Strengthening Telemedicine Medication Abortion Coverage (TMAB) in Medicaid: Leveraging Non-Physician Practitioners (NPPs)[1]

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Medicaid provides health care coverage to people with low incomes and certain disabilities. The program is state-led and funded through a mix of federal and state money. Federal rules limit what federal funding can be used for, but many states will dedicate separate state funds to expand beyond these restrictions. Regarding abortion, seventeen states[2] currently use state funds to provide care in instances other than the extremely limited circumstances for which federal funding can be used. In Fall 2024, authors undertook desk research on these states, focused specifically on policies that impact NPP provision of telemedicine medication abortion to Medicaid beneficiaries.[3] Three key opportunities to promote NPP provision of TMAB emerged and are explained below.

WHY NPPs?

Reasons to maximize NPP engagement in TMAB include: (1) research shows that patients are as safe and care is as effective, (2) NPPs are an important part of the Medicaid workforce, and (3) increasing the number and types of professionals providing care bolsters access.

POLICY OPPORTUNITIES FOR STATE MEDICAID PROGRAMS

Medicaid programs should provide coverage for NPPs in line with their full scope of practice.

In all of the states reviewed, NPPs are permitted to provide TMAB care under their license. Moreover, nurse practitioners and certified nurse-midwives practice independently (at point of licensure or after a transition period). Physician assistants are subject to supervision in the majority of states, but telephone and electronic communication are widely accepted forms of supervision.

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[1] We are using this term to refer to nurse practitioners, certified nurse-midwives, and physician assistants.

[2] AK, CA, CT, HI, MA, MD, ME, MN, MT, NM, NY, NJ, IL, OR, RI, VT, WA. State funding for abortion is forthcoming in additional states. Delaware has enacted legislation expanding abortion coverage in Medicaid effective January 1, 2025. Nevada is expected to implement state coverage of abortion based on a court ruling that found the state's public funding ban on abortion coverage violates Nevada's Equal Rights Amendment. In Colorado, voters recently passed a ballot initiative creating a right to abortion in the state constitution and allowing the use of public funds for abortion.

[3] Researchers recognize that health care providers, regulators, and other experts may have additional knowledge and/or different interpretations. We welcome the insight. Please contact rlandauer@law.harvard.edu.

Despite this, two of the states reviewed (Montana and New Jersey) maintain explicit physician-only abortion requirements in the Medicaid program and several more states (e.g., Alaska, Connecticut, Illinois, and New York) reference physician involvement in determining medical necessity and/or in signing paperwork that must be submitted with a claim for reimbursement. It is often unclear when these references to physicians are an unenforced, relic of the past, or are active requirements. Additionally, in one state (Hawaii), Medicaid appears to impose more restrictive physician assistant supervision requirements than required under their license.

Another approach: States may expressly authorize any provider eligible to perform abortions to sign related paperwork or have more general "signature recognition" laws in place—i.e., laws that allow NPPs to sign paperwork within their scope of practice, even when, for example, an outdated reference to physicians remains on a particular form.

Heightened restrictions on providers in the Medicaid program are especially concerning because pregnant people who are low-income and people with disabilities are subject to additional access barriers than the rest of the population.

An enabling policy environment is one that supports feasibility from a financial perspective, in addition to robust practice authority.

Several states treat NPPs differently than physicians, in ways that negatively impact NPP reimbursement (e.g., by reimbursing NPPs at less than 100% of the physician fee schedule). However, enabling reimbursement policies are particularly important in the context of TMAB; the feasibility of providing care is already impacted by issues such as the sufficiency of rates, inconsistent use of the global medication abortion code, S0199, and (lack of) reimbursement for core related services such as language translation and the cost of mailing medications.

Another approach: Strategies to support NPP participation in Medicaid include reimbursing NPPs at the same rate as physicians and allowing NPPs to enroll as billing providers.

Provider guidance helps ensure that care authorized by the State is able to be provided.

It can be difficult to identify how Medicaid programs approach TMAB, especially as to care provided by NPPs. The lack of clarity may result in fewer providers offering the service.

Another approach: California's Medicaid program offers a good example of clarifying guidance. The document discusses eligible providers, billing codes and other reimbursement information, and telehealth. Answers are clearly- worded and include regulatory references.