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January 2019

MEDICAID

CMS Action Needed to Ensure Compliance with Abortion Coverage Requirements

GAO-19-159

GAO Highlights

Highlights of GAO-19-159, a report to congressional requesters

January 2019

MEDICAID

CMS Action Needed to Ensure Compliance with Abortion Coverage Requirements

Why GAO Did This Study

While federal law prohibits federal funding for abortions in most circumstances, state Medicaid programs are required to cover abortions in limited circumstances. CMS is responsible for monitoring state compliance with federal requirements. However, concerns have been raised about challenges women may face obtaining Medicaid coverage for abortions eligible for federal funding, as well as with abortion access more broadly.

GAO was asked to review issues related to abortion access. This report examines (1) factors that may present challenges to women, including Medicaid beneficiaries, accessing abortions; and (2) federal and state information on the number of abortions eligible for federal Medicaid funding. GAO reviewed federal laws, regulations, and data sources; surveyed and received responses from Medicaid program officials in all 50 states and the District of Columbia; conducted a literature review; and interviewed CMS officials and eight abortion providers selected based on factors such as variation in Medicaid abortion coverage and geography.

What GAO Recommends

GAO is making three recommendations to CMS to ensure state compliance with federal requirements for Medicaid abortion coverage, including coverage of the drug used for medical abortions. The Department of Health and Human Services concurred with these recommendations.

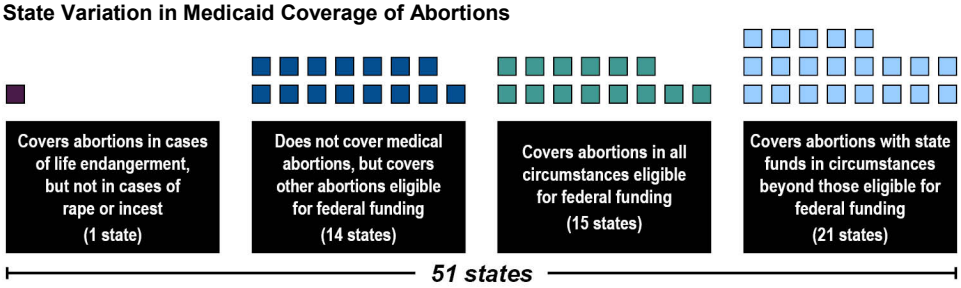
View GAO-19-159. For more information, contact Carolyn L. Yocom at (202) 512-7114 or YocomC@gao.gov.

What GAO Found

Women could face various challenges accessing abortions depending on where they live, and Medicaid beneficiaries may face additional challenges in some states. GAO identified seven key factors that could pose challenges to women accessing abortions, based on its interviews with providers and review of the literature: gestational limits, mandatory counseling, out-of-pocket costs, parental involvement requirements, provider availability, stigma and harassment, and waiting period requirements. The presence of these factors and their effect on abortion access—such as delays in care or increased costs—varied by state.

GAO also found that state variation in Medicaid abortion coverage and payment requirements could further complicate access for program beneficiaries. State Medicaid programs are generally required to cover abortions and can seek federal funding for such coverage when the pregnancy is the result of an act of rape or incest, or the life of the pregnant woman would be endangered unless an abortion is performed. States may also cover abortions under other circumstances, but federal funds may not be used. In GAO's survey, one state reported not covering abortions in cases of rape or incest, and 14 states reported not covering the drug used in medical abortions, which they are generally required to cover if the abortion is otherwise eligible for federal funding. Officials from the Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicaid, were unaware that these states were not covering the drug, and thus, have not taken any actions to address states' non-compliance.

State Variation in Medicaid Coverage of Abortions



Source: GAO analysis of state survey responses. | GAO-19-159

Note: Unlike surgical abortions, medical abortions use drugs to terminate a pregnancy.

Federal information on the number of abortions eligible for federal Medicaid funding is incomplete, limiting CMS's ability to ensure proper payments and states' coverage of such abortions. For example, the form CMS-64, which states use to report Medicaid expenditures, does not collect information on the number of abortions paid for by managed care—the delivery system serving most Medicaid beneficiaries. It also does not include this information from 8 states that GAO identified as incorrectly reporting abortion costs on the form. While also not complete, state information reported in GAO's survey was more comprehensive, and showed a wide range in the number of abortions eligible for federal funding covered across the 42 states that reported such information.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
FDA	Food and Drug Administration
FFS	fee-for-service
HHS	Department of Health and Human Services
MCO	managed care organization
T-MSIS	Transformed Medicaid Statistical Information System

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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January 4, 2019

The Honorable Diana DeGette
Ranking Member
Subcommittee on Oversight and Investigations
Energy and Commerce Committee
House of Representatives

The Honorable Jan Schakowsky
House of Representatives

Medicaid, a joint federal-state health financing program, is one of the nation's largest sources of coverage for medical and other health-related services. In fiscal year 2017, Medicaid covered acute health care, long-term care, and other services for an estimated 74 million low income and medically needy individuals.[1] While federal law prohibits federal funding for abortions in most circumstances, state Medicaid programs are required to cover an abortion if the pregnancy is the result of rape or incest, or the life of the pregnant woman would be endangered unless an abortion is performed.[2] In these circumstances, abortions are eligible for

[1]See, Department of Health and Human Services, Centers for Medicare & Medicaid Services, Office of the Actuary, *2017 Actuarial Report on the Financial Outlook for Medicaid* (Washington, D.C.: 2018).

[2]In annual appropriations acts, Congress prohibits the Department of Health and Human Services from funding abortions in most circumstances through appropriations legislation. This restriction is commonly referred to as the Hyde Amendment, named after the sponsor of the initial prohibition enacted in 1976, Representative Henry J. Hyde. In recent years, the restriction has applied to all abortions except where the pregnancy is the result of rape or incest; or where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. See Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2019, Pub. L. No. 115-245, §§ 506-07, 132 Stat. 2981 (2018).

federal funding.[3] In addition, states can, at their own expense, choose to cover this procedure beyond the circumstances outlined in federal law.[4]

The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicaid, has a critical role in monitoring states' compliance with federal requirements, including ensuring that federal funding is provided only for eligible abortions and that state Medicaid programs cover abortions eligible for such funding. However, members of Congress and others have raised concerns about women's access to abortions across states, including for Medicaid beneficiaries in circumstances eligible for federal funding. For example, concerns have been raised about the availability of facilities providing abortions, which could affect women's access. A recent study found that the number of abortion clinics varied greatly across the country with the Northeast having nearly three times more clinics than the Midwest based on regional population size.[5] Another study found that the number of abortion clinics has declined over time and that more than a third of women across the country live in a county without an abortion clinic.[6]

[3]The federal government matches each state's Medicaid expenditures for services according to a statutory formula called the Federal Medical Assistance Percentage. For purposes of this report, we refer to the three circumstances in which federal funding for abortion is available under federal law as rape, incest, or life endangerment. Collectively, we refer to abortions in these three circumstances as abortions eligible for federal funding. According to CMS guidance, the Hyde Amendment does not restrict federal funding for the treatment of spontaneous or missed abortions, or for the costs of treating any medical problems resulting from a medically unsupervised abortion or abortions related to ectopic pregnancies. As a result, such circumstances are not considered abortions for the purposes of this report.

[4]States may not pay for such abortions using the state's share of Medicaid expenditures used to draw down federal matching funds.

[5]See Cartwright, Alice F., et. al., "Identifying National Availability of Abortion Care and Distance From Major US Cities: Systematic Online Search," *J Med Internet Res,* vol. 20, no. 5 (2018). Specifically, through online searches conducted in 2017, the study identified the presence of abortion clinics across four geographic areas in the United States (Northeast, Midwest, South, and West): the Northeast had one clinic for every 55,662 women; the Midwest had one clinic for every 165,886 women; the West had one clinic for every 67,883 women; and the South had one clinic for every 145,645 women.

[6]See Jones, Rachel K., and Jenna Jerman, "Abortion Incidence and Service Availability in the United States, 2014," *Perspectives on Sexual and Reproductive Health*, vol. 49, no. 1 (2017): 17–27.

You asked us to examine issues related to women's access to abortions. This report examines

1. factors that may present challenges to women, including Medicaid beneficiaries, accessing abortions; and
2. federal and state information on the number of abortions eligible for federal Medicaid funding.

To examine factors that may present challenges to women, including Medicaid beneficiaries, accessing abortions, we reviewed federal laws and regulations, and surveyed Medicaid officials in all 50 states and the District of Columbia (hereafter, states) regarding their scope of abortion coverage, including coverage of medical abortions, and their requirements for Medicaid payment for abortions eligible for federal funding.[7] All states responded to the survey. In addition, we interviewed eight abortion providers about access challenges women may face. These eight providers offered services in 21 states that represented more than 40 percent of the total national Medicaid population, but varied in terms of their Medicaid abortion coverage and geography. Our findings from these interviews are not generalizable. We also conducted a literature review to identify peer-reviewed studies that examined factors that could present challenges to women accessing abortions. We searched multiple reference databases for relevant studies published between January 2007 and September 2017, and identified 637 studies that were potentially relevant.[8] To further refine our search, we reviewed the abstract of each study to ensure the articles met certain criteria.[9] For the studies remaining, we examined their methodologies to determine whether they were sufficiently reliable for the purposes of our reporting objectives. As a result of these efforts, we identified 52 studies to include

[7]As opposed to surgical abortions, medical abortions use prescription drugs to terminate a pregnancy, and, depending on the medication, are indicated for use through 10 weeks of pregnancy.

[8]We performed a structured search of databases, including ProQuest, CINAHL, Dialog, and Scopus.

[9]Specifically, we excluded studies where the research (1) was not focused on the United States; (2) was not empirically analytical; (3) did not directly analyze the effect of a factor on a woman's ability to obtain an abortion (i.e., analyzed the effect of a factor on mental health outcomes); (4) did not focus on the civilian population; (5) evaluated personal characteristics or issues that may present challenges to obtaining abortions, such as income level or age; and (6) analyzed a number of factors together so the individual effect of any one factor could not be identified.

in our review.[10] For more details on the literature review and a list of studies we reviewed, see appendix I. We also interviewed officials from CMS and other relevant organizations representing a range of perspectives on women's access to abortions.[11]

To examine federal information on the number of abortions eligible for federal Medicaid funding, we reviewed available federal data sources, such as the form CMS-64, which states use to report Medicaid expenditures to CMS for the purpose of determining federal funding, and interviewed CMS officials.[12] To examine state information, we obtained responses through our survey to questions regarding the number of abortions eligible for federal funding that state Medicaid programs covered and denied for fiscal years 2013 through 2017. We asked states to report information by delivery system type and by the circumstance eligible for federal funding (rape, incest, or life endangerment). We did not independently verify state-reported information, but did follow up with states to clarify inconsistencies or outliers we identified.[13] On that basis, we determined that the state-reported information was sufficiently reliable for the purposes of our reporting objectives.

We conducted this performance audit from May 2017 to January 2019, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our

[10]To the extent the literature or interviews identified any state laws as presenting challenges to abortion access, we did not independently verify those laws or review their constitutionality.

[11]We interviewed or obtained written responses from the following 10 organizations: American Association of Pro-Life Gynecologists; American College of Obstetrics and Gynecology; Guttmacher Institute; Kaiser Family Foundation; National Abortion Federation; National Network of Abortion Funds; Medicaid and CHIP Payment and Access Commission; National Academies of Sciences; National Academy for State Health Policy; and, Danco Laboratories, the drug manufacturer of Mifeprex, a drug used in medical abortions. We also contacted the National Governors Association and the National Association of Medicaid Directors, which did not have ongoing work in this area; and the Lozier Institute, National Right to Life, and Family Research Council, none of which provided a response.

[12]We determined that federal data sources were not reliable for the purposes of determining the number of abortions eligible for federal Medicaid funding.

[13]For example, we followed up with states that initially reported not paying for any abortions eligible for federal funding during the 5-year period and with states who reported paying for the highest number of such abortions during the same time frame.

findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Abortion in the United States

In 1973, the U.S. Supreme Court concluded in Roe v. Wade that a woman has a fundamental right protected by the U.S. Constitution to decide whether to terminate her pregnancy.[14] However, the Court also recognized that a state may have an interest sufficient to regulate abortion after the first trimester of the pregnancy or proscribe abortion after the fetus reaches viability, the point at which the fetus could live outside the womb. Over time, states have adopted a range of abortion-related laws or policies, including the following examples.

- **Gestational limits:** Prohibiting abortions after a specified gestational age.
- **Insurance limitations:** Limiting insurance coverage of abortions to certain circumstances in either publicly or privately funded insurance plans.
- **Laws regulating abortion providers:** Requiring abortion providers to meet certain standards, such as standards that specify facility room size or corridor widths.
- **Mandatory counseling:** Requiring specific information, including information on fetal development or gestational age of the fetus, be provided to a woman prior to an abortion.
- **Parental involvement:** Requiring the consent or notification of one or both parents for minors seeking an abortion.
- **Waiting periods:** Requiring a certain amount of time to elapse between informed consent—which may include mandatory counseling—and having an abortion.[15]

[14]410 U.S. 113 (1973).

[15]Informed consent is the general requirement that patients give permission for a procedure only after receiving information about its benefits, risks, and treatment alternatives.

Since Roe v. Wade was decided, many of these state laws have been challenged, and the Court, in reviewing these laws, has considered whether they impose an undue burden on a woman's right to choose an abortion.[16] Most recently, in 2016, the Court found that two Texas laws regulating abortion providers offered few, if any, health benefits and posed a substantial obstacle to women seeking abortions.[17] Therefore, the Court found that these two Texas laws constituted an undue burden and were unconstitutional.

The number of abortions performed in the United States has steadily declined over the past 30 years, with the abortion rate reaching its lowest point in 2014—the most recent year data were available—at 14.6 abortions per 1,000 women of reproductive age, according to a 2017 study.[18] This study attributed this decline primarily to a decrease in the number of unintended pregnancies and to a lesser extent, laws or policies that may limit women's access to abortions.

Abortions are typically performed in a clinic or other nonhospital setting and involve one of two methods: medical abortion or surgical abortion. Medical abortions involve using prescription drugs to terminate a pregnancy. The prescription drug mifepristone, sold under the brand name Mifeprex, in combination with the prescription drug misoprostol, is the only Food and Drug Administration (FDA) approved medication for medical abortions in the United States, and is approved for use through

[16]In establishing the undue burden standard, the Court considered whether a waiting period provision in Pennsylvania law "had the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion." In its decision, the Court upheld the waiting period requirement, overruling a prior decision that had followed Roe's legal framework. Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992).

[17]Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016). The first law required a physician performing an abortion to have active admitting privileges at a hospital within 30 miles from the location at which the abortion is performed, and the second required abortion facilities to meet the same health and safety standards applicable to ambulatory surgical centers.

[18]See Jones and Jerman, "Abortion Incidence and Service Availability in the United States, 2014." The Center for Disease Control and Prevention estimated the abortion rate to be 12.1 in 2014. See Jatlaoui TC, Shah J, Mandel MG, et al. "Abortion Surveillance — United States, 2014," *MMWR Surveillance Summary*, vol.66, No. SS-24 (2017):1–48. However, the center's analysis did not include data from California, Maryland, and New Hampshire; therefore, for the purposes of this report, we cite the rate used in the Jones and Jerman study, because it surveyed the known universe of abortion-providing facilities in the United States.

10 weeks gestation. FDA has restricted the administration of Mifeprex to patients in certain healthcare settings under the supervision of a certified prescriber; thus, the drug cannot be sold in retail pharmacies. According to Danco Laboratories, the manufacturer of Mifeprex, there is at least one certified Mifeprex provider in every state. Surgical abortions, which can involve different procedures depending on the stage of a women's pregnancy, account for the majority of abortions in the United States. However, according to a recent study, the incidence of medical abortions increased 7 percent from 2011 to 2014, with medical abortions accounting for 31 percent of all nonhospital abortions in 2014.[19]

Medicaid Coverage of Abortions

Medicaid expenditures are financed by both the federal government and the states. In order to receive federal funding for Medicaid expenditures, states must adhere to a broad set of federal requirements and administer their programs consistent with individual state plans approved by CMS.[20] However, Medicaid, by design, allows significant flexibility for states to design and implement their programs. States have some discretion in, among other things, setting Medicaid eligibility standards and provider payment rates; determining the amount, scope, and duration of covered benefits; and developing their own administrative structures. For example, states must cover certain mandatory populations and services—including abortions in cases of rape, incest, or life endangerment—but may impose certain requirements on that coverage, such as requiring authorization before a service is provided. States may also opt to cover other optional populations and services, including abortions for which federal funding is not available.

States may also decide how Medicaid-covered services provided to beneficiaries will be delivered. For example, states may pay health care providers for each service they provide—referred to as fee-for-service (FFS)—or contract with managed care organizations (MCO) to provide a

[19]See Jones and Jerman, "Abortion Incidence and Service Availability in the United States, 2014." The Center for Disease Control and Prevention reported that 22.6 percent of abortions were medical abortions in 2014.

[20]The federal government matches state Medicaid program expenditures through the Federal Medical Assistance Percentage. For most Medicaid expenditures, federal law specifies that the match will be no lower than 50 percent and no higher than 83 percent. For certain Medicaid enrollees, states receive a higher federal match based on whether the state expanded Medicaid, as provided for under the Patient Protection and Affordable Care Act. See 42 U.S.C. § 1396d(b).

specific set of Medicaid-covered services to beneficiaries and pay them a set amount per beneficiary, typically per month. While most states use both delivery systems, the percentage of beneficiaries served through comprehensive MCOs has grown in recent years, and represented nearly 70 percent of all Medicaid beneficiaries in 2016.[21]

Oversight of the Medicaid program is also shared by the federal government and the states, and is aimed, in part, at ensuring that funds are used appropriately and that beneficiaries have access to covered services. With respect to abortion coverage, federal law and CMS guidance outline specific requirements for federal funding to be available. For example, states that claim federal funding for abortions in the case of life endangerment must obtain a physician's certification that the abortion is necessary for this purpose.[22] While there is not a similar certification requirement for federal funding of abortions in cases of rape or incest, CMS guidance specifies that states may impose certain additional requirements on providers and beneficiaries as a condition of Medicaid payment for abortions eligible for federal funding, provided such requirements are reasonable and do not deny or impede coverage for such abortions.

In the case of medical abortions, federal law does not specifically require Medicaid coverage of the prescription drugs used to terminate a pregnancy. However, state Medicaid programs that opt to cover prescription drugs—which is the case in all 51 states—are generally required to cover outpatient drugs of any manufacturer participating in the Medicaid Drug Rebate Program.[23] Danco Laboratories has a rebate

[21]See Centers for Medicare & Medicaid Services, *Medicaid Managed Care Enrollment and Program Characteristics*, 2016 (Spring 2018).

[22]Federal law specifies that federal funding for an abortion in the circumstance of life endangerment is only available in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, *as certified by a physician*, place the woman in danger of death unless an abortion is performed. CMS regulation directs states to obtain a physician certification in writing that contains the name and address of the patient. See 42 C.F.R. § 441.203 (2017).

[23]The Medicaid Drug Rebate Program provides significant discounts to state Medicaid programs in the form of rebates for certain outpatient prescription drugs. States that elect to cover outpatient drugs in their Medicaid program must cover all FDA-approved drugs made by a manufacturer that has entered into a rebate agreement, outside of certain permitted exclusions or restrictions that are outlined in the law. See 42 U.S.C. §1396r-8(d).

agreement for Mifeprex, and, as result, states should generally cover it for abortions in the circumstances eligible for federal funding. In determining states' compliance with this requirement, CMS guidance states that the agency will consider several factors, including a state's authority to set limitations on covered outpatient drugs under relevant state laws.[24]

To inform its oversight of Medicaid, CMS relies on state-reported data that contain information on multiple aspects of the program. States claiming federal funding for Medicaid services, including abortions, are required to report quarterly expenditures to CMS on the form CMS-64. CMS uses these data to pay states for the federal share of program spending and the agency is responsible for ensuring that federal payments are made appropriately. Additionally, states submit Medicaid expenditure and utilization data that can be linked to individual beneficiaries to CMS on a monthly basis through the agency's new Transformed Medicaid Statistical Information System (T-MSIS).[25]

Multiple Factors Could Present Challenges to a Woman's Access to Abortions Depending on Where She Lives

Through provider interviews, we identified multiple factors that could present challenges to women accessing abortions, but the extent to which these factors were present in a state varied, as did their effect on access. In addition, the studies we reviewed examined some of these factors more than others, but often pointed to the challenges they could pose. Medicaid beneficiaries may experience further challenges accessing abortions in some states due to variation in Medicaid abortion coverage and related payment requirements.

[24]See Department of Health and Human Services, Health Care Financing Administration, State Medicaid Director Letter #01-018 (Baltimore, Md.: March 30, 2001). Under the rebate program, states have the discretion to establish certain limitations on the coverage of covered outpatient drugs, such as the utilization of preferred drug lists and prior authorization processes. See 42 U.S.C. § 1396r-8(d)(4) and (5). However, according to CMS, the effect of such limitations should not result in the denial or unreasonable restriction of access to clinically appropriate, medically necessary treatments using covered outpatient drugs.

[25]T-MSIS is CMS's primary effort to improve its collection of Medicaid expenditure and utilization data, and replace the Medicaid Statistical Information System, which our past work had identified as having deficiencies. See, for example, GAO, *Medicaid: Data Sets Provide Inconsistent Picture of Expenditures*, GAO-13-47 (Washington, D.C.: Oct. 29, 2012); and *Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements*, GAO-17-173 (Washington, D.C.: Jan. 6, 2017).

Providers and Literature Pointed to Multiple Factors that Could Present Challenges to Women Accessing Abortions across States

We identified seven key factors as potential challenges to women accessing abortions based on our interviews with eight selected providers: (1) gestational limits; (2) mandatory counseling; (3) out-of-pocket costs; (4) parental involvement; (5) provider availability; (6) stigma and harassment; and (7) waiting periods.[26] (See table 1.)

Table 1: Key Factors That Could Present Challenges to Women Accessing Abortions

Factor	Provider description of potential challenges and examples
Gestational limits	Gestational limits could cause women to drive long distances to a provider if they pass the limit in their own state and need to seek an abortion in another state where the limit is higher, which, in turn, can increase women's costs and delay care. • One provider noted that a state it serves allows abortions up to 24 weeks, and, due to lower gestational limits in surrounding states, the provider sees many women from out-of-state who are facing increased costs, because they have traveled farther to have the abortion.
Mandatory counseling	Mandatory counseling could include information aimed at discouraging women from having an abortion. • One provider noted that counseling materials mandated by the state include a pamphlet about pregnancy crisis centers, which the provider suggested were aimed at dissuading women from having an abortion.
Out-of-pocket costs	In addition to the cost of the abortion procedure, women could incur additional costs associated with travel, time off work, and child care, and could have to delay the procedure until they can cover all of these costs. • One provider noted that it can take women additional time to obtain the funds they need to cover the costs associated with the abortion. The provider said that such a delay can, for example, mean that the patient moves from being eligible for a medical abortion to needing a surgical abortion.
Parental involvement	Parental consent or notification could be challenging for minors, particularly those whose parents do not grant consent for an abortion, and therefore must seek judicial bypass from a judge to obtain one. Obtaining judicial bypass could be challenging logistically and could delay the procedure for as long as a month. • One provider noted that parental involvement requirements can be more complicated in states where both parents must consent. Also, this provider noted that rural courts can be less adept than urban courts at considering judicial bypass, because they do not hear such proceedings as often.
Provider availability	Limited provider availability could delay care for women or could require them to travel long distances to find an abortion provider, increasing their costs. Geography, difficulty hiring providers, and certain state laws regulating abortion providers could affect provider availability. • One provider noted that for one state it serves, there are no physicians who perform abortions. Therefore, the provider must fly physicians in from another state, which can create delays in providing care.

[26]As discussed later in this report, our interviews with selected providers also pointed to the scope of a state's Medicaid abortion coverage and related payment requirements as key factors that could present challenges to abortion access.

Factor	Provider description of potential challenges and examples
Stigma and harassment	Stigma and harassment, including public protesting and intense regulatory oversight, could intimidate women and providers, affecting their ability to access or provide abortions, respectively. • One provider said that protesting is a near constant presence outside its clinics, which can be loud, disruptive, threatening, and hard for patients and providers to navigate.
Waiting periods	Waiting periods could increase costs associated with an abortion when two visits must be made (one for informed consent and one for the procedure) and could delay care. • One provider noted that one state it serves requires two in-person visits; 72 hours between each visit that excludes weekends and holidays; and the same doctor to see the patient for both visits.

Source: GAO analysis of interviews with eight selected abortion providers. | GAO-19-159

The extent to which these factors are present in a state varies. For example, one provider who did not identify stigma and harassment as a factor affecting women in the state it operates in noted that women from all over the country come to its clinics. The provider said this was because women see its clinics as a safer place to obtain an abortion than seeking care in their own state, where they would likely be stigmatized or harassed. Additionally, providers in some states told us that they were able to cover the entire cost of the abortion and pay for associated costs, such as transportation, for women who could not afford to pay, while providers in other states said that they could not cover the entire cost of the abortion due to funding limitations. See figure 1 for an example of differences in factors present in two states.

Figure 1: Comparison of Factors Identified as Potential Challenges to Women's Access to Abortions in Two States

Source: GAO interviews with eight selected abortion providers. | GAO-19-159

[a]According to a provider familiar with State A, the state requires abortion clinics performing abortions after 14 weeks and 6 days to have a blood bank available in case of an emergency, and the one clinic in the state does not perform abortions after this point, because it cannot support a blood bank to meet the requirement.

[b]Medicaid covers abortions in limited circumstances in State A, but according to a provider familiar with the state, the one clinic does not bill Medicaid, and private insurance or assistance are often not viable options.

[c]According to a provider familiar with State A, this state has a 72 -hour waiting period.

[d]According to a provider familiar with State B, Medicaid or private insurance covers abortions for most women, and private assistance is generally available for women who self-pay, if needed.

In addition, a factor could be more challenging in one state versus another, depending on the details of the factor and other factors present. For example, one provider noted that the 24-hour waiting period in one state it serves poses a minimal challenge, because women can complete part of the process online and only make one visit to the abortion provider. Conversely, a provider in another state said that the state's 72-hour waiting period requires two in-person visits and that the same doctor be present at both, which can create delays in care and increase costs, particularly if the woman needs to travel a long distance for her appointments. Differences in access can also exist within a state. Most notably, some selected providers pointed out that women in a state's rural

areas typically have more limited access to abortion providers than those who live in the state's urban areas.

The 52 studies we reviewed examined the key abortion access factors identified through our interviews with selected providers, though some factors were studied more than others.[27] (See app. I.) Most of the reviewed studies conducted statistical analyses to evaluate the effects of a factor on abortion access and often identified access challenges.[28] For example, nearly two-thirds of the statistical studies for the three most commonly studied factors—out-of-pocket costs, parental involvement, and provider availability—found that the factor adversely affected a measure of abortion access.[29] (See table 2.)

[27]In addition to the key factors identified through our interviews with providers, the studies we reviewed sometimes looked at other factors that could present challenges to abortion access. For example, one study looked at the effects of requiring pre-abortion ultrasound viewing and found that the requirement had a small, but statistically significant, increase in the number of women deciding to continue their pregnancy. See Upadhyay, Ushma D., et. al., "Evaluating the Impact of a Mandatory Pre-Abortion Ultrasound Viewing Law: A Mixed Methods Study," *PLoS One,* vol. 12, no.7 (2017).

[28]We also identified a more limited number of studies that reported on women's experiences accessing abortions through surveys or interviews. These studies often found that women experienced challenges related to the factors providers identified, particularly provider availability and out-of-pocket costs. For example, one study analyzed national data from over 700 women and found that the majority of the women delayed their abortion, because they needed time to raise money. See Roberts, Sarah C. M., et. al., "Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States," *Women's Health Issues,* vol. 24, no. 2 (2014): e211-e218.

[29]Effects identified in the remaining studies of each factor were not statistically significant.

Table 2: Examples of Abortion Access Challenges Identified in Reviewed Studies

Factor	Examples of findings
Out-of-pocket costs	• One national study found that the demand for abortions drops by 2 percent for every $10 increase in the price of abortion procedures.[a] • One national study found that two-thirds of women who had second trimester abortions reported delays due to cost, while fewer than one-third of women who had first trimester abortions reported delays due to cost.[b]
Parental involvement	• One national study found that when parental consent is required for minors, the average state's abortion rate drops by 17 percent compared with states without parental consent laws.[c] • One national study found that parental consent can be associated with delays in obtaining an abortion, with minors delaying an abortion until they are 18-years-old, if able to do so.[d]
Provider availability	• One national study compared women who receive first trimester abortions with women who have later term abortions, and found that women without a provider within 50 to 100 miles were more likely to delay their abortion to the second trimester.[e] • One study found that a state's abortion rate dropped by 13 percent after the enactment of a state law requiring physicians to have hospital admitting privileges, which resulted in the closure of several abortion clinics.[f]

Source: GAO literature review. | GAO-19-159

[a]Medoff, Marshall H. "Biased Abortion Counseling Laws and Abortion Demand," The Social Science Journal, vol. 46, (2009): 632-643.

[b]Foster, Diana Greene and Katrina Kimport, "Who Seeks Abortions at Or After 20 Weeks?" Perspectives on Sexual & Reproductive Health, vol. 45, no. 4 (2013): 210-218.

[c]Medoff, Marshall H. "The Response of Abortion Demand to Changes in Abortion Costs." Social Indicators Research, vol. 87, no. 2 (2008): 329-346.

[d]Colman, Silvie and Ted Joyce, "Minors' Behavioral Responses to Parental Involvement Laws: Delaying Abortion Until Age 18," Perspectives on Sexual and Reproductive Health, vol.41, no. 2 (2009): 119-126.

[e]Jones, Rachel K. and Jenna Jerman, "Characteristics and Circumstances of U.S. Women Who Obtain very Early and Second-Trimester Abortions," PLoS One, vol. 12, no.1 (2017).

[f]Grossman, Daniel, et. al., "Change in abortion services after implementation of a restrictive law in Texas," Contraception, vol. 90, no. 5 (2014): 496-501.

The other factors identified by providers—gestational limits, stigma and harassment, mandatory counseling, and waiting periods—were less frequently examined in the reviewed studies, and the findings from these studies were more mixed. For example, gestational limits and stigma and harassment were the least studied of all the factors with only three and two studies, respectively, and the reviewed studies found both adverse effects on access, as well as effects that were statistically insignificant. While there were more studies on waiting periods, the results were similarly mixed, with at least one study suggesting that the type of waiting period could change the effect on access. This study found that while a waiting period requiring two in-person visits could delay care, the effect of

waiting periods that required fewer in-person visits was not significant.[30] Finally, for mandatory counseling, the studies we reviewed rarely found that the factor had a statistically significant effect on a measure of abortion access (2 of 10 studies).

Variation in State Coverage and Payment Requirements Could Further Challenge Medicaid Beneficiaries' Access to Abortions

In responding to our survey, 29 states reported limiting abortion coverage for Medicaid beneficiaries to the three circumstances required under federal law—rape, incest, and life endangerment—while 21 states reported broader abortion coverage. The remaining state, South Dakota, reported that it limits abortion coverage for Medicaid beneficiaries to circumstances when the pregnancy endangers the life of the woman, and does not cover abortions in cases of rape or incest. CMS confirmed that South Dakota's Medicaid state plan does not include coverage of abortions in cases of rape or incest, and shared a letter it sent to the state in 1994 outlining that the state's coverage did not comply with federal law and expressing CMS's intent to work with the state on possible solutions. However, according to CMS officials, the agency has not taken any action since that time to ensure South Dakota's compliance, and does not have plans to do so.[31] As a result, Medicaid beneficiaries in South Dakota do not have Medicaid coverage for abortions in cases of rape or incest.

States also varied in the extent to which their Medicaid programs covered Mifeprex, the prescription drug most commonly used for medical abortions. (See fig. 2.) As previously noted, state Medicaid programs that opt to cover prescription drugs—which is the case in all 51 states—are generally required to cover outpatient drugs of any manufacturer participating in the Medicaid Drug Rebate Program, subject to a few

[30]See Jones, Rachel K. and Jenna Jerman, "Characteristics and Circumstances of U.S. Women Who Obtain very Early and Second-Trimester Abortions," *PLoS One,* vol. 12, no.1 (2017).

[31]According to CMS officials, the agency generally does not review Medicaid state plans for compliance unless the agency is reviewing a state plan amendment. Further, officials said that when reviewing a state plan amendment, they only review the page of the state plan that the state is proposing to amend and limit their review of the page to information that is related to the amendment. However, we found that CMS approved a South Dakota state plan amendment on a page relating to physician services in 1994 and a page relating to inpatient and outpatient services in 2012, both of which indicated that abortion in the case of rape or incest was not covered by the state plan. According to CMS officials, South Dakota's state plan amendments did not make changes to abortion coverage and, therefore, the state's lack of coverage of abortion in cases of rape or incest was not reviewed.

statutory exceptions.[32] CMS officials told us that Mifeprex, which became a covered outpatient drug in 2001, does not meet any of the exceptions for categorical exclusion from coverage.[33] However, 14 states reported that they do not cover Mifeprex.[34] Without such coverage, Medicaid beneficiaries seeking abortions in these states would have to find another way to pay for the drug or undergo a surgical abortion instead. CMS officials were not aware that these states did not cover Mifeprex, and thus the agency had not taken any action to address states' non-compliance.

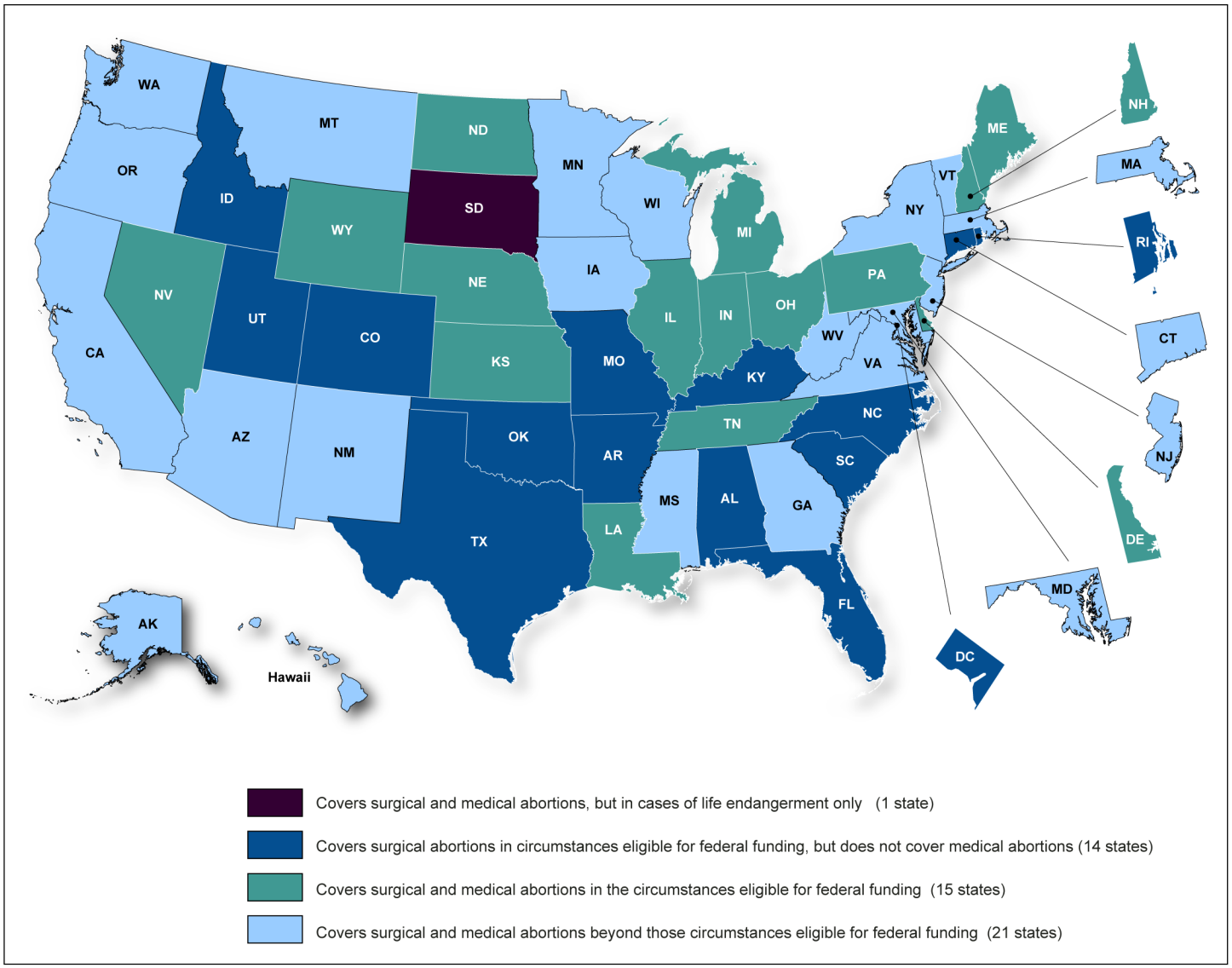
[32]Federal law permits states to categorically exclude a participating manufacturer's drugs from coverage under a few limited exceptions, such as drugs used for weight loss or for cosmetic purposes. See 42 U.S.C. § 1396r-8(d).

[33]CMS officials noted that states may impose certain reasonable limitations, such as medical necessity or prior authorization processes, on Mifeprex coverage, but those limitations may not categorically exclude Mifeprex from coverage or result in the denial or unreasonable restriction of access to clinically appropriate treatments using Mifeprex. CMS officials also noted, consistent with CMS guidance, that that the Medicaid drug rebate law does not supersede state laws, which may impose additional limitations, such as informed consent. See Department of Health and Human Services, State Medicaid Director Letter #01-018.

[34]The 14 states that reported not covering Mifeprex were Alabama, Arkansas, Colorado, District of Columbia, Florida, Idaho, Kentucky, Missouri, North Carolina, Oklahoma, Rhode Island, South Carolina, Texas, and Utah.

The remaining 37 states reported that their Medicaid program covered Mifeprex for abortions. As of June 2018, the manufacturer of Mifeprex identified 13 of these states as having requested a Medicaid rebate—indicating that these states' Medicaid programs actually covered the drug for a beneficiary —within the last 3 years: Alaska, California, Connecticut, Illinois, Maryland, Minnesota, New Mexico, New York, Ohio, Oregon, Pennsylvania, Virginia, and Washington.

Figure 2: State-Reported Information on Medicaid Coverage of Abortions



Sources: GAO analysis of state survey responses (data); Map Resources (map). | GAO-19-159

Notes: State survey responses and related follow-up were collected from November 2017 to October 2018. As opposed to surgical abortions, medical abortions use prescription drugs to terminate a pregnancy. Federal funding is available only for abortions in cases of rape, incest, or life endangerment, as defined by law, but states may offer coverage in additional circumstances using state funds.

Beyond differences in the scope of their abortion coverage, states varied in the types of requirements they imposed as a condition of Medicaid payment for abortions eligible for federal funding, which could also affect women's access to the procedure. Provider certification that the abortion met the circumstances of rape, incest, or life endangerment was the most common requirement reported by states. Other commonly reported requirements included provider certification of counseling, beneficiary certification of rape or incest, documentation of rape or incest, and prior authorization by the state Medicaid agency. (See table 3.)

Table 3: Examples of State-Reported Requirements for Medicaid Payment of Abortions Eligible for Federal Funding

Requirement	Number of states reporting requirement	Description
Provider certification of rape, incest, or life endangerment[a]	43	The provider performing the abortion must certify that in his/her professional opinion the pregnancy endangers the life of the Medicaid beneficiary, or is a result of rape or incest, and include this certification with the payment claim.
Beneficiary certification of rape or incest	14	The Medicaid beneficiary must certify that an act of rape or incest occurred and that the pregnancy was a result of that rape or incest, and this certification must be included with the payment claim.
Documentation of rape or incest[b]	14	Documentation that the beneficiary reported the rape or incest to a law enforcement or other public agency must be included with the payment claim.
Prior authorization	7	Coverage for the abortion must be approved by the state Medicaid agency before the procedure is performed.
Provider certification of counseling for the abortion	7	The provider performing the abortion must certify that the Medicaid beneficiary has received counseling for the abortion prior to the procedure being performed, and include this certification with the payment claim.

Source: GAO analysis of state survey responses. | GAO-19-159

Notes: Federal funding is available only for abortions in cases of rape, incest, or life endangerment, as defined by law. States are required to obtain physician certification when claiming federal funds for an abortion in the case of life endangerment, but the other requirements reported by states are not required under federal law, nor is physician certification required when states use state-only funds to provide abortion coverage. Some states reported additional requirements for Medicaid payment of abortions that are not reflected in this table. For example, two states required the Medicaid Director to review documentation of medical records and approve claims.

[a]While 43 states had this requirement for life endangerment, 40 states had it for rape or incest.

[b]Of the 14 states requiring documentation, some specifically required a police report, and other states allowed the beneficiary the option of either filing a police report or filing a report with another public agency, such as a public health agency.

The details of particular requirements also varied across states. For example, among the 32 state Medicaid programs that claimed federal

funding for abortions, we reviewed available documents implementing the federal requirement that physicians certify the abortion is necessary in the case of life endangerment and found differences among the states. In particular, some states' documents incorporated the statutory wording of the life endangerment exception, others incorporated the wording of the related federal regulation, and others used different wording.[35] Additionally, CMS officials told us that the agency does not require that physicians fill out a specified form to meet the certification requirement, and the 32 states varied in whether or not they had such a form.[36] In another example, of the 14 states that required documentation of cases of rape or incest, some states specifically required a police report, and other states allowed the beneficiary the option of either filing a police report or filing a report with another public agency, such as a public health agency.

Finally, states also varied in terms of the number of requirements they imposed specific to Medicaid payment of abortions eligible for federal funding. For example, some states had no requirements specifically for these abortions, while one state had all five of the requirements most commonly reported.[37] In general, states that used state-only funds to

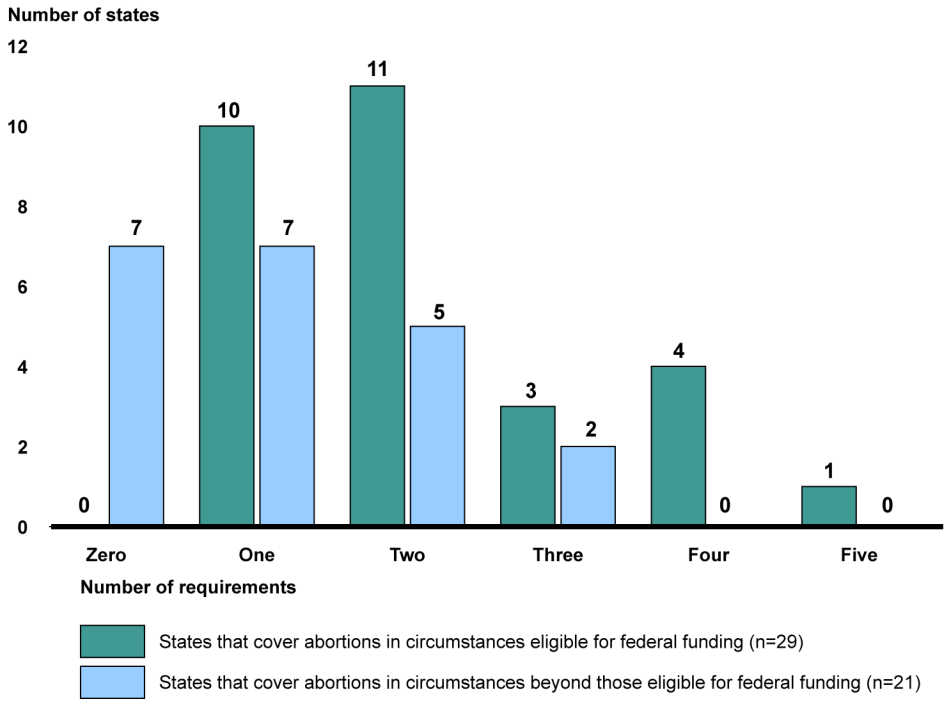
[35]CMS regulations, issued in 1987, require that, in order for the abortion to be eligible for federal funding in the case of life endangerment, a physician must certify "that on the basis of his professional judgment, the life of the mother would be endangered if the fetus were carried to term," and provide that the certification must contain the name and address of the patient. See 42 C.F.R. § 441.203 (2017). However, since 1997, federal law has specified that federal funding for an abortion in the circumstance of life endangerment is only available in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

[36]Our work was not designed to assess states' compliance with the physician certification requirement for abortions performed in the case of life endangerment. However, the variation we identified in states' implementation of this requirement raises questions about whether all states' approaches are consistent with federal requirements. We have informed CMS of the variation we identified among states, so that the agency may consider whether clarification regarding this requirement is necessary to ensure state compliance.

[37]As states typically had the same requirements for all circumstances to which they applied, we did not count requirements separately for each circumstance. For example, in a state that requires provider certification for abortion in cases of rape, incest, or life endangerment provider certification would count as one requirement. Three states—Kentucky, Maryland, and Massachusetts —required provider certification for life endangerment, but not for rape or incest. South Carolina reported having all five of the most commonly reported requirements.

cover abortions in circumstances beyond those eligible for federal funding had fewer requirements. (See fig. 3.)

Figure 3: Frequency with Which States Impose Certain Requirements for Medicaid Payment of Abortions Eligible for Federal Funding



Source: GAO analysis of state survey responses. | GAO-19-159

Notes: Federal funding is available only for abortions in cases of rape, incest, or life endangerment, as defined by law, but states may offer coverage in additional circumstances using state funds. Requirements are the five most commonly reported by states in our survey and include provider certification that the abortion arose from circumstances of rape, incest, or life endangerment; beneficiary certification that the abortion arose from circumstances of rape or incest; documentation of rape or incest; prior authorization of abortion procedures; and provider certification of counseling for the abortion. One state did not report any of these five requirements, but does require that the Medicaid Director review all abortion claims.

Our interviews with the eight selected providers suggest that the scope of a state's Medicaid abortion coverage and related payment requirements could affect abortion access. For example, six selected providers said that they rarely submit abortion claims to state Medicaid programs that limit abortion coverage to circumstances eligible for federal funding, in part, because obtaining payment is challenging; involves multiple, often unclear requirements; and frequently results in denied claims. One of these providers noted that not obtaining Medicaid payment puts additional

pressure on already strained resources, affecting its ability to cover abortions for women in general. Conversely, two providers operating in states with broader Medicaid abortion coverage stated that they frequently submit claims for abortions and receive payment.

State-reported information on denied abortion claims suggests that the difficulty the selected providers faced in obtaining Medicaid payment for abortions eligible for federal funding in certain states could exist in other states.[38] Specifically, among the 15 states reporting information on denials of payment for abortions in circumstances eligible for federal funding, denial rates ranged from 4 percent to nearly 90 percent, with about half of the 15 states reporting denial rates of 60 percent or more.[39] While we did not ask states to report on their reasons for denying Medicaid payment for abortions, some states provided this information. For example, one state said that its high denial rate is due to the initial denial of all claims for abortions in cases of life endangerment that do not have the recipient's address, as required by federal regulation.[40] In addition, 7 states reported having no payment denials, 4 of which did not receive any claims for abortions eligible for federal funding over the 5-year period.

Findings from the studies we reviewed also highlight the potential effect of states' Medicaid coverage and payment requirements on a woman's access to abortions. Eight studies that examined the effect of limiting Medicaid abortion coverage to those eligible for federal funding found that such coverage limits were associated with a reduction in the number of women having abortions.[41] For example, one of these studies analyzed

[38]In our survey, we asked states to report denials of payment for abortions for which providers claimed Medicaid payment in the circumstances of rape, incest, or life endangerment. We did not assess whether those claims were, in fact, eligible for federal funding under federal requirements.

[39]Among the 15 states, denial rates tended to be higher for FFS when compared with managed care. For example, in Delaware, the denial rate for FFS abortions was nearly 90 percent, while the denial rate for managed care abortions was 13 percent.

State-reported data reflect a claim's status at the time states responded to our survey. Claims that are denied may later be paid as the result of factors, such as the appeals process.

[40]See 42 C.F.R. § 441.203 (2017).

[41]Three other studies that examined the effect of limiting Medicaid abortion coverage to those eligible for federal funding did not have statistically significant findings.

national data from 1985 to 2005 and found that limiting Medicaid coverage to abortions eligible for federal funding reduced a state's abortion rate by 8 to 9 percent.[42] In addition, six studies that examined providers' experiences obtaining Medicaid payment for abortions corroborated many of the concerns raised by our selected providers. For example, one study examining abortion provider experiences in six states found that many providers choose not to bill Medicaid for abortions, because obtaining payment for the procedure requires a significant time commitment, and when states do pay, the amount is typically lower than the cost of providing the abortion.[43]

Information on Abortions Eligible for Federal Medicaid Funding Is Incomplete, but Showed a Wide Range in the Number of Procedures Covered across States

The usefulness of federal information—namely CMS-64 data—for identifying the number of abortions eligible for federal Medicaid funding is limited, which could hamper CMS's efforts to ensure proper payments and states' coverage of abortions in cases of rape, incest, or life endangerment. In particular, the CMS-64 does not include the following information.

- **Abortions states paid for through MCOs.** The CMS-64 does not include information on abortions eligible for federal funding provided to Medicaid beneficiaries through MCOs, because states are not required to identify expenditures for individual managed care services on the form.[44] In our survey, 23 states reported claiming federal Medicaid funding for abortions from fiscal years 2013 through 2017 that were, at least in part, paid for through MCOs.
- **Abortions in states reporting FFS abortions incorrectly.** The CMS-64 is also an incomplete information source, because of inaccurate state reporting. CMS requires states to report FFS

[42]See New, Michael J., "Analyzing the Effect of Anti-Abortion U.S. State Legislation in the Post-Casey Era," *State Politics & Policy Quarterly,* vol. 11, no. 1 (2011): 28-47.

[43]See Kacanek, Deborah, et. al., "Medicaid Funding for Abortion: Providers' Experiences with Cases Involving Rape, Incest and Life Endangerment," *Perspectives on Sexual and Reproductive Health,* vol. 42, no. 2 (2010): 79-86.

[44]While the CMS-64 requires states to report the aggregate monthly capitated payment made to MCOs rather than expenditures for individual managed care services, for any abortion to be eligible for federal Medicaid funding, states must maintain supporting documentation sufficient to validate that the service was eligible for such funding and retain the support for the claim for review by CMS staff.

abortions for which they claim federal funding on line 14 of the form.[45] However, in our survey, eight states reported that they include the costs of such abortions on other lines of the CMS-64, such as on the lines for outpatient hospital or physician services.[46] According to agency officials, CMS conducts quarterly reviews of the CMS-64 data states report. CMS officials also said that reviewers are not required to confirm whether states that report no abortions on line 14 have accurately reported the information, which means that reviewers may not identify states reporting abortions elsewhere. As a result, information from the CMS-64 does not accurately reflect the number of FFS abortions for all states that may be claiming federal Medicaid funding.

In addition, because state Medicaid programs use the CMS-64 to claim federal funding for services provided, the form does not include information from states that covered abortions for Medicaid beneficiaries in circumstances of rape, incest, or life endangerment, but did not seek federal funding for those costs. In our survey, 15 states—accounting for nearly half the Medicaid population nationwide—reported that, from fiscal years 2013 through 2017, they did not claim federal funding for abortions covered by their programs.[47]

In comparison with the CMS-64 data, the information states reported through our survey was more comprehensive. For example, 16 states claiming federal Medicaid funding provided us information on the number of abortions paid for through MCOs, information that was not captured on the CMS-64 as individual services, but often represented a significant portion of the abortions covered by these states. Similarly, the 8 states we identified as incorrectly reporting their FFS abortions on the CMS-64 reported the number of such abortions to us, and these states accounted for half of all FFS abortions for which states reported claiming federal

[45]CMS guidance requires states to report such FFS abortions, including medical abortions, regardless of the type of provider. The guidance further directs states to break out abortions by life endangerment, rape, and incest, and to count abortions only once even if expenditures for the procedure are claimed over multiple quarters.

[46]These eight states were the District of Columbia, Florida, Maine, Mississippi, Nevada, Oklahoma, Rhode Island, and South Carolina.

[47]In addition, three states reported not covering any abortions eligible for federal funding during the survey timeframe, which would also not be captured in the CMS-64.

funding in our survey.[48] As a result, the number of abortions for which states claimed federal funding that was reported to us was substantially higher than the number in CMS's annual reports to Congress on such abortions, which are based on CMS-64 data. From fiscal year 2013 to fiscal year 2016—the latest year of data available from CMS's annual reports—our survey identified nearly 5,000 abortions for which states claimed federal funding versus the approximately 550 identified in the agency's reports.[49]

However, the information on abortions eligible for federal funding that states reported to us was also incomplete.

- Nine states, accounting for about one-third of total Medicaid enrollment, were unable to provide any information.[50] These states use only state funds to pay for abortions, and, for example, do not require providers to report the circumstance for the abortion when requesting Medicaid payment, including those eligible for federal funding.
- Six states provided only FFS information, though they also reported paying for abortions through MCOs.[51] Because over 60 percent of Medicaid beneficiaries in five of these states are enrolled in MCOs, information was not available for a significant portion of their beneficiaries.

There were also other, smaller gaps in the states' information. For example, six states were not able to provide information for at least 1 year

[48]This calculation is based on information from 27 states that reported claiming federal funding for FFS abortions in our survey; however, information from Florida and Kentucky, which also reported claiming federal funding for FFS abortions, was not included in the calculation due to data limitations.

[49]See Department of Health and Human Services, Office of the Assistant Secretary for Financial Resources, *FY 2018 Moyer Material*, (Washington, D.C.: 2017). A significant portion of the difference between the number in this report and the number in our survey was attributable to Nevada, which did not report FFS abortion data on line 14 of the CMS-64, but did report FFS information to us, and Pennsylvania, which was able to report abortions paid for through managed care to us that were not available through the CMS-64. Six states reported covering, but not claiming, federal funding for abortions in our survey. These states covered less than 100 abortions eligible for federal funding from fiscal year 2013 to fiscal year 2016.

[50]These nine states were California, Connecticut, Hawaii, Massachusetts, New Mexico, New York, Oregon, Washington, and West Virginia.

[51]These six states were Colorado, Georgia, Illinois, Nebraska, Ohio, and Wisconsin.

of the survey time frame, and one state was not able to provide information on abortions in the case of life endangerment, which, based on information provided by other states, typically accounts for the majority of abortions eligible for federal Medicaid funding.[52]

While not always complete, 42 states reported information to us on abortions eligible for federal Medicaid funding, which showed a wide range in the number of procedures covered across states.[53] Most of these states (37 of 42) reported covering 15 or fewer abortions eligible for federal funding per year, on average, from fiscal years 2013 through 2017, though this number may be understated in some states due to the data limitations discussed above.[54] However, during this same time frame, 3 states (Iowa, South Dakota, and Wyoming) reported covering no abortions eligible for federal funding, and 2 states (Nevada and Pennsylvania) reported annually covering an average of more than 300 and 700 such abortions, respectively.[55] (See app. II.)

Additionally, when excluding Nevada and Pennsylvania, states reporting information showed an aggregate decrease in the number of abortions eligible for federal Medicaid funding they covered during the fiscal year 2013 through fiscal year 2017 time period (from 383 to 200).[56] When data from these two states were included, there was an aggregate increase

[52]Rhode Island did not provide information for fiscal year 2013; Florida, Maryland, South Carolina, and Tennessee did not provide information for fiscal year 2017; Michigan did not provide MCO information for fiscal years 2013 and 2014; and New Jersey did not provide the number of abortions in the case of life endangerment.

In most of the 21 states that could report information by circumstance, the majority of abortions covered were in the case of life endangerment. However, in 4 of these states—Illinois, Minnesota, North Dakota, and Wisconsin—the majority of abortions covered were for cases of rape.

[53]Six of these states covered, but did not claim federal funding for, abortions in cases of rape, incest, or life endangerment.

[54]State-reported data reflect a claim's status at the time states responded to our survey. Claims that are paid may be later denied as the result of factors, such as utilization review.

[55]Nebraska reported covering no FFS abortions eligible for federal funding, but could not report information on abortions paid for through managed care; so whether the state covered such abortions is unknown. Pennsylvania and Nevada noted that their reported numbers could include data on a small number of women who had miscarriages, but needed an abortion procedure to remove the fetus.

[56]These numbers are based on information from 39 states, because data from Vermont was not included due to data limitations.

(from 876 to 1,544), as the number of abortions covered by Nevada and Pennsylvania was much higher in later years.[57]

T-MSIS could be a potential future source of more complete information on the number of abortions eligible for federal Medicaid funding. However, in two reports issued in January 2017 and December 2017, we examined T-MSIS implementation and identified issues with the completeness and comparability of T-MSIS data across states, as well as uncertainty with respect to how CMS will ensure the quality of the data or use them for oversight purposes.[58] Based on our findings, we recommended that CMS expedite efforts to ensure the quality of T-MSIS data and articulate its plan and associated time frame for using these data for oversight. CMS agreed with these recommendations, but as of October 2018, the agency had not fully implemented them, and we continue to believe that these recommendations remain valid. Further, due to ongoing concerns regarding the quality of T-MSIS data and the small number of abortion services relative to other Medicaid services, CMS officials said that the agency has focused its oversight efforts in other areas.

Conclusions

CMS has a central role in monitoring states' compliance with federal requirements for coverage of abortions eligible for federal funding in the Medicaid program. However, our work identified limitations in CMS's oversight. In the case of South Dakota, CMS is aware that the state does not cover abortions in cases of rape or incest, as required by federal law, but has not taken any action in 25 years to ensure the state's compliance. CMS was not aware of the14 states that reported not covering Mifeprex despite the requirement to do so under federal law. Without such coverage, Medicaid beneficiaries seeking abortions in these states would have to find another way to pay for the drug or undergo a surgical abortion. Finally, incomplete federal data on the number of abortions eligible for federal Medicaid funding—in part, due to inaccuracies that we identified in the reporting of these expenditures by eight states—limit the

[57]In addition to Nevada and Pennsylvania, 12 other states experienced an increase in the total number of abortions eligible for federal funding covered by their Medicaid programs over the time period. However, the increases in these states were often small and offset by drops in the number of such abortions covered in other states, such as Illinois, that also reported larger numbers of covered abortions.

[58]See GAO-17-173 and GAO-18-70.

agency's ability to ensure that states are covering such abortions and that federal payments are made appropriately.

Recommendations

We are making the following three recommendations to the Administrator of CMS.

- CMS should take action to ensure South Dakota's Medicaid state plan provides coverage for abortions in cases of rape and in cases of incest, in addition to life endangerment, to comply with federal law, which currently requires such coverage. (Recommendation 1)
- CMS should determine the extent to which state Medicaid programs are in compliance with federal requirements regarding coverage of Mifeprex and take actions to ensure compliance, as appropriate. (Recommendation 2)
- CMS should determine the extent to which state Medicaid programs are accurately reporting fee-for-service abortions on line 14 of the CMS-64 and take actions to ensure accuracy, as appropriate. (Recommendation 3)

Agency Comments

We provided a draft of this product to the Department of Health and Human Services for comment. In its written comments, HHS concurred with our recommendations and indicated a commitment to working with states to address them. In doing so, HHS noted that while CMS encourages states to design their Medicaid programs to meet the needs of local beneficiaries, states must operate their programs consistent with all applicable federal laws, including those referenced in our report. HHS also provided technical comments, which we incorporated as appropriate. HHS's comments are reprinted in appendix III.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the appropriate congressional committees, the Secretary of HHS, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs can be found on the last page of this report. Major contributors to this report are listed in appendix IV.

Carolyn L. Yocom
Director, Health Care

Appendix I: Literature Review

To identify studies examining factors that may present challenges to women, including Medicaid beneficiaries, accessing abortions, we conducted a literature review of recently published studies. Specifically, we searched for relevant studies published from January 2007 through September 2017. We searched various peer reviewed and industry journals using databases, including ProQuest, CINAHL, Dialog, and Scopus. Key terms included various combinations and iterations of "abortion," "access," "challenge," "limit," "restrict," "obtain," "deny," "state regulation," "state law," "state rule," "state policy," "Medicaid," "parental consent," "parental notification," "counseling," "waiting period," "ultrasound," "ambulatory surgical," "surgical center," "admitting privileges," "hospital distance," "hospital proximity," "hospital miles," "room size," "corridor," "procedure room," "transfer patient," "targeted regulation of abortion providers," "TRAP law," "stigma," "violence," "protest," harass," "gestational limit," "term limit," "out-of-pocket," "expense," "provider availability," "provider shortage," and "provider participation." From our search, we identified 637 studies.

We systemically reviewed the abstracts of these studies to determine which ones examined factors that may present challenges to women accessing abortions. In doing so, we excluded studies where the research (1) was not focused on the United States; (2) was not empirically analytical, such as theoretical articles and opinion pieces; (3) did not directly analyze the effect of a factor on a woman's ability to obtain an abortion (i.e., analyzed the effect of a factor on mental health outcomes, contraception use, or unintended birth); (4) did not focus on the civilian population; (5) evaluated personal characteristics or issues that may present challenges to obtaining abortions, such as income level or age; and (6) analyzed a number of factors together so the individual effect of any one factor could not be identified. For the studies remaining, we examined their methodologies to determine whether they were sufficiently reliable for the purposes of our reporting objectives. After taking these steps, 52 studies remained.

The 52 studies were then reviewed and coded by analysts to determine the type of abortion access factor identified. We focused our analysis on key factors identified through interviews with selected abortion providers: (1) gestational limits; (2) mandatory counseling; (3) Medicaid challenges; (4) out-of-pocket costs, (5) parental involvement, (6) provider availability, including certain state laws regulating abortion providers; (7) stigma or harassment; and (8) waiting periods. Table 4 identifies these 52 studies and summarizes the factors they examined.

Table 4: Studies Reviewed, by Key Factors that Could Present Challenges to Women Accessing Abortions

Study	Factor Examined							
	Gestational limits	Mandatory counseling	Medicaid challenges	Out-of-pocket costs	Parental involvement	Provider availability	Stigma and harassment	Waiting periods
1. Blanchard, Kelly, Jill L. Meadows, Hialy R. Gutierrez, Curtiss P.S. Hannum, Ella F. Douglas-Durham, and Amanda J. Dennis. "Mixed-Methods Investigation of Women's Experiences with Second-Trimester Abortion Care in the Midwest and Northeast United States." *Contraception*, (2017).	-	-	-	✓	-	✓	-	-
2. Grossman, Daniel, Kari White, Kristine Hopkins, and Joseph E. Potter. "Change in Distance to Nearest Facility and Abortion in Texas, 2012 to 2014." *Jama*, vol. 317, no. 4 (2017): 437-439.	-	-	-	-	-	✓	-	-
3. Jerman, Jenna, Lori Frohwirth, Megan L. Kavanaugh, and Nakeisha Blades. "Barriers to Abortion Care and their Consequences for Patients Traveling for Services: Qualitative Findings from Two States." *Perspectives on Sexual and Reproductive Health*, vol. 49, no. 2 (2017): 95-102.	-	-	-	-	-	✓	-	-
4. Johns, Nicole E., Diana Greene Foster, and Ushma D. Upadhyay. "Distance Traveled for Medicaid-Covered Abortion Care in California." *BMC Health Services Research*, vol.17, (2017): 287.	-	-	-	-	-	✓	-	-
5. Jones, Rachel K. and Jenna Jerman. "Characteristics and Circumstances of U.S. Women Who Obtain very Early and Second-Trimester Abortions." *PLoS One*, vol. 12, no.1 (2017).	-	-	✓	✓	-	✓	-	✓
6. Quast, Troy, Fidel Gonzalez, and Robert Ziemba. "Abortion Facility Closings and Abortion Rates in Texas." *Inquiry: A Journal of Medical Care Organization, Provision and Financing*, vol. 54, (2017).	-	-	-	-	-	✓	-	-
7. Upadhyay, Ushma D., Katrina Kimport, Elise K. O. Belusa, Nicole E. Johns, Douglas W. Laube, and Sarah C. M. Roberts. "Evaluating the Impact of a Mandatory Pre-Abortion Ultrasound Viewing Law: A Mixed Methods Study." *PLoS One*, vol. 12, no.7 (2017).	-	-	-	✓	-	-	-	-
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9. Baum, Sarah E., Kari White, Kristine Hopkins, Joseph Potter E., and Daniel Grossman. "Women's Experience Obtaining Abortion Care in Texas after Implementation of Restrictive Abortion Laws: A Qualitative Study." *PLoS One*, vol. 11, no. 10 (2016).	-	-	-	-	-	✓	-	-
10. French, Valerie, Renaisa Anthony, Chelsea Souder, Christine Geistkemper, Eleanor Drey, and Jody Steinauer. "Influence of Clinician Referral on Nebraska Women's Decision-to-Abortion Time." *Contraception*, vol. 93, (2016): 236-243.	-	-	-	✓	-	✓	-	-

Study	Factor Examined							
	Gestational limits	Mandatory counseling	Medicaid challenges	Out-of-pocket costs	Parental involvement	Provider availability	Stigma and harassment	Waiting periods
11. Fuentes, Liza, Sharon Lebenkoff, Kari White, Caitlin Gerdts, Kristine Hopkins, Joseph E. Potter, and Daniel Grossman. "Women's Experiences Seeking Abortion Care Shortly After the Closure of Clinics due to a Restrictive Law in Texas." *Contraception*, vol. 93, (2016): 292-297.	-	-	-	-	-	✓	-	-
12. Gerdts, Caitlin, Liza Fuentes, Daniel Grossman, Kari White, Brianna Keefe-Oates, Sarah E. Baum, Kristine Hopkins, Chandler W. Stolp, and Joseph E. Potter. "Impact of Clinic Closures on Women Obtaining Abortion Services After Implementation of a Restrictive Law in Texas." *American Journal of Public Health*, vol. 106, (2016): 857-864.	-	-	-	-	-	✓	-	-
13. Karasek, Deborah, Sarah C. M. Roberts, and Tracy A. Weitz. "Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence before Arizona's Two-Visit 24-Hour Mandatory Waiting Period Law." Women's Health Issues: Official Publication of the Jacobs *Institute of Women's Health*, vol. 26, no.1 (2016): 60-66.	-	-	-	✓	-	-	-	-
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15. Roberts, Sarah C. M., David K. Turok, Elise Belusa, Sarah Combellick, and Ushma D. Upadhyay. "Utah's 72-Hour Waiting Period for Abortion: Experiences among a Clinic-Based Sample of Women." *Perspectives on Sexual and Reproductive Health*, vol. 48, no. 4 (2016): 179-187.	-	-	-	-	-	-	-	✓
16. Sanders, Jessica N., Hilary Conway, Janet Jacobson, Leah Torres, and David K. Turok. "The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion." *Women's Health Issues: Official Publication of the Jacobs Institute of Women's Health*, vol. 26, no. 5 (2016): 483-487.	-	-	-	✓	-	✓	-	✓
17. Upadhyay, Ushma D., Nicole E. Johns, Sarah L. Combellick, Julia E. Kohn, Lisa M. Keder, and Sarah CM Roberts. "Comparison of Outcomes Before and After Ohio's Law Mandating use of the FDA-Approved Protocol for Medication Abortion: A Retrospective Cohort Study." *PLoS Medicine*, vol. 13, no. 8 (2016).[a]	-	-	-	-	-	-	-	-
18. White, Kari, Victoria deMartelly, Daniel Grossman, and Janet M. Turan. "Experiences Accessing Abortion Care in Alabama among Women Traveling for Services." *Women's Health Issues: Official Publication of the Jacobs Institute of Women's Health*, vol. 26, no. 3 (2016): 298-304.	-	-	-	-	-	✓	-	-
19. Canes-Wrone, Brandice and Michael C. Dorf. "*Measuring the Chilling Effect." New York University Law Review*, vol. 90, (2015): 1095.	✓	-	-	-	-	✓	-	-

Study	Factor Examined							
	Gestational limits	Mandatory counseling	Medicaid challenges	Out-of-pocket costs	Parental involvement	Provider availability	Stigma and harassment	Waiting periods
20. Chevrette, Marianne and Haim Arie Abenhaim. "Do State-Based Policies have an Impact on Teen Birth Rates and Teen Abortion Rates in the United States?" *Journal of Pediatric and Adolescent Gynecology*, vol. 28, (2015): 354-361.	-	✓	-	-	✓	-	-	✓
21. MacAfee, Lauren, Jennifer Castle, and Regan N. Theiler. "Association between the New Hampshire Parental Notification Law and Minors Undergoing Abortions in Northern New England." *Obstetrics and Gynecology*, vol.125, (2015): 170-174.	-	-	-	-	✓	-	-	-
22. Medoff, Marshall H. "The Impact of Antiabortion Criminal Activities and State Abortion Policies on Abortion Providers in the United States." *Journal of Family and Economic Issues*, vol. 36, (2015): 570-580.	-	✓	✓	-	✓	✓	✓	✓
23. Grossman, Daniel, Sarah Baum, Liza Fuentes, Kari White, Kristine Hopkins, Amanda Stevenson, and Joseph E. Potter. "Change in abortion services after implementation of a restrictive law in Texas." *Contraception*, vol. 90, (2014): 496-501.	-	-	-	-	-	✓	-	-
24. Janiak, Elizabeth, Ichiro Kawachi, Alisa Goldberg, and Barbara Gottlieb. "Abortion Barriers and Perceptions of Gestational Age among Women Seeking Abortion Care in the Latter Half of the Second Trimester." *Contraception*, vol. 89, (2014): 322-327.	-	-	-	✓	-	-	-	-
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26. Ostrach, Bayla and Melissa Cheyney. "Navigating Social and Institutional Obstacles: Low-Income Women Seeking Abortion." *Qualitative Health Research*, vol. 24, no. 7 (2014): 1006-1017.	-	-	✓	✓	-	-	-	-
27. Roberts, Sarah C. M., Heather Gould, Katrina Kimport, Tracy A. Weitz, and Diana Greene Foster. "Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States." *Women's Health Issues*, vol. 24, no. 2 (2014): e211-e218.	-	-	✓	✓	-	-	-	-
28. Upadhyay, Ushma D., Tracy A. Weitz, Rachel K. Jones, Rana E. Barar, and Diana Greene Foster. "Denial of Abortion because of Provider Gestational Age Limits in the United States." *American Journal of Public Health*, vol. 104, (2014): 1687-1694.	✓	-	-	✓	-	-	-	-
29. Dennis, Amanda and Kelly Blanchard. "Abortion Providers' Experiences with Medicaid Abortion Coverage Policies: A Qualitative Multistate Study." *Health Services Research*, vol. 48, no. 1 (2013): 236-252.	-	-	✓	-	-	-	-	-
30. Foster, Diana Greene and Katrina Kimport. "Who Seeks Abortions at Or After 20 Weeks?" *Perspectives on Sexual & Reproductive Health*, vol. 45, no. 4 (2013): 210-218.	-	-	-	✓	-	✓	-	-

Study	Factor Examined							
	Gestational limits	Mandatory counseling	Medicaid challenges	Out-of-pocket costs	Parental involvement	Provider availability	Stigma and harassment	Waiting periods
31. Jones, Rachel K. and Jenna Jerman. "How Far did U.S. Women Travel for Abortion Services in 2008?" *Journal of Women's Health*, vol. 22, no. 8 (2013): 706-713.	-	-	-	✓	-	-	-	✓
32. Dennis, Amanda and Kelly Blanchard. "A Mystery Caller Evaluation of Medicaid Staff Responses about State Coverage of Abortion Care." *Women's Health Issues*, vol. 22, no. 2 (2012): e143-e148.	-	-	✓	-	-	-	-	-
33. Bessett, Danielle, Katey Gorski, Deepani Jinadasa, Marcy Ostrow, and Megan J. Peterson. "Out of Time and Out of Pocket: Experiences of Women Seeking State-Subsidized Insurance for Abortion Care in Massachusetts." *Women's Health Issues*, vol. 21, supplement 3 (2011): S21-S25.	-	-	✓	-	-	-	-	-
34. Dennis, Amanda, Kelly Blanchard, and Denisse Córdova."Strategies for Securing Funding for Abortion Under the Hyde Amendment: A Multistate Study of Abortion Providers' Experiences Managing Medicaid." *American Journal of Public Health*, vol. 101, no. 11(2011): 2124-2129.	-	-	✓	-	-	-	-	-
35. Hussey, Laura S. "Is Welfare Pro-Life? Assistance Programs, Abortion, and the Moderating Role of States." *The Social Service Review*, vol. 85, no. 1 (2011): 75-107.	-	-	-	-	-	✓	-	-
36. Jacobson, Mireille, and Heather Royer. "Aftershocks: The Impact of Clinic Violence on Abortion Services." *American Economic Journal: Applied Economics*, vol. 3, no. 1 (2011): 189-223.	-	-	-	-	-	-	✓	-
37. New, Michael J. "Analyzing the Effect of Anti-Abortion U.S. State Legislation in the Post-Casey Era." *State Politics & Policy Quarterly*, vol. 11, no. 1 (2011): 28-47.	-	✓	✓	-	✓	-	-	-
38. Hussey, L. S. "Welfare Generosity, Abortion Access, and Abortion Rates: A Comparison of State Policy Tools." *Social Science Quarterly*, vol. 91, no. 1 (2010): 266-283.	-	-	-	-	-	✓	-	-
39. Joyce, Ted. "Parental Consent for Abortion and the Judicial Bypass Option in Arkansas: Effects and Correlates." *Perspectives on Sexual and Reproductive Health*, vol. 42, no. 3 (2010): 168-175.	-	-	-	-	✓	-	-	-
40. Kacanek, Deborah, Amanda Dennis, Kate Miller, and Kelly Blanchard. "Medicaid Funding for Abortion: Providers' Experiences with Cases Involving Rape, Incest and Life Endangerment." *Perspectives on Sexual and Reproductive Health*, vol. 42, no. 2 (2010): 79-86.	-	-	✓	-	-	-	-	-
41. Medoff, Marshall H. "State Abortion Policies, Targeted Regulation of Abortion Provider Laws and Abortion Demand." *Review of Policy Research*, vol. 27, no. 5 (2010): 577-594.	-	✓	✓	✓	✓	✓	-	✓
42. Zavodny, Madeline and Marianne P. Bitler. "The Effect of Medicaid Eligibility Expansions on Fertility, "*Social Science & Medicine*, vol. 71, no. 5 (2010): 918-924.	-	-	✓	-	-	-	-	-

Study	Factor Examined							
	Gestational limits	Mandatory counseling	Medicaid challenges	Out-of-pocket costs	Parental involvement	Provider availability	Stigma and harassment	Waiting periods
43. Colman, Silvie and Ted Joyce. "Minors' Behavioral Responses to Parental Involvement Laws: Delaying Abortion Until Age 18." *Perspectives on Sexual and Reproductive Health*, vol.41, no. 2 (2009): 119-126.	-	-	-	-	✓	-	-	-
44. Medoff, Marshall H. "Biased Abortion Counseling Laws and Abortion Demand." *The Social Science Journal*, vol. 46, 2009): 632-643.	-	✓	✓	✓	✓	-	-	-
45. Medoff, Marshall H. "The Relationship between State Abortion Policies and Abortion Providers." *Gender Issues*, vol. 26, (2009): 224-237.	-	✓	✓	-	✓	✓	-	✓
46. Colman, Silvie, Ted Joyce, and Robert Kaestner. "Misclassification Bias and the Estimated Effect of Parental Involvement Laws on Adolescents' Reproductive Outcomes." *American Journal of Public Health*, vol. 98, no. 10 (2008): 1881-1885.	-	-	-	-	✓	-	-	-
47. Foster, Diana G., Rebecca A. Jackson, Kate Cosby, Tracy A. Weitz, Philip D. Darney, and Eleanor A. Drey. "Predictors of Delay in each Step Leading to an Abortion." *Contraception*, vol. 77, (2008): 289-293.	-	-	✓	✓	-	✓	-	-
48. Medoff, Marshall H. "The Response of Abortion Demand to Changes in Abortion Costs." *Social Indicators Research*, vol. 87, (2008): 329-346.	-	✓	✓	✓	✓	-	-	✓
49. Gius, Mark Paul. "The Impact of Provider Availability and Legal Restrictions on the Demand for Abortions by Young Women." *The Social Science Journal*, vol. 44, (2007): 495-506.	-	✓	✓	-	-	✓	-	-
50. Jackson, D. Lynn. "State Policy Restrictions on Abortion: Implications for Social Workers." *Journal of Policy Practice*, vol. 6, no. 4 (2007): 25-43.	✓	-	✓	✓	✓	✓	-	✓
51. Kelly, Kimberly and Linda Grant. "State Abortion and Nonmarital Birthrates in the Post-Welfare Reform Era: The Impact of Economic Incentives on Reproductive Behaviors of Teenage and Adult Women." *Gender & Society*, vol. 21, no.6 (2007): 878-904.	-	✓	✓	-	✓	✓	-	-
52. Medoff, Marshall H. "Price, Restrictions and Abortion Demand." *Journal of Family and Economic Issues*, vol. 28, (2007): 583-599.	-	-	✓	✓	✓	-	-	✓
Total	**3**	**10**	**21**	**18**	**16**	**25**	**2**	**12**

Legend: - = Not examined; ✓=Examined.
Source: GAO analysis of reviewed studies.| GAO-19-159

[a]This study did not examine any of the key factors identified through our interviews with providers. Rather, it looked at the effect of a state law mandating the use of the Food and Drug Administration approved protocol for medical abortions on a variety of outcomes, including the incidence of medical abortions in the state.

Appendix II: State-Reported Information on the Number of Covered Abortions Eligible for Federal Medicaid Funding

Table 5: State-Reported Information on the Number of Covered Abortions Eligible for Federal Medicaid Funding between Fiscal Years 2013 through 2017

State	Claimed federal funding for abortions	Average number of abortions eligible for federal funding covered per year
Alabama	Yes	6.2
Alaska	No	1.2
Arizona	Yes	3.8
Arkansas	Yes	0.4
California	No	Not Reported[a]
Colorado	Yes	26.6[b]
Connecticut	No	Not Reported[a]
Delaware	Yes	13.8
District of Columbia	Yes	11.6
Florida	Yes	9.3[c]
Georgia	Yes	3.2[b]
Hawaii	No	Not Reported[a]
Idaho	Yes	4.2
Illinois	Yes	69.4[b]
Indiana	Yes	2.6
Iowa	Not Applicable[d]	0
Kansas	Yes	1.2
Kentucky	Yes	4.2
Louisiana	No	0.4
Maine	Yes	10.4
Maryland	No	3.8[c]
Massachusetts	No	Not Reported[a]
Michigan	Yes	6.6[e]
Minnesota	Yes	2.6
Mississippi	Yes	14.8
Missouri	Yes	6
Montana	Yes	0.6
Nebraska	Unknown[f]	0[b]
Nevada	Yes	319
New Hampshire	Yes	2.8
New Jersey	No	8.8[g]
New Mexico	No	Not Reported[a]
New York	No	Not Reported[a]

State	Claimed federal funding for abortions	Average number of abortions eligible for federal funding covered per year
North Carolina	No	4.2
North Dakota	Yes	1.2
Ohio	Yes	4.2[b]
Oklahoma	Yes	6.6
Oregon	No	Not Reported[a]
Pennsylvania	Yes	717
Rhode Island	Yes	38.5[h]
South Carolina	Yes	5.3[c]
South Dakota	Not Applicable[d]	0
Tennessee	Yes	2[c]
Texas	Yes	5.8
Utah	Yes	0.4
Vermont	Yes	<10[i]
Virginia	Yes	8.4
Washington	No	Not Reported[a]
West Virginia	No	Not Reported[a]
Wisconsin	No	2.6[b]
Wyoming	Not Applicable[d]	0

Source: GAO analysis of state survey responses. | GAO-19-159

Notes: Federal funding is available only for abortions in cases of rape, incest, or life endangerment, as defined by law, but states may offer coverage in additional circumstances using state funds. State-reported information reflects a claim's status at the time states responded to our survey. Claims that are paid or denied may change status up to several years after the date of service as the result of factors, such as utilization review or the appeals process. Unless otherwise noted, state-reported information includes abortions paid for by fee-for-service (FFS) and managed care to the extent those delivery systems exist in a state.

[a]Could not provide information because only uses state funds to pay for abortions, and, for example, does not require providers to report the circumstance for the abortion when requesting Medicaid payment.

[b]Number is likely understated because, while the state reported paying for abortions through managed care, it could only provide information for abortions paid for through FFS. (States are not required to report expenditures for individual managed care services for the purpose of claiming federal funding, and this information was not always readily available.) In states that could not provide managed care information, the percentage of the Medicaid population in managed care in 2016 was the following: Colorado, 10 percent; Georgia, 68 percent; Illinois, 61 percent; Nebraska 78 percent; Ohio, 80 percent; and Wisconsin, 63 percent.

[c]Could not report information for fiscal year 2017; average based on 4 years of information.

[d]Reported paying for no abortions eligible for federal funding over the time period.

[e]Could not report managed care information for fiscal years 2013 and 2014.

[f]Did not pay for any abortions through fee-for-service, but could not provide managed care information due to a change in managed care contracts. However, the state said that if it did pay for abortions through managed care, it would have claimed federal funding.

[g]Could not report information on abortions in the case of life endangerment.

[h]Could not report data for fiscal year 2013; average based on 4 years of information.

[i]Reported paying for fewer than 10 abortions eligible for federal funding during the time frame of our survey, but provided no further details.

Appendix III: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

DEC 14 2018

Carolyn L. Yocom
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*MEDICAID: CMS Action Needed to Ensure Compliance with Abortion Coverage Requirements*" (GAO-19-159).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Matthew D. Bassett
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – MEDICAID: CMS ACTION NEEDED TO ENSURE COMPLIANCE WITH ABORTION COVERAGE REQUIREMENTS (GAO-19-159)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report on Medicaid coverage of abortion services.

The Medicaid program is, by design, administered by states within Federal guidelines. HHS/Centers for Medicare & Medicaid Services (CMS) expects states to administer their programs within those programmatic guidelines. While HHS/CMS encourages states to design their Medicaid programs to meet the needs of local beneficiaries, states must operate their programs consistent with all applicable Federal laws, including those highlighted in this draft GAO report. CMS will continue to work with states as they manage their Medicaid programs in accordance with Federal laws and guidance.

GAO's recommendations and HHS's responses are below.

Recommendation 1
CMS should take action to ensure South Dakota's Medicaid state plan provides coverage for abortions in cases of rape and incest, in addition to life endangerment, to comply with federal law, which currently requires such coverage.

HHS Response
HHS concurs with this recommendation. CMS will again notify South Dakota that their Medicaid state plan is not in compliance with federal law regarding coverage for abortions in cases of rape and incest and urge the state to comply.

Recommendation 2
CMS should determine the extent to which state Medicaid programs are in compliance with federal requirements regarding coverage of Mifeprex and take actions to ensure compliance, as appropriate.

HHS Response
HHS concurs with this recommendation. CMS will notify applicable state Medicaid programs that they are not in compliance with federal requirements regarding coverage of Mifeprex and urge their compliance.

Recommendation 3
CMS should determine the extent to which state Medicaid programs are accurately reporting fee- for-service abortions on line 14 of the CMS-64 and take actions to ensure accuracy, as appropriate.

HHS Response
HHS concurs with this recommendation. CMS believes that accurate reporting is important for all aspects of program management. CMS will work to ensure states understand how to accurately report these services on the CMS-64.

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Appendix IV: GAO Contact and Staff Acknowledgements

GAO Contact

Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov.

Staff Acknowledgements

In addition to the contact named above, Susan Anthony (Assistant Director), Rachel Svoboda, (Analyst-in-Charge), Marcia Crosse, Julianne Flowers, Sandra George, Ashley Nurhussein, Sara Rizik, and Jennifer Rudisill made key contributions to this report. Also contributing were Sarah Gilliland, Kaitlin Farquharson, Drew Long, Vikki Porter, and Eric Wedum.