phone between April and October 2019. They lasted ≤100 minutes, were audio-recorded, transcribed, and coded in Dedoose. We developed code summaries to identify salient themes across interviews.

Results: All participants supported the law and expected benefits to patients. Many struggled to implement the policy because of difficulties obtaining certification to bill the state Medicaid program, confusing and cumbersome paperwork requirements, reimbursement delays, confusing claim denials, and uncertain protocols for Medicaid patients covered under the exceptions defined by the Hyde Amendment. Nearly all participants expressed concern that low reimbursement rates were insufficient to cover costs. Implementation was easier for multiservice clinics and those nested in larger institutions. Several clinics closed during implementation; one clinic opened. Clinics leveraged internal resources, external funding, and technical assistance to ensure that Medicaid enrollees could receive care without costs.

Conclusions: Implementing Medicaid coverage for abortion requires proactive and responsive state institutions, improvements to reimbursement processes, and adequate reimbursement rates. In Illinois, successful implementation depended on clinic adaptability, external support, and advocacy.

Implications: Our research suggests that successful, sustainable implementation of Medicaid coverage for abortion depends on state policies that allow clinics to enroll patients, process claims in 30 to 90 days, and receive reimbursements covering the cost of care. Without these measures, ensuring immediate patient access may depend upon clinics mobilizing resources and external transitional support.

1. Introduction

Medicaid is a program that assists individuals with limited incomes with medical costs, yet policies such as the Hyde Amendment restrict use of this program for abortion care. The Hyde Amendment restricts federal funding for abortion in state-based Medicaid insurance programs to only those procedures provided in cases of rape, incest, and threats to the life of the patient, forcing Medicaid patients with limited resources to pay out-of-pocket. Although some Medicaid patients may receive financial assistance from clinics or abortion funds, this assistance may not cover the full cost and the remaining out-of-pocket cost may be an unsurmountable barrier to obtaining care. Researchers have documented associations between financial barriers—including a lack of insurance coverage—and delays to abortion care or the inability to ac-

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cess care [1-6]. Further, researchers have demonstrated that financial barriers may be especially burdensome for racially minoritized and economically marginalized people who cannot use Medicaid to cover their abortion [7].

To help ensure Medicaid recipients can access abortion alongside other health services, some states use their own revenues to cover care beyond the Hyde exceptions. On January 1, 2018, Illinois passed Public Act 100-0538 (known as HB40) and became the first Midwestern state to volunteer state funds to cover abortion care for Medicaid recipients; 6 other states voluntarily cover abortion care through Medicaid and 9 states do so pursuant to a court order [8]. Since approximately 76% of female Medicaid recipients are of reproductive age in Illinois, HB40 has the potential to significantly expand abortion access in the state [9].

Despite previous research on the impact of expanded Medicaid coverage of abortion and reduced financial barriers for patients, little is known about how shifting to Medicaid payment could impact abortion providers' capacity to offer care. Recent evidence from Oregon, where reproductive health coverage was expanded, suggests that patient access depends on a clinics' ability to enroll pregnant patients in Medicaid and provide care before the patient's application to the program is fully processed (presumptive eligibility) so that abortion care is covered without delays [10, 11]. Research comparing abortion providers' experiences billing Medicaid programs shows that billing practices vary by state, with providers in states that voluntarily cover abortion experiencing fewer challenges than those in states covering abortion by court orders or with laws not fully implemented [10-13]. However, there is a lack of research exploring the impact on clinics that shift from a patient population paying out of pocket or receiving financial assistance to a population seeking care that will be reimbursed by Medicaid.

For some clinics, this shift reflects a significant change for clinic operations centered around receiving direct payment or reimbursement from abortion funds. Since abortion was only covered by Medicaid in such rare instances, many clinics had never become certified to bill Medicaid for services. In order to bill Medicaid, clinics have to apply for and receive certification, submit claims, and wait for reimbursement. In Illinois, most Medicaid participants are in enrolled in managed care organizations (MCOs) where providers bill the MCO for services, while a small percent remain in fee-for-service Medicaid where the providers bill the state directly. However, when implementation of HB40 began, Illinois directed providers to bill MCOs only for abortions that fall under the Hyde exceptions and send the remaining claims directly to the state, adding another step in the billing process.

Illinois' policy change offers an opportunity to evaluate state implementation of Medicaid coverage for abortion and the impact on clinics. Lessons learned can inform providers and policymakers elsewhere as states consider expanding Medicaid coverage for abortion. Our study aimed to explore the perspectives and experiences of clinicians and administrators at clinics offering abortion before and after state Medicaid funding, with lessons for implementation.

2. Methods

2.1. Recruitment

Our recruiting pool consisted of all known clinics providing abortion at the time of HB40's effective date (January 1, 2018) and those that began providing services in the year following (to December 31, 2018). In 2017, the Guttmacher Institute reported 25 abortion-providing clinics in the state [14]. Clinic types included hospitals, private offices, reproductive health care organizations, and practices where abortion care was the primary focus. We recruited clinicians and administrators at these clinics using personal and professional contacts and participant referral, utilizing participants' recommended contacts to reach out to additional eligible participants. Of the 33 individuals invited to participate, 23 completed interviews, 5 declined due to lack of time, and 5 yielded no response after reaching out by phone or email at least 3 times. The 23 interviewed participants included clinicians and administrators representing 15 clinics that provide care through 35 clinical sites across Illinois.

2.2. Data collection

Two researchers (A.B. and C.Z., both with 5 years of qualitative research experience) conducted interviews between April and October 2019, 16 to 22 months after the enactment of HB40. Interviews lasted $\leq$100 minutes and were conducted in person or by phone. In order to capture multiple perspectives from each clinic, we interviewed multiple people from the same clinic, and sometimes in the same interview. We covered the following topics: clinical services, insurance, reimbursement, barriers and facilitators to implementation of the Medicaid policy change, changes in population and services since the policy change, and perspectives on the impact of Medicaid coverage for abortion access. We audio-recorded all interviews, and a transcription company transcribed audio-files. Before data analysis, members of the study team verified transcripts against the audio files for accuracy. We compensated participants for participation with a $60 gift card. The University of Chicago's Institutional Review Board approved the study.

2.3. Analysis

We used a thematic content approach to inform data analysis [15]. The study team developed a codebook based on the interview guide and included emergent themes found in the transcripts. Two members of the study team (C.Z. and L.H., who has 8 years of qualitative research experience) coded 2 transcripts and met with a third study team member (AB) to review coding for consistency and concordance as well as to discuss issues of coding disagreement. Once the team established a sufficient level of coding concordance, the 2 original coders independently coded the remaining transcripts. The final codebook included codes predetermined from the interview guide, and codes that emerged directly from the data. The study team used Dedoose qualitative data software (Dedoose version 8.0) to code all transcripts. We then developed code summaries based on salient themes to facilitate in-depth analysis and synthesis [16]. We present themes related to clinic experiences implementing Medicaid coverage for abortion care, along with representative participant quotations.

3. Results

Of the 23 interviewed participants, 20 were female and 3 male. While collected, we do not report participant ages, sexual orientation, race/ethnicity of non-white respondents, or city of residence to protect confidentiality. Most ($n = 20$) self-identified as white or Caucasian. Most were physicians ($n = 12$), 10 were administrators, and there was 1 nurse-practitioner. One participant spoke about experiences at 2 different clinics. We spoke to participants at 8 "multiservice clinics," where abortion as well as other reproductive health services were offered. These included hospitals, private offices, and a large reproductive health care organization. In addition, we spoke to participants at 7 "abortion clinics," where abortion care was the primary focus of daily operations. While other researchers use alternative typologies for abortion clinics (e.g., specialized abortion clinics, nonspecialized clinics, hospitals, and physicians' offices), our findings point to key implementation differences between these 2 categories [14]. Addition-

ally, this reporting approach allows us to best ensure participant and clinic confidentiality.

3.1. Providers supported the law

Participants expressed widespread support for Medicaid coverage for abortion and many were eager to see abortion care covered like other health services. Participants expressing support focused on the benefit to patients and clinics of incorporating abortion coverage into the state's Medicaid program. As 1 administrator at a multiservice clinic observed,

> I think this is every woman's right…to get these types of services and just because you may have low income or be in some other financial need, or whatever your situation is, the right to have these services is for everybody.

One provider at a multiservice clinic noted, "I do see it as a victory because it's so rare that there's good public discussion on how abortion should be part of regular medicine." Another provider at an abortion clinic expressed, "There was surprise and excitement and relief. I think it was a really big deal…when you have a win like [HB40]."

3.2. The challenge of low reimbursement rates

Despite strong support for HB40, many participants also voiced concern with the financial implications of Medicaid expansion for clinics given low reimbursement. One administrator at an abortion clinic described the tension between fulfilling the clinic's mission and confronting financial challenges:

> [HB40] is meeting one of our missions, which is to again provide access to all…so, it is allowing us to fulfill our mission and our values. But, again, from an operational perspective, it is going to become limiting. And unless something happens dramatically with the reimbursement rates, it's gonna be hard for us all.

Nearly all participants expressed that Medicaid reimbursement rates were outdated and insufficient to cover costs of providing abortion care; this was especially problematic for abortion clinics compared to multi-service clinics. The rates had remained flat for decades and did not account for a patient's specific procedure. One abortion clinic participant described the reimbursement rate as "less than 50% of what it would cost us to do a first-trimester abortion" and further explained that this would be especially challenging since "60-plus percent of our patients are either [insured with] Medicaid currently or Medicaid eligible."

Following HB40, one new abortion clinic opened that specialized in providing medication abortion and early surgical abortion. At the same time, one abortion clinic closed and one multiservice clinic stopped providing abortion care. Another abortion clinic operating in a multiservice health center halted abortion services temporarily. Participants from these shuttered clinics described low Medicaid reimbursement rates as a contributing factor in the decision to discontinue abortion services. An administrator explained, "it turned out that so many of our patients were Medicaid patients it just was unsustainable."

Given these concerns about reimbursement, several participants pointed out that a law meant to increase abortion access for patients needs to address financial sustainability to ensure providers remain available. There was specific concern that clinics offering a higher volume of procedures later in gestation would be the most affected. A provider from an abortion clinic offering such procedures worried that without abortion funds providing financial assistance and with such low reimbursement rates, "places like us who provide these later gestational age cases, we would no longer be here." Low reimbursement rates often had a larger impact on abortion clinics than multiservice clinics, as abortion clinics were more likely to provide care to high volumes of abortion patients across the spectrum of gestational periods.

3.3. Operational challenges

Relative to multiservice clinics situated within larger institutions, abortion clinics faced operational challenges in implementing HB40 because of the difficulty of becoming newly certified to accept Medicaid insurance, the challenges with navigating relationships with Illinois' Medicaid MCOs, and because of the difficulties they faced submitting and processing Medicaid claims. One provider at an abortion clinic reflected on the concerns they had about HB40 implementation and the need for better preparation ahead of passage:

> We, the providers, were very concerned about what would happen before the law was passed and we kept saying…We need to increase the reimbursement; we need to…get the paper billing into electronic billing. We should do all these things ahead of time so there won't be this major mess after the law is passed.

Clinics affiliated with larger institutions benefited from both technical and administrative support as well as a more diverse and reliable payor mix that could create financial buffers during implementation. Another participant at a hospital-affiliated multiservice clinic discussed the advantage of belonging to organizations that are big enough to "pull money from other places because they believe the services that we offer are important."

To work around their disadvantages relative to multiservice clinics, abortion clinics mobilized resources to facilitate Medicaid certification, raise institutional awareness of HB40, reduce the administrative burdens of policy implementation, and increase abortion care reimbursement rates.

3.3.1. Difficulties obtaining Medicaid certification

Many abortion clinics had not been certified by the state to accept Medicaid payments for their services before January 1, 2018, and these clinics experienced challenges becoming certified after HB40 was passed. To start the process, clinics had to pay a nominal fee to apply for certification, but in some cases the costs of certification included infrastructure changes to meet regulatory requirements. For example, 1 administrator at an abortion clinic explained how they had to replace a wall to install a special door to meet their facility's requirements for receiving Medicaid payments.

While some clinics received technical assistance from health care consultants, they described the administrative process as demanding and felt there was minimal guidance from the state. One administrator from an independent abortion clinic described confusion completing online forms, having to wait on hold for hours to seek guidance, only to experience 5- to 12-month long delays between paperwork submission and certification for a single clinical site.

3.3.2. Low institutional awareness of HB40

Participants with new and previous Medicaid certification described challenges getting claims approved, including denials and delays linked to small clerical errors, unclear policy guidance, and difficulty finding a person to contact and ask questions at agency offices. A few participants specifically pointed to a general lack of awareness within state institutions that abortion was supposed to be covered. One administrator at an abortion clinic observed the confusion among state agencies, MCOs, and clinics on the billing process:

> I know in the beginning, [staff at the state Medicaid agency] were confused too […]. They didn't even –most of them, for

months, didn't even know about the law and so it was a learning process I think for everyone.

Clinics already certified to accept Medicaid, particularly those with direct public funding, reported stable relationships with the Medicaid state agency and most of the Medicaid MCOs offering plans. Those working toward certification did not generally describe which MCOs they planned to work with, but 1 administrator at an abortion clinic mentioned some difficulty when exploring whether their clinic could be added to the provider networks of MCOs,

> We started contacting them because we just wanted to get on the ball and see how this is rolling. A lot of them were saying they're not taking any more facilities on or providers and so that has been difficult.

Participants found the lack of awareness of the policy change among MCOs charged with carrying out state policy compounded practical problems that were accruing in clinics as they began to create and file claims for reimbursement after providing abortion care to Medicaid recipients.

3.3.3. Difficulties with paper claim submission processes

Particularly burdensome for a number of participants was a requirement that every claim for Medicaid coverage of abortion include a specific paper form (Form 2390—Abortion Payment Application Form) that could not be electronically generated. The form included a section where providers had to indicate reason for the procedure (e.g., rape, incest, a threat to the life of a patient, threats to the health of a patient or "elective procedure"). According to several participants, clinics had to procure typewriters in order to complete the form properly. Participants found the form a logistical obstacle to reimbursement because it, and all abortion claims paperwork, had to be submitted by mail to the state. This requirement for paper copies also made it more difficult for clinics to track submitted claims.

The institutional purpose of the form was unclear to participants. One participant explained that the paper forms existed so the state could seek reimbursement from the federal government for the small number of abortions that would be covered under the Hyde exceptions. Some also explained that the form was used to distinguish whether reimbursement would come from the MCOs (for those procedures covered by federal funds) or directly from the state (for "elective" procedures.) A few participants felt this form created unnecessary confusion and ethical dilemmas as clinics were asked to indicate whether there was a "health"-related reason or whether the abortion was "elective", with some arguing all abortions are "health-related." One provider at a multiservice clinic observed the form was "not only a barrier to the actual process of billing but also completely nonsensical from a medical point of view. It shouldn't matter. The reason for the abortion shouldn't determine what insurance company pays for it."

Beyond filling out the Form 2390, the claim submission process itself was described as burdensome. One participant from an abortion clinic talked about having to resubmit the same claim multiple times to the state, each time responding to a different bureaucratic rationale for rejection:

> It's like you fixed one thing because they send you a claim saying, it's missing this box and only this box. So, you've made sure that's on there, send it again. Now they're saying another box is missing, but it's the same claim that was done the first time and it was okay.

This particular participant's clinic had been waiting 7 months for reimbursement from the first claim they submitted under the law. Another provider at a multiservice clinic pointed out how clinics have 190 days to correct a submitted claim, but, with the Form 2390 requirement and the confusion over implementation, that window "doesn't work when it's taking the administration four-and-a-half months to process our claims."

3.3.4. Difficulties qualifying for Medicaid presumptive eligibility

In Illinois, pregnant patients can be granted presumptive Medicaid eligibility by qualifying health facilities. This way, the clinic can provide immediate care and be assured of reimbursement once the patient is officially enrolled in Medicaid. While participants at several clinics mentioned checking Medicaid coverage and assessing eligibility ahead of a patient's visit, only 1 participant noted that their clinic could grant patients presumptive eligibility through Medicaid. As 1 provider at a multiservice clinic explained,

> Our hope is that [abortion care] would be just like any other pregnancy-related care, in that if you meet the standards, you get presumptive eligibility, and then you can bill for your service before the patient actually has Medicaid, which is how it works with prenatal care for certain providers.

However, most clinics could not be certified to offer presumptive eligibility enrollment because they did not meet the state requirements.

3.4. External resources needed for successful, sustainable policy implementation

During implementation of HB40, many clinics leveraged transitional grant funding, internal funding, and technical assistance from external sources to help mitigate financial losses and ensure patient access. These financial supports seemed to prove especially critical for abortion clinics. Several participants at clinics not yet certified or at clinics experiencing delayed reimbursement said that this transitional funding helped their clinics offset the costs of care for patients with Medicaid coverage as they worked through the implementation. An administrator at an abortion clinic explained how transitional grant funding became critical to ensuring patient access once it became clear that low-income patients would no longer be eligible for financial support provided by a national abortion funding organization, as these funds were reserved funds for patients in states that lacked Medicaid coverage of abortion: "so that's when the [transition funding] was offered…to help tide everybody over." Clinics also received support from externally funded consultants to advise on processes for Medicaid certification and billing, and to troubleshoot with state agencies. A provider at an abortion clinic described the dual significance of this external transitional funding and technical assistance,

> One has been the ability to be able to continue to care for patients in a seamless way. Equally importantly, we've been able to have more resources to move forward in the implementation process.

External resources allowed at least 5 clinics to provide no-cost care to patients who would be candidates for presumptive eligibility if clinics were allowed to enroll patients. Some clinics also received technical assistance from organizations that were already Medicaid certified and some clinics gained information and resources from a legal advocacy organization. A few participants discussed how clinics shared information with state agency officials on how to improve implementation by raising reimbursement rates, shifting to electronic billing, and amending the criteria so clinics offering abortion care could become certified to offer presumptive eligibility.

4. Discussion

Providers and others working in abortion care supported Illinois' Medicaid coverage expansion and saw clear benefits for patients, but faced numerous barriers that made implementation challenging and, in some cases, threatened the sustainability of their clinic. In response, clinics leveraged external resources to absorb temporary losses and ensure that Medicaid enrollees could receive care without costs. In documenting implementation challenges, our study findings highlight the lessons that can be learned and applied in other states to assure a smoother transition.

The barriers Illinois abortion providers faced in implementing Medicaid coverage for abortion echo those found in previous research comparing clinic experiences of Medicaid coverage of abortion [13, 17]. In line with other studies, our case demonstrates that low reimbursement rates for abortion care in state Medicaid programs are central impediments to policy implementation in this area [12]. As well, in line with other research, our study demonstrates the importance of presumptive eligibility and timely approval for coverage in state-level efforts to fund abortion care for Medicaid eligible pregnant people [10, 11, 17]. We build on these studies by providing insight on practical policy implementation issues and opportunities to avoid such concerns in other states.

Our findings also underscore the fragility of the safety net for abortion care. Of the estimated 862,000 abortions performed each year nationwide, 60% take place in stand-alone clinics that specialize in abortion care (16% of all facilities) [14]. As previous research has documented, this concentration of abortion care in stand-alone clinics in the US has emerged over time to ensure patient-centered, supportive abortion access but also in response to legal, structural, and political pressures that marginalize abortion care [18-20]. Our findings suggest that additional support for abortion clinics relative to multiservice clinics may be needed in response to significant shifts in health insurance policy.

HB40's passage in a context of low rates was mentioned as a factor contributing to the closure of at least 2 clinics. Medicaid reimbursement rates in Illinois remained unchanged for many years and were lower than other states, especially for procedures later in gestation [12]. Abortion clinics serving patients later in gestation were considered at risk of closing or suspending more complex abortion procedures if the rates were not raised. These findings suggest that ensuring adequate reimbursement rates should be prioritized before or alongside any effort to expand Medicaid coverage for abortion.

Operational challenges meant that clinics struggled through Medicaid certification processes while institutional officials were slow to adopt policy changes, and worked with advocacy organizations, health care consultants, and each other to press for institutional reforms surrounding issues they were unable overcome. Some clinics also relied on external funding to support implementation and ensure patients with Medicaid could be seen at no cost while the clinic established Medicaid billing. Thus, our findings also suggest that supportive stakeholders and provider communities play a key role in supporting policy implementation.

Building on provider feedback, major policy implementation issues were addressed by the Illinois Department of Health and Family Services starting in late 2019 and into early 2020. These changes resolved many of the challenges that emerged from our thematic analysis. They included a switch from paper to electronic claim filing, removal of the paper Form 2390 requirement, and, most recently, regulations that will allow abortion clinics to offer Medicaid presumptive eligibility to appropriate patients [21-23]. Reimbursement rates were also raised to be more in-line with rates in other states [24].

Our research provides useful recommendations for expansions of Medicaid coverage of abortion in other settings (Table 1). Find-

Table 1
Recommendations for states expanding Medicaid coverage of abortion

State Medicaid agencies should...
Affirm abortion providers are eligible to grant presumptive eligibility for pregnant patients
Process claims in a timely manner (with most payments made within 30 days as indicated by federal guidelines (see 42 U.S.C. §1396a(a)(37)(A))
Allow for electronic claim filing, either directly through the state or through managed care entities, without the burden of additional forms not required for other services
Establish adequate reimbursement rates, adjusted for gestational age, before coverage expansion
Reduce burdens on providers and establish clear protocols if claims meeting Hyde Amendment exceptions for coverage will be paid by federal Medicaid funds
Provide technical support for all providers seeking Medicaid certification
Ensure awareness of Medicaid policy change and education regarding claims processing among employees of the state agencies

ings suggest that successful, sustainable implementation of Medicaid coverage for abortion depends on policies and procedures that make it feasible for clinics to enroll patients, process claims in 30 to 90 days without major logistical hurdles, and receive reimbursements that cover the cost of care. State agencies should incorporate abortion provider's expertise as they develop approaches to policy implementation. When abortion clinics are not involved in policy development and implementation for Medicaid coverage of abortion care, many clinics will encounter financial deficits that can lead to clinic closure. Clinics in Illinois were able to secure short-term financial assistance, but this may not be feasible in other settings.

4.1. Limitations

The experiences with clinic implementation described here are filtered through the perspectives of the participants interviewed, which may contain recall bias. Providers and administrators were interviewed 16 to 22 months following enactment of HB40 and thus the experiences reported here reflect a specific point in time during implementation. Some challenges described by participants were resolved or changed as the state implemented new billing and reimbursement policies, though these changes occurred after the interview timeframe. While we attempted to speak with administrators directly involved in the submitting claims/billing processes, in some cases, we were only able to speak with providers at larger institutions who did not have in-depth knowledge about billing processes. However, these providers voiced few concerns about financial or administrative implications of the law, especially since many were already Medicaid certified and provided other Medicaid-covered services. Given we spoke to a sample of abortion providers, we realize these comments may not be reflective of the experience of every abortion clinic provider in Illinois. We also recognize that our recommendations in this article are based on provider experiences in Illinois, which may not be directly transferable to other states.

4.2. Conclusion

Following implementation of a state law removing restrictions on abortion coverage in Illinois' Medicaid program, abortion care clinicians and administrators across the state expressed enthusiasm for the policy change. They also expressed frustration at aspects of its implementation. Clinics mobilized resources to meet patients' needs in the new policy environment. They advocated for administrative changes and improvements to reimbursement processes, incorporating direct input from affected providers. For all clinics, especially abortion clinics, faster pathways to Medicaid certification, immediate capability to offer presumptive eligibility enrollment for Medicaid, rapid reimbursement processes, and responsive communication from state institutions are all likely to reduce barriers in implementing policies that support Medicaid coverage of abortion.

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