



## State Approaches to Improving Reproductive and Sexual Health Access and Service Delivery in Medicaid during the COVID-19 Pandemic and Beyond

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All 50 states and the District of Columbia have made changes to their Medicaid programs in light of the COVID-19 emergency. Most of these changes were made to maintain or expand health coverage and adapt more flexible methods for delivering health care services including family planning services, STI testing and treatment, and other reproductive and sexual health care. The Centers for Medicare & Medicaid Services (CMS), the federal agency responsible for administering the Medicaid program, approved these changes through legal authorities that allow for temporary changes during a public health or national emergency. The end date for these changes depends on the authority being used by the state.<sup>1</sup> Many of the current protective measures are tied to official emergency declarations. Thus, once the emergencies end states will lose the authority to continue these interventions, even if they are still needed to address continuing health care and coverage challenges in the ensuing months and beyond. In addition, after the official emergencies end, most states are anticipating years-long severe economic downturns, which could have lasting impacts on the scope and delivery of reproductive and sexual health (RSH) services in Medicaid. Now is the time to identify ways to maintain the current protections and coverage for Medicaid enrollees and mitigate future reductions in RSH services and coverage for Medicaid enrollees.<sup>2</sup>

NHeLP conducted a 50-state review of state Medicaid websites of COVID-19 related policies related to reproductive and sexual health care.<sup>3</sup> This issue brief describes some of the temporary Medicaid and other health care policies and practices states put in place during the pandemic to facilitate the coverage and delivery of reproductive and sexual health services We

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<sup>1</sup> To learn more about what Medicaid authorities are available to states responding to the COVID-19 pandemic, see Leonardo Cuello, Nat'l Health Law Prog., *Overview on Using Medicaid to Respond to COVID-19* (March 19, 2020), <https://healthlaw.org/resource/overview-on-using-medicaid-to-respond-to-covid-19/>.

<sup>2</sup> Sarah Somers and Jane Perkins, Nat'l Health Law Prog., *Top Ten List: Transitions in the Medicaid Program in Light of COVID-19* (May 2020), <https://healthlaw.org/resource/top-ten-list-transitions-in-the-medicaid-program-in-light-of-covid-19/>.

<sup>3</sup> NHeLP thanks the law firm of Hughes Hubbard & Reed for their pro bono assistance with conducting the review.

also highlight those examples and best practices that we believe states should consider making permanent once the public health emergency ends.

### **1. Continuous coverage for reproductive and sexual health services**

The Families First Coronavirus Response Act (FFCRA) provides states with a temporary 6.2 percentage increase in the federal share of certain Medicaid spending as long as the state meets certain requirements that ensure the continuous coverage of individuals enrolled in Medicaid since March 18, 2020 or later.<sup>4</sup> CMS guidance interpreted the continuous coverage requirement as prohibiting most negative Medicaid actions during the public health emergency (PHE), including barring states from cutting benefits or increasing cost-sharing for Medicaid beneficiaries. Every state has implemented a range of policies based on these federal requirements, which has safeguarded against coverage interruptions that would have affected access to reproductive and sexual health care during the pandemic. The increase in federal funding and accompanying coverage requirements will last through the end of the calendar year quarter in which the public health emergency (PHE) ends. As of the date of this publication, the Secretary of Health & Humans Services has signaled that the PHE will likely remain in place for the entirety of 2021.<sup>5</sup>

#### **a. Suspending disenrollments**

Under the continuous coverage provision, state Medicaid agencies cannot disenroll most beneficiaries (who were enrolled as of March 18, 2020) through the end of the PHE. The continuous coverage requirement applies to Medicaid enrollees in both full-scope and most limited scope programs, including pregnancy-related coverage. As such, states that could terminate coverage after 60-days postpartum when providing Medicaid coverage on the basis of pregnancy before the pandemic, must now provide continuous Medicaid coverage for these enrollees throughout the public health emergency. Several states have issued guidance, provider bulletins, or other publications to inform Medicaid providers and enrollees of this requirement. For example, Kansas' Department of Health and the Environment issued an FAQ for pregnant people that included a specific question and response to this question:

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<sup>4</sup> Section 6008, Pub. L. 116-127 (116th Congress, 2d session).

<sup>5</sup> See Dep't of Health & Human Serv., Letter to Governors (Jan. 21, 2021), <https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf>.

Q. If I have Medicaid/KanCare coverage for my pregnancy, how will it be affected by this pandemic?

A. As a KanCare beneficiary during your pregnancy, your coverage will extend beyond the typical coverage period of 60-days postpartum, until the end of the month in which the COVID-19 emergency period ends. Make sure that your contact information, including phone number and email, are always up-to-date with your KanCare provider so any changes in your benefits can be communicated to you easily.<sup>6</sup>

Oregon's Medicaid COVID-19 Provider Guide also clarified that eligibility will continue even for beneficiaries who had qualified for limited coverage programs including pregnancy-related Medicaid.<sup>7</sup>

The continuous coverage requirement also applies to other limited-scope Medicaid programs, such as family planning expansion programs. Thus, individuals who may have been automatically disenrolled and lost coverage for limited family planning services such as contraceptive access or cervical cancer screenings under the pre-pandemic enrollment rules, may continue to receive these services through the end of the PHE without interruption. There will be many issues states must consider in preparation for the end of the public health emergency. In December 2020, CMS released guidance informing states how they should begin planning for the resumption of normal eligibility and enrollment operations.<sup>8</sup> States should use the time now to implement policies that continue to minimize disruptions in coverage.

According to a survey conducted by the Kaiser Family Foundation, women are more likely to have gone without health care during the pandemic compared to men, and women with health and economic challenges prior to the pandemic have experienced worsening health conditions

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<sup>6</sup> Kansas Dept. of Health and Environment, *Frequently Asked Questions (FAQs) for Perinatal and Infant Populations* (March 8, 2021), <https://www.coronavirus.kdheks.gov/DocumentCenter/View/359/FAQs-for-Pregnant-Perinatal-Populations-PDF---11-18-20>.

<sup>7</sup> Oregon Health Authority, *Oregon Medicaid COVID-19 Provider Guide* (Updated April 30, 2021), <https://www.oregon.gov/oha/HSD/OHP/Tools/Oregon%20Medicaid%20COVID-19%20Provider%20Guide.pdf>.

<sup>8</sup> CMS, Dear State Health Official (SHO# 20-004)(Dec. 22, 2020), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20004.pdf>.

as a result of skipping health care services during the pandemic.<sup>9</sup> Routine access to RSH services has been shown to be effective in helping to increase the use of preventive care and better health outcomes.<sup>10</sup> Thus, gaps in care could lead to higher numbers of individuals experiencing severe health issues even after the health emergency from the pandemic resolves. States should consider policies that suspend disenrollment in order to preserve enrollee access to health care including family planning, pregnancy and postpartum care. States should also slowly phase in eligibility reviews after the emergency period ends, instead of overloading state systems by reviewing all of the backlog in the first month

b. Premium waivers

FFCRA's requirements also prohibited states from charging higher premiums than were in place as of January 1, 2020. During the PHE, some state Medicaid programs with a share-of-cost or premium went even further. These states recognized the financial hardship caused by the pandemic and implemented policies that allowed enrollees to request a waiver. For example, California allowed individuals enrolled in the state's Medi-Cal Access Program (MCAP) who experienced financial hardship to request to waive their monthly premium payment.<sup>11</sup> Usually states are permitted to charge monthly premiums for pregnant people with incomes above 150 percent of the federal poverty level, such as those covered under MCAP. Yet Medicaid enrollees and their families will likely face ongoing financial hardships even after the pandemic. Thus, states should consider extending the time for premium waivers and suspend discontinuances even after the PHE ends.

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<sup>9</sup> Brittini Frederiksen et al., Kaiser Family Found. *Women's Experiences with Health Care During the COVID-19 Pandemic: Findings from the KFF Women's Health Survey* (Mar. 22, 2021), <https://www.kff.org/womens-health-policy/issue-brief/womens-experiences-with-health-care-during-the-covid-19-pandemic-findings-from-the-kff-womens-health-survey/>. This report occasionally uses the words "woman" or "women." This is not intended to be exclusionary. NHeLP recognizes that cisgender and transgender women, and gender non-conforming and nonbinary individuals need access to the full range of reproductive and sexual health services. We have tried to limit the use of "woman" or "women" when necessary to explain the language used in policy, and in conformity with cited research or data.

<sup>10</sup> Kinsey Hasstedt, Guttmacher Inst., *More than a Pack of Pills: The Many Components and Health Benefits of Quality Family Planning* (Sept 2014), <https://www.guttmacher.org/gpr/2014/09/more-pack-pills-many-components-and-health-benefits-quality-family-planning>.

<sup>11</sup> Cal. Dep't Health Care Servs., *Important information about Medi-Cal and COVID-19* (May 19, 2020), <https://www.dhcs.ca.gov/Documents/Beneficiary-Outreach-Letter.pdf>.

## 2. Simplifying eligibility for and enrollment in reproductive and sexual health coverage programs

In addition to the continuing coverage requirement preserving coverage already obtained, states have also implemented policies that minimize existing barriers to enrolling in Medicaid coverage programs through temporary federal and state authorities.

### a. Online/telephonic enrollment

Some family planning expansion and other limited-scope Medicaid programs that had not accepted online or telephonic enrollments before the pandemic used the new flexibilities to allow individuals to submit applications without appearing in-person and completing a paper application. This flexibility is particularly important for applicants and beneficiaries without internet access or a computer, or for populations who often encounter barriers to accessing benefits, such as persons with disabilities, older adults, and those who are unhoused. In California, Medicaid providers for a number of limited scope reproductive and sexual health care programs such as the state's family planning expansion program, breast and cervical cancer screening program, breast and cervical cancer treatment program, and minor consent program (for confidential family planning, pregnancy, STI testing and treatment, substance use and mental health services) were required to accept enrollment applications over the phone in addition to in-person office visits.<sup>12</sup>

### b. Presumptive eligibility

Currently, 30 states allow presumptive eligibility determinations to be made for pregnant women under Medicaid, and three states allow for it under the Children's Health Insurance Program (CHIP).<sup>13</sup> This option allows states to grant authority to certain providers to begin treating pregnant people when they first seek treatment rather than waiting several weeks to begin treatment after a final Medicaid eligibility determination has been made by the state.

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<sup>12</sup> Cal. Dep't Health Care Servs., *Update to Information on Coronavirus for Family PACT* (March 26, 2020), <https://www.dhcs.ca.gov/services/ofp/Documents/OFP-Notice-COVID19-Update.pdf>. Cal. Dep't Health Care Servs., *Every Woman Counts (EWC) Primary Care Provider (PCP) Information Notice Program Update Regarding COVID-19 Public Health Emergency* (April 2, 2020), <https://www.dhcs.ca.gov/Documents/COVID-19/EWC-Primary-Care-Provider-COVID-19-Notice.pdf>. Cal. Dep't Health Care Servs., *Breast and Cervical Cancer Treatment Program Presumptive Eligibilities due to COVID-19* (Apr. 17, 2020), <https://www.dhcs.ca.gov/services/med-cal/eligibility/Pages/BCCTP-PE-COVID19.aspx>.

<sup>13</sup> Kaiser Family Found., *Presumptive Eligibility in Medicaid and CHIP* (Jan. 1, 2021), <https://www.kff.org/health-reform/state-indicator/presumptive-eligibility-in-medicare-chip/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

Similarly, some states with Medicaid family planning expansion programs allow individuals seeking covered family planning services to receive same-day services through the presumptive eligibility for family planning option. Presumptive eligibility can be particularly important amid public health emergencies such as COVID-19, as it provides an easier entry point to enrollment and ensures individuals seeking planning services and pregnant people are able to access care in a timely manner.

Oregon sought to maximize flexibilities to help residents receive coverage as quickly as possible by expanding the types of entities that can make presumptive eligibility determinations. The state applied for and received CMS approval to designate and contract with community partner organizations to make presumptive eligibility determinations. These contracted entities, once certified, are permitted to make determinations for “Parent or Other Caretaker Relative, MAGI Adult, MAGI Pregnant Woman, MAGI Child, Former Foster Care Youth Medical, Breast and Cervical Cancer Treatment Program.”<sup>14</sup>

c. Auto-renewals

Traditionally, state Medicaid agencies must review an enrollee’s eligibility at least once every 12 months, and for some populations (MAGI categories) the state cannot review more frequently than that. This process is called the recertification or redetermination process. The redetermination process sometimes results in coverage loss for eligible enrollees because they didn’t complete the renewal process on time or the state agency did not properly process the renewal documents. During the PHE, many states simplified and automatically renewed eligible Medicaid enrollees in their coverage program. For example, Texas issued guidance informing enrollees in the Medicaid family planning program that “current [] recipients will have their benefits renewed automatically and will remain active throughout the pandemic. No further action is necessary at this time.”<sup>15</sup> States should continue using automatic Medicaid renewals (also called “ex parte renewals”) beyond the PHE to ensure eligible individuals maintain their coverage.

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<sup>14</sup> MAGI or “Modified Adjusted Gross Income” refers to a methodology for determining income eligibility for Medicaid. CMS, *Oregon State Plan Amendment (SPA) OR-20-0010* (June 18, 2020), <https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/20-0010.pdf>.

<sup>15</sup> Texas Health and Human Services, *COVID-19: Updates for Healthy Texas Women and Family Planning Program*, <https://www.healthytexaswomen.org/sites/htw/files/documents/htw-fpp-covid-updates.pdf>.

### 3. Increased telehealth delivery of reproductive and sexual health care

Millions of people accessed health care services—including reproductive and sexual health services—via telehealth during the pandemic. Telehealth is the use of digital technologies to deliver health care, health information, and other health services by connecting two or more users - principally the patient and the provider - in separate locations. The patient is located at the “originating site” and the provider is located at the “distant site.”<sup>16</sup>

A Kaiser Family Foundation survey found that women are more likely to have gone without health care during the pandemic compared to men.<sup>17</sup> A larger share of women than men were also found to have skipped recommended preventive services in response to the pandemic, particularly Latina/x women.<sup>18</sup> Telehealth has played an important role in helping Medicaid enrollees receive reproductive and sexual health services from their provider during the PHE. Although less than 15 percent of women enrolled in Medicaid had a telehealth visit prior to March 1, 2020 (before the start of the PHE), that number increased dramatically to 42 percent by December 2020.<sup>19</sup> CMS has also encouraged the use of telehealth to help promote health care access for Medicaid enrollee during the pandemic.<sup>20</sup>

#### a. Maximizing telehealth modalities to include telephone only

Before the COVID-19 pandemic, all fifty states and Washington, D.C. already allowed for Medicaid reimbursement of telehealth services in Medicaid fee-for-service in the form of live

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<sup>16</sup> Fabiola Carrion, Nat'l Health Law Prog., Medicaid Principles on Telehealth (May 2020), <file:///C:/Users/Priscilla/Downloads/Medicaid-Telehealth-Principles-FINAL.FORMATTED.pdf>.

<sup>17</sup>Brittini Frederiksen et al., *supra* note 9.

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> See CMS, *State Medicaid & CHIP Telehealth Toolkit Policy Considerations for States Expanding Use of Telehealth- COVID-19 Version*, <https://www.medicaid.gov/medicaid/benefits/downloads/medicaidchip-telehealth-toolkit.pdf>; *State Medicaid & CHIP Telehealth Toolkit Policy Considerations for States Expanding Use of TelehealthCOVID-19 Version: Supplement #1* (Oct. 14 2020), <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkitsupplement1.pdf>; *NEW FAQs – Released June 30, 2021 COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies* (June 30, 2020), <https://www.medicaid.gov/state-resource-center/downloads/covid-19-new-faqs.pdf>; *Medicaid State Plan Fee-for-Service Payments for Services Delivered Via Telehealth*, <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf>.

videoconferencing.<sup>21</sup> After the pandemic began, several states expanded telehealth services for Medicaid enrollees by removing originating site and device requirements, and increasing the use of audio-only technology. For example, Mississippi implemented policies that allowed reimbursement for audio-only consultations and waived “any limitation on the use of audio-only telephonic consultations.”<sup>22</sup> Wisconsin also issued temporary guidance allowing providers to “remove services utilizing interactive synchronous (real-time) technology, including audio-only phone communication” for certain covered services.<sup>23</sup>

States should make these expanded definitions of telehealth permanent. They should also specify that reproductive and sexual health services are included when they can be delivered with functional equivalency to face-to-face services. For example, Wyoming explicitly lists family planning clinics as an authorized “originating site” for furnishing covered services via telehealth to eligible Medicaid enrollees.<sup>24</sup>

#### b. Telehealth delivery of family planning services

Family planning services are essential to an individual’s health and well-being, particularly for the sixteen million women who are enrolled in Medicaid and of reproductive age. Telehealth plays a vital role in broadening the ability for Medicaid enrollees to receive time-sensitive reproductive and sexual health care.

Before the pandemic, few states had adopted specific measures to ensure Medicaid coverage of family planning services and supplies delivered via telehealth.<sup>25</sup> Soon after the public health emergency, additional states released specific guidance on the use telehealth delivery of family planning services. For example, North Carolina issued temporary guidance that enables providers to deliver a broad range of family planning services via telehealth or virtual patient

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<sup>21</sup> See Ctr. for Connected Health Pol’y, *State Telehealth Laws & Reimbursement Policies* (Fall 2020), <https://www.cchpca.org/sites/default/files/2020-10/CCHP%2050%20STATE%20REPORT%20FALL%202020%20FINAL.pdf>.

<sup>22</sup> Mississippi Division of Medicaid, *Emergency Telehealth Policy* (Mar. 20, 2020), [https://medicaid.ms.gov/wp-content/uploads/2020/03/Emergency-Telehealth-Policy-3.20.20\\_V2.pdf](https://medicaid.ms.gov/wp-content/uploads/2020/03/Emergency-Telehealth-Policy-3.20.20_V2.pdf).

<sup>23</sup> Forward Health Update 2020-15, *Additional Services to be Provided Via Telehealth* (May 11, 2020), <https://www.forwardhealth.wi.gov/kw/pdf/2020-15.pdf>.

<sup>24</sup> Institutional Manual ICD10 (Rev. April 1, 2020), p. 109, [https://wymedicaid.portal.conduent.com/manuals/Manual\\_Institutional\\_04\\_01\\_20.pdf](https://wymedicaid.portal.conduent.com/manuals/Manual_Institutional_04_01_20.pdf).

<sup>25</sup> For example, California had issued guidance on Medicaid coverage of family planning services provided via telehealth shortly before the pandemic. See Cal. Dep’t Health Care Servs., *Revised Medi-Cal Telehealth Manual* (Jan. 2020), <https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf>.

communication (which North Carolina defines as telephone calls) to Medicaid enrollees.<sup>26</sup> Texas also authorized the use of telehealth for its family planning expansion program during the pandemic.<sup>27</sup> Washington issued a billing guide on family planning and telehealth during the public health emergency, specifying the codes for services that can be delivered via telehealth.<sup>28</sup> Ideally these flexibilities can remain after the pandemic ends.

It is important to note that states cannot impose any cost-sharing on family planning services, whether those services are delivered in-person or via telehealth.<sup>29</sup> In addition, most contraceptive methods can be prescribed without physical examinations or laboratory tests.<sup>30</sup> For example, injectable contraception can be prescribed for self-administration. Patients can receive instructions on how to perform self-injections via video-conferencing or over the phone.<sup>31</sup> The American College of Obstetricians and Gynecologists (ACOG) has also confirmed that telehealth can be used to screen new clients requesting contraceptives that can be self-administered.<sup>32</sup>

### c. Telehealth delivery of abortion services

The telehealth delivery of medication abortion evolved dramatically in the midst of the COVID-19 pandemic. One study found that COVID-19 changed abortion delivery among 87 percent of

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<sup>26</sup> NC Medicaid Division of Health Benefits, *Special Bulletin COVID-19 #86: Telehealth and Virtual Patient Communications Clinical Policy Modifications - Family Planning Services for MAFDN Beneficiaries* (May 11, 2020), <https://medicaid.ncdhhs.gov/blog/2020/05/11/special-bulletin-covid-19-86-telehealth-and-virtual-patientcommunications-clinical>.

<sup>27</sup> Texas Health & Human Servs., *COVID-19: Updates for Healthy Texas Women and Family Planning Program*, <https://www.healthytexaswomen.org/sites/htw/files/documents/htw-fpp-covidupdates.pdf>.

<sup>28</sup> Washington State Health Care Auth., *Family Planning Only (FPO) Program Billing Guide for telemedicine/telehealth services offered during the COVID-19 outbreak, Frequently Asked Questions*, <https://www.hca.wa.gov/assets/billers-and-providers/Family-Planning-Only-COVID-19.pdf>.

<sup>29</sup> 42 U.S.C. §§1396o(a)(2)(d), (b)(2)(d), 1396o-1(b)(3)(B)(vii).

<sup>30</sup> Physical examinations or laboratory tests are required for: (1) Intrauterine devices; (2) combined hormonal contraception (if the patient needs to have their blood pressure assessed); and (3) diaphragms and cervical caps. For more information about what types of contraceptive methods can be prescribed without a physical exam or lab test, see Fabiola Carrion et al., Nat'l Health Law Prog., *Medicaid Coverage of Family Planning Services Delivered via Telehealth* (Dec. 2020), <https://healthlaw.org/resource/medicaid-coverage-of-family-planning-services-delivered-via-telehealth/>.

<sup>31</sup> See, e.g., Nat'l Family Planning & Reprod. Health Assoc., *Self-Administration of Injectable Contraception* (Apr. 20, 2020), <https://www.nationalfamilyplanning.org/file/documents---service-delivery-tools/NFPRHA---Depo-SQ-Resource-guide---FINAL-FOR-DISTRIBUTION.pdf>.

<sup>32</sup> See Am. C. of Obstetricians & Gynecologists, *COVID-19 FAQs for Obstetrician–Gynecologists*, Gynecology, <https://www.acog.org/clinical-information/physician-faqs/covid19-faqs-for-ob-gyns-gynecology>.

independent abortion clinics including shifting follow-up appointments to video or phone calls, implementing or increasing telehealth consultations and screenings, and making medication abortion pills more easily accessible for the patient.<sup>33</sup> These measures were needed to guarantee safe access to abortion care while minimizing contact with health care personnel.

Even with these adaptations, accessing medication abortions during the pandemic was challenging.<sup>34</sup> For over 20 years, the FDA has imposed significant restrictions—known as Risk Evaluation and Mitigation Strategy (REMS) requirements—on dispensing and distributing mifepristone, one of the two medications needed to complete a medication abortion. One of the restrictions required individuals to pick up their medication in person even though it can be safely self-administered at home. In addition, Medicaid covers a limited number of abortions due to a long-standing annual appropriations bill rider known as the Hyde Amendment, which only requires coverage in the narrow circumstances of rape, incest, or life endangerment.<sup>35</sup>

Advocates challenged the in-person dispensing requirement during the pandemic, when stay-at-home orders were in place and some providers were forced to reduce their clinic hours. On July 13, 2020, a judge for the U.S. District Court for the District of Maryland granted a preliminary injunction against the FDA's enforcement of the in-person dispensing requirement, ruling that the REMS' requirement placed an "undue burden" on patients' constitutional rights to abortion care and severely jeopardized the health and economic stability of patients, their families, and clinic staff during the COVID-19 pandemic. The requirement was reinstated in a January 2021 decision by a majority opinion of the U.S. Supreme Court, which granted a request by the Trump Administration to reapply the FDA's in-person dispensing requirement. The requirement was lifted again after the Biden Administration re-examined the issue and conducted an in-depth literature review. In an April 12, 2021 letter to ACOG, the FDA lifted the in-person dispensing requirement until the end of the COVID-19 pandemic.<sup>36</sup>

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<sup>33</sup> Ushma D. Upadhyay et al., *Adoption of No-Test and Telehealth Medication Abortion Care Among Independent Abortion Providers in Response to COVID-19*, X CONTRACEPTION 2 (2020), <https://www.sciencedirect.com/science/article/pii/S2590151620300320>.

<sup>34</sup> To learn more the telehealth delivery of abortion services, see Fabiola Carrion et al., Nat'l Health Law Prog., *Medicaid Coverage of Medication Abortion Delivered via Telehealth* (March 2021), <https://healthlaw.org/resource/medicaid-coverage-of-medication-abortion-delivered-via-telehealth/>.

<sup>35</sup> U.S. Dep't of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Pub. L. No. 115-245, 132 Stat. 2981, 3118, §§ 506-07 (2018).

<sup>36</sup> FDA, April 12, 2021 Letter to Maureen G. Phipps et al., [https://www.aclu.org/sites/default/files/field\\_document/fda\\_acting\\_commissioner\\_letter\\_to\\_acog\\_april\\_12\\_2021.pdf](https://www.aclu.org/sites/default/files/field_document/fda_acting_commissioner_letter_to_acog_april_12_2021.pdf).

Rather than impeding access to time-sensitive abortion care, the FDA should continue its current policy beyond the PHE and permanently remove unnecessary restrictions such as the REMS in-person requirement to allow mifepristone to be sent by mail and expanding the medication abortion provision through telemedicine.

#### 4. Increased flexibilities for pharmacy access

Timely access to prescription drugs and devices became a challenge for many Medicaid enrollees while stay-at-home orders and social distancing guidelines were in place during the pandemic. Younger women in particular reported that they delayed or were not able to get birth control due to the COVID-19 pandemic.<sup>37</sup>

In an effort to minimize in-person contact during the pandemic, states waived prior authorization requirements and utilization controls in an effort to reduce barriers to accessing Medicaid-covered prescription drugs, including contraceptives. Many states, including Arizona and Connecticut relaxed quantity limits or allowed early refills for prescription drugs, allowing Medicaid enrollees to reduce the number of trips to the pharmacy to refill their contraceptives.<sup>38</sup> Oklahoma implemented pharmacy flexibilities to encourage the use of 90-day supplies for certain “maintenance medications,” and expanded the list of maintenance drugs to include HIV medications.<sup>39</sup> Colorado went even further and authorized 100-day supply for maintenance medications, which include some types of contraceptives.<sup>40</sup>

Most Medicaid-covered reproductive and sexual health services are available to enrollees without premiums or cost-sharing, however some are subject to out-of-pocket costs. For example, states can impose nominal cost sharing on certain prescription drugs if the drug is

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<sup>37</sup> Eight percent of women ages 18-25 and seven percent of women ages 26-35 said they delayed or were not able to get birth control, compared to three percent of women ages 36-49. Brittini Frederiksen, *supra* note 9.

<sup>38</sup> Arizona Health Care Cost Containment System, *AHCCCS Prior Authorization (PA) and Concurrent Review (CR) Standards during COVID-19 Emergency for Health Plans* (Updated May 1, 2020), <https://www.azahcccs.gov/AHCCCS/Downloads/COVID19/AHCCCSAandCRStandardsCOVID19.pdf>. See also Connecticut Dep’t of Social Services, *Provider Bulletin 2020-13* (Mar 2020), [https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=PB20\\_13.pdf&URI=Bulletins/PB20\\_13.pdf](https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=PB20_13.pdf&URI=Bulletins/PB20_13.pdf).

<sup>39</sup> Oklahoma Health Care Authority, *What is OHCA doing for SoonerCare members?*, <http://okhca.org/about.aspx?id=24603> (last visited May 10, 2021).

<sup>40</sup> Health First Colorado, *COVID-19 Guidance for Pharmacies* (June 4, 2020), <https://www.colorado.gov/pacific/sites/default/files/COVID%20Guidance%20for%20Pharmacies%20060420.pdf>.

not listed on the state's "preferred" drug listing. During the pandemic, some states such as Missouri waived all pharmacy copays.<sup>41</sup>

Some states such as Maine broadened access to prescriptions by encouraging the use of mailed, drive-through and home delivery of prescription drugs, supplies, and equipment without the signature of the beneficiary.<sup>42</sup>

States also waived limitations on who can prescribe certain covered Medicaid benefits. For example, California used its 1135 waiver approval to temporarily allow for pharmacy dispensing of self-administered Depo-Provera.<sup>43</sup>

State Medicaid programs generally have discretion to limit or expand access to covered drugs even during non-PHE periods. Therefore, states may adjust those limits without action from CMS, though in some cases, a state plan amendment may be needed.<sup>44</sup>

## 5. Specifying the inclusion of abortions and sterilizations as essential services

There is overwhelming agreement among medical and health organizations in the U.S. and globally that abortion continues to be essential during the COVID-19 crisis and therefore must remain available. ACOG, the Society for Maternal-Fetal Medicine, and other prominent medical organizations in the U.S. affirm that "to the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure."

Yet, some elected officials tried to exploit the COVID-19 pandemic to block access to essential abortion services. Officials in eleven states tried to effectively ban abortion in their state citing

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<sup>41</sup> Missouri Department of Social Services, *COVID-19: Pharmacy Copayment Exemption* (May 6, 2020), <https://dss.mo.gov/mhd/providers/pages/hot-tips-2020.htm#200506-2>.

<sup>42</sup> Maine Dep't of Health and Human Servs., *COVID-19 Guidance for Pharmacies and Prescribers* (Updated March 26, 2020), [https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/pdfs\\_doc/COVID-19/COVID-19-Guidance-Pharmacies-Prescribers-Updated-03262020.pdf](https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/pdfs_doc/COVID-19/COVID-19-Guidance-Pharmacies-Prescribers-Updated-03262020.pdf).

<sup>43</sup> Cal. Dep't Health Care Servs., *Information Regarding the Use of Subcutaneous Depot Medroxyprogesterone Acetate During the 2019 Novel Coronavirus Public Health Emergency* (Apr. 9, 2020), <https://www.dhcs.ca.gov/Documents/COVID-19/Medi-Cal-FFS-Depo-Provera-SQ-Temp-Policy.pdf>.

<sup>44</sup> For more information, see Wayne Turner and Abigail Coursolle, Nat'l Health Law Prog., *Ensuring People Have Access to Prescription Drugs During the COVID-19 Pandemic* (Mar. 18, 2020), <https://healthlaw.org/ensuring-people-have-access-to-prescription-drugs-during-the-covid-19-pandemic/>.

abortions as “elective” or “non-essential” health procedures.<sup>45</sup> Advocates filed lawsuits and successfully invalidated all of the orders, however the governors’ orders were found to have negative impacts on abortion access in some of these states.<sup>46</sup> Delays in abortion care can increase the risk of complications and may require additional provider visits compared to abortions provided earlier in pregnancy.

Individuals seeking postpartum sterilizations also experienced barriers during the COVID-19 pandemic. Unlike other forms of contraception, sterilization procedures require the use of an operating room and personal protective equipment (PPE). Given the need to conserve PPE and minimize infectious exposure, CMS recommended canceling or delaying “elective” procedures. However, the term “elective” was left up to interpretation by clinicians, hospitals, and elected officials.<sup>47</sup> While data on the prevalence of such restrictions and their long-term impact are not yet available, some provider experiences suggests that the state restrictions resulted in the de-prioritization of sterilizations.<sup>48</sup>

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<sup>45</sup> State actions that were successfully blocked by court order are Alabama, Ohio, Oklahoma, and Tennessee. State actions that are no longer in effect due to settlement outside of court, a new state executive order, or governor action are Alaska, Arkansas, Iowa, Kentucky, Louisiana, Mississippi, West Virginia, and Texas. Kaiser Family Foundation, *State Action to Limit Abortion Access During the COVID-19 Pandemic* (Aug. 10, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/state-action-to-limit-abortion-access-during-the-covid-19-pandemic/>.

<sup>46</sup> Abortions declined in Texas during the executive order. Stay-at-home orders, facilities’ coronavirus precautions, and patients’ reluctance to seek in-person care may also have contributed to the decline. Other Texas patients traveled out of state or requested medications online. Abortions at 12 weeks’ GA or more increased after the order expired, which likely reflects delays in care among those who waited for an appointment and facilities’ limited capacity to meet backlogged patient need. Although abortions later in pregnancy are very safe, they are associated with a higher risk of complications and may require additional visits compared with those provided earlier in pregnancy. See Kari White et al., *Changes in Abortion in Texas Following an Executive Ban During the Coronavirus Pandemic* (Jan. 2021), *JAMA* 2021, [https://jamanetwork.com/journals/jama/fullarticle/2774731?questAccessKey=29d1d7b2-d86e-4d60-b757-bd2a0d71ab37&utm\\_source=silverchair&utm\\_medium=email&utm\\_campaign=article\\_alert-jama&utm\\_content=olf&utm\\_term=010421](https://jamanetwork.com/journals/jama/fullarticle/2774731?questAccessKey=29d1d7b2-d86e-4d60-b757-bd2a0d71ab37&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=olf&utm_term=010421).

<sup>47</sup> Although the American College of Obstetricians and Gynecologists (ACOG) has issued policy strongly stating that postpartum sterilization is urgent and not elective, many institutions and state Medicaid offices specified sterilization as “elective” and denied coverage for sterilization procedures completed during the peak of the pandemic. See ACOG, *Access to postpartum sterilization Committee Opinion No. 530, OBSTET. GYNECOL.* 2012; 120:212-15.

<sup>48</sup> Megan L. Evans et al., *COVID-19 Highlights the Policy Barriers and Complexities of Postpartum Sterilization* (Jan 2021), *CONTRACEPTION*, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7557287/#b0010>.

To prevent future attempts to undermine access to abortions and sterilizations during a public health emergency, states should issue executive orders that affirmatively include abortion and sterilization services as essential health care, such as New Jersey and Virginia.<sup>49</sup>

## 6. Pregnancy services

Concerns about the increased risk of severe illness from COVID-19 for pregnant people prompted hospitals and clinics to quickly adopt policies aimed at protecting and reducing the risk of COVID-19 exposure for pregnant people and newborns. These concerns pushed Medicaid providers to make immediate changes to the delivery of pregnancy services early in the pandemic. One of the most common and frequently used changes was the adoption of telehealth practices to reduce the number of in-person visits and minimize the risk of COVID-19 infection. Telehealth can be leveraged in many ways to help provide and support the comprehensive provision of prenatal and postpartum care.<sup>50</sup> Pregnancy care provided to Medicaid enrollees through telehealth must achieve the same quality of care as if delivered in-person. Telehealth cannot result in a decrease in the overall services, treatment, or interventions available to the pregnant person.

### a. Telehealth delivery of prenatal care

Pregnancy care providers adopted telehealth practices early in the pandemic. Prenatal appointments that would have been conducted in-person were shifted to telehealth appointments, including videoconference and telephone appointments. Providers also combined some screenings and vaccinations into a single in-person visit instead of more frequent, periodic visits. Some states developed policies to clarify the use of telehealth services to deliver prenatal and other pregnancy services. In North Carolina, the state's Medicaid agency issued a bulletin allowing Medicaid providers to conduct prenatal and postpartum visits

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<sup>49</sup> New Jersey Joint Information Center Media Release, Governor Murphy Suspends All Elective Surgeries, Invasive Procedures to Preserve Essential Equipment and Hospital Capacity (Mar. 23, 2020), <https://t.e2ma.net/message/bezr1c/vds5dt> (making "explicit exemption for family planning and termination of pregnancies"). See also Commonwealth of Virginia, Order of the Governor and State Health Commissioner, <https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/Order-of-Public-Health-Emergency-Two--Order-of-The-Governor-and-State-Health-Commissioner.pdf> (declaring "this Order does not apply to the full suite of family planning services and procedures").

<sup>50</sup> For more information about the benefits and challenges of telehealth delivery of pregnancy care, see Amy Chen, Nat'l Health Law Prog., *Medicaid Coverage of Pregnancy Care Delivered Via Telehealth* (Jan. 2021), <https://healthlaw.org/resource/medicaid-coverage-of-pregnancy-care-delivered-via-telehealth>.

via telemedicine.<sup>51</sup> In Louisiana, the Department of Insurance waived the requirement that the patient and provider need have a prior relationship in order to utilize telehealth as a modality for delivery pregnancy care.<sup>52</sup>

b. Labor and delivery

The effort to reduce overall risk and exposure to COVID-19 allowed providers to adopt more flexibilities to deliver prenatal care remotely, however it also prompted providers to impose in-person restrictions on a pregnant person during labor and delivery. Many hospitals limited the number of people that could accompany a birthing person to only one support person during labor and delivery. This meant that pregnant people often had to choose between a partner or another critical birth support person such as a doula to accompany them, with most individuals choosing a partner to attend the labor and delivery. Thus, doulas had no other option than to support laboring pregnant people virtually, through video calls or even phone calls. These hospital limitations made it difficult for doulas to provide the type of support birth doulas are trained for. Recognizing the important role doulas play in reducing maternal health disparities, some states including California and Colorado issued explicit guidance allowing doulas to accompany a birthing patient during labor and delivery, in addition to another support person.<sup>53</sup> New Jersey's Department of Health issued an executive order also permitting a support person and a doula to attend the labor and delivery, and requires COVID-19 testing of all three individuals.<sup>54</sup>

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<sup>51</sup> North Carolina Medicaid Division of Health Benefits, *Special Bulletin COVID-19 #49: Telehealth Clinical Policy Modifications – Interim Perinatal Care Guidance* (Apr. 17, 2020)

<https://medicaid.ncdhhs.gov/blog/2020/04/17/special-bulletin-covid-19-49-telehealth-clinical-policy-modificationsinterin/>.

<sup>52</sup> Louisiana Department of Insurance, Declaration of Emergency Rule 37 Sec. 3309(B.)

<https://ldi.la.gov/docs/default-source/documents/legaldocs/rules/Rule37-cur-TelemedicineAndNet/>.

<sup>53</sup> California Dept. of Public Health, All Facilities Letter Visitors Guidance (AFL 20-38.6),

<https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-38.aspx> (stating “the presence of a partner or support person is essential to the mental health of patients who are in labor and delivery. CDPH recommends that up to two support persons be allowed to be present with the patient. In addition to the support person(s), CDPH recommends that a doula, if desired by the patient, be permitted to be present if prior arrangements have been made with the hospital and the doula complies with hospital PPE and infection control guidelines.”). *See also* Colorado Dept. of Public Health & Environment, *COVID-19 Perinatal and Breastfeeding Guidance* (Updated Jan. 2021), <https://drive.google.com/file/d/1CGIV1EPvsCM7RLD-HaGR8oepZCASBvzk/view>.

<sup>54</sup> New Jersey Dept. of Health, Executive Directive No. 20-020 (Oct. 2020), [https://nj.gov/health/legal/covid19/6-29-20\\_ExecutiveDirectiveNo20-020\\_LaborDelivery.pdf](https://nj.gov/health/legal/covid19/6-29-20_ExecutiveDirectiveNo20-020_LaborDelivery.pdf).

c. Postpartum care and lactation counseling via telehealth

The pandemic also prompted some states to craft specific policies to expand access to postpartum care. For example, Alabama issued a policy allowing Medicaid providers to reimburse for telephonic postpartum visits.<sup>55</sup> Colorado issued guidance regarding antepartum care, breastfeeding, and discharge.<sup>56</sup> Nebraska's state Medicaid agency also issued guidance clarifying that "Medicaid funded prenatal care and lactation counseling can be provided through telehealth."<sup>57</sup>

States should seek to make permanent many of these telehealth and telephonic flexibilities. The addition of telehealth modalities can help pregnant and postpartum individuals living in rural areas or those who otherwise do not have reliable internet access or transportation to communicate more regularly with their provider and receive care and support throughout their pregnancy and postpartum period.

## 7. Sterilization

Neither CMS nor individual state Medicaid agencies instituted any changes to the mandatory sterilization consent form process during the pandemic. While CMS encouraged states to implement telehealth flexibilities to reduce exposure and comply with state shelter-in-place orders, there were no federal changes made to temporarily allow for oral consent or electronic signatures on the sterilization consent form to begin the 30-day waiting period in lieu of a hand-written signature. Very few states issued any guidance related to sterilization procedures. Washington state issued guidance authorizing the use of electronic signatures as an acceptable alternative to an in-person signature on the sterilization consent form for the enrollee and interpreter.<sup>58</sup>

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<sup>55</sup> Alabama Medicaid Agency Alert, *Temporary Changes to allow Reimbursement for Telephonic Postpartum Visits* (Mar. 27, 2020), [https://medicaid.alabama.gov/documents/1.0\\_ALERTS/1.0\\_2020/1.0\\_ALERT\\_Temporary\\_Changes\\_Allowing\\_Telephonic\\_Postpartum\\_Visit\\_Reimbursement\\_3-27-20.pdf](https://medicaid.alabama.gov/documents/1.0_ALERTS/1.0_2020/1.0_ALERT_Temporary_Changes_Allowing_Telephonic_Postpartum_Visit_Reimbursement_3-27-20.pdf).

<sup>56</sup> Colorado Dept. of Public Health & Environment, *COVID-19 Perinatal and Breastfeeding Guidance* (Updated Jan. 2021), <https://drive.google.com/file/d/1CGIV1EPvsCM7RLD-HaGR8oepZCASBvzk/view>.

<sup>57</sup> Nebraska Dept. of Health and Human Services, *General Statewide Telehealth – COVID-19 Frequently Asked Questions* (Updated April 2020), <https://dhhs.ne.gov/Documents/COVID-19%20General%20Statewide%20Telehealth%20FAQ.pdf>.

<sup>58</sup> Washington State Health Care Authority, *Sterilization consent forms signatures during the COVID-19 pandemic*, <https://www.hca.wa.gov/assets/program/sterilization-consent-COVID19.pdf>,

The continuous coverage requirement in the Families First Coronavirus Response Act prohibits states from ending a person's Medicaid coverage during the public health emergency and extends the timeframe a patient has insurance coverage for sterilization. However, providers were uncertain whether the 180-day expiration date of the sterilization consent form could be extended due to state orders to delay "elective procedures," or if patients would be required to complete another sterilization consent form.<sup>59</sup>

Some states requested CMS approval to extend the informed consent period beyond 180 days.<sup>60</sup> These requests were not approved. North Carolina's Medicaid agency published a clinical policy in response to their inquiry with CMS that the 180-day signature requirement on the federal sterilization consent form could not be waived.<sup>61</sup> The notice also clarified that the requirement for an enrollee's signature at least 30 days prior to a sterilization procedure is also still in effect.<sup>62</sup>

## 8. Sexual health

The U.S. was already experiencing high rates of sexually transmitted infection (STI) rates before the COVID-19 pandemic. STI rates in 2019 showed record numbers of chlamydia and gonorrhea, however the public health emergency made STI rates in 2020 difficult to track.<sup>63</sup> Many sexual health screening clinics reported having to reduce hours or temporarily close their office during the pandemic.<sup>64</sup> In some areas, STI test kits and laboratory supplies ran low because manufacturers were redirecting their products for use in coronavirus tests.

The CDC issued alerts beginning in April 2020 to provide guidance for the clinical management of STIs at locations that limited in-person services.<sup>65</sup> The CDC issued additional Dear Colleague

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<sup>59</sup> Megan L. Evans et al., *supra* note 48.

<sup>60</sup> See e.g., California Dept. of Health Care Services, *Request for Additional Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency* (March 19, 2020), <https://www.dhcs.ca.gov/Documents/COVID-19/CA-1135-Waiver-Request-2-031920.pdf>.

<sup>61</sup> NC Medicaid Division of Health Benefits, *Clinical Policy 1E-3, Sterilization Procedures- Sterilization Consent Form* (Dec. 15, 2020), <https://medicaid.ncdhhs.gov/blog/2020/12/15/clinical-policy-1e-3-sterilization-procedures-sterilization-consent-form>.

<sup>62</sup> *Id.*

<sup>63</sup> Jan Hoffman, *The New York Times*, *People are Still Having Sex. So Why Are S.T.D. Rates Dropping?* (Oct. 28, 2020), <https://www.nytimes.com/2020/10/28/health/covid-std-testing.html>.

<sup>64</sup> National Coalition of STD Directors, *Sexual Health Clinics and Our Nation's COVID-19 Response* (Oct. 2020), <https://www.ncsddc.org/wp-content/uploads/2020/10/Clinic-Call-Report-10.23.2020-final.pdf>.

<sup>65</sup> CDC, *Dear Colleagues Letter* (April 6, 2020), <https://www.cdc.gov/std/dstdp/DCL-STDTreatment-COVID19-04062020.pdf>.

letters offering guidance on how states and clinics could approach the shortage of STI test kits.<sup>66</sup> In response, states leveraged some of the temporary health care delivery flexibilities to try to mitigate the need for STI screening and treatment services. Many sexual health clinics established or expanded at home self-collection testing as an alternative to in-person testing.<sup>67</sup> These testing kits were sent by mail or available for curbside pick-up. Sexual health clinics also pivoted to adopt telehealth practices such as conducting screening calls before scheduling an in-person diagnostic visit. In addition, the shortage of some STI treatment medications and testing supplies prompted the CDC to recommend that sexual health clinics partner with pharmacists to provide patients with needed injectable treatments.<sup>68</sup>

### **9. Accessibility of Information and Resources on Reproductive and Sexual Health Services during the COVID-19 pandemic**

NHeLP's 50-state review revealed large variations in the accessibility of information on states' department of health and/or Medicaid websites. Some states posted COVID-related policy changes across multiple webpages and publication types, and it was not uncommon to discover a link to a previous publication was no longer available.

State Medicaid policy is already complex; the frequency of federal and state COVID-19 updates to existing Medicaid rules made it even more difficult to understand the landscape of reproductive and sexual health-related changes. We urge state Medicaid agencies to invest time and resources into better managing and organizing their webpages to make information more accessible to providers and enrollees. Centralizing online information and content became particularly important during the pandemic, when stay-at-home orders were put in place, and millions of Medicaid enrollees relied on telehealth modalities to communicate with their providers and receive care. For example, the Washington State Department of Health's Sexual & Reproductive Health Program created a COVID-19 Toolkit on Telehealth and Telemedicine that included a compilation of links to state telehealth guidance documents that covered family planning, sterilizations and other reproductive and sexual health services.<sup>69</sup>

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<sup>66</sup> CDC, Dear Colleagues Letter (Sept. 3, 2020), <https://www.ncsddc.org/wp-content/uploads/2020/09/Diagnostic-Test-Shortage.pdf?source=email>.

<sup>67</sup> National Coalition of STD Directors, *Sexual Health Clinics and Our Nation's COVID-19 Response* (Oct. 2020), <https://www.ncsddc.org/wp-content/uploads/2020/10/Clinic-Call-Report-10.23.2020-final.pdf>.

<sup>68</sup> CDC, *STD Treatment Options During COVID-19 Webinar* powerpoint presentation (May 2020), <https://www.cdc.gov/std/prevention/std-clinic-guidance-during-covid-19-webinar-5-12-2020.pdf>.

<sup>69</sup> Sexual and Reproductive Health Program, Washington State Dep't of Health, *COVID-19 Toolkit: Telehealth and Telemedicine* (Sept 2020), <https://www.doh.wa.gov/Portals/1/Documents/Pubs/930-153-Covid-19ToolkitTelehealthandTelemedicine.pdf>.

**Conclusion**

There will be an increased need for Medicaid coverage in all states, particularly if the economic recession created by the pandemic continues beyond the public health emergency. States can make many of their temporary improvements permanent through Medicaid state plan amendments or other existing mechanisms to ensure individuals can easily qualify for, enroll in, and obtain Medicaid coverage and Medicaid-funded reproductive and sexual health care services. Without adequate and accessible reproductive and sexual health care services, the inequities that the pandemic exposed so clearly will continue to harm the health and wellbeing of marginalized communities in the U.S., including low-income people, rural populations, people of color, LGBTQ people, people with disabilities, and immigrants.