Frequently Asked Questions about Integrating Medication Abortion Care into Federally Qualified Health Centers, Community Health Centers, and Title X Sites

1. Our health center gets 330 and/or Title X funds. Can we provide abortions?

Yes. It is a common misconception that FQHCs cannot provide abortions. The restrictions that health centers face regarding abortion are on their federal funds, not on the institution as a whole.

Federally Qualified Health Centers (FQHCs) and other health centers that receive federal funding can and do provide services outside the scope of their 330 grant, including abortion, as long as the services are not directly or indirectly supported by federal funds. Your clinic may have revenue streams, such as grants, state funding, or revenue from other out-of-scope services (also known as "other lines of business"), that do not restrict the type of services you can provide to your patients. Several federal statutes and rules dictate this conclusion and provide guidance as to how FQHCs may offer abortion services consistent with their federal 330 grant (read more about this on page 6 of the National Association of Community Health Center's Federal Law Requirements for Women's Reproductive Health Services at Health centers) and HRSA Compliance Manual. You will need to fiscally separate out all direct and indirect costs, such as supplies and staff time, used to provide abortions services. There are several resources that can assist your Finance department to facilitate this. Check out the Practical Guide on How to Provide Abortion Care at FQHCs and Title X Health Centers, Administrative Billing Guide and the Guidelines for General Ledger Recordkeeping for FQHCs.

Title X recipients must ensure that their abortion activities are separate and distinct from Title X activities and supported with non-Title X funding. To date, this does not require a separate facility or separate staff. For example, a common waiting room and common staff are permissible if costs and salaries are properly allocated. All abortion-related activities must be performed in a program that is separate from the Title X project.

2. I've been told that our malpractice won't cover abortions. How do I find out if that is true?

Your business office should be able to give you a copy of your clinic's malpractice policy. If your health center is an FQHC and obtains its liability insurance through the federal government's Federal Tort Claims Act (FTCA) program, your malpractice policy will only cover the services that your FQHC is federally funded to provide. Abortion is explicitly excluded. However, "add-on" or "wrap-around" policies are available. Some health centers have already purchased a wrap-around policy for other areas of care that

the Federal insurance does not cover (hospital medicine, obstetric deliveries). Contact us at program@reproductiveaccess.org for more information. You can review the TEACH Workbook table on other malpractice options through their online workbook.

3. Our health center gets 330 and/or Title X funds. Can we provide early pregnancy loss (EPL) care?

Yes. As EPL care does not involve a viable pregnancy, FQHCs are allowed to provide expectant, medical, and procedural management of EPL and are permitted to do so within their health center scope of project. This means that these services can be supported by the section 330 grant, are eligible for Medicaid Prospective Payment System, sliding fee scale, Medicare FQHC reimbursement, and Federal Tort Claims Act coverage (if FTCA deeming requirements are met). The State Medicaid Manual (Chapter 4, Section 4432, page 4-428), published by Centers for Medicare and Medicaid Services (CMS), states that "noninduced, naturally occurring abortions are not subject to the abortion restriction. Therefore, FFP (Federal Financial Participation) is available for the costs associated with treating spontaneous and missed abortions." See this National Association of Community Health Center's webinar for further explanation.

We recommend documenting your EPL care protocol in a policy that clearly states the clinical circumstances for which you will be providing this care. You should also clearly document in a patient's chart with appropriate ICD-10 codes that the care is for a spontaneous abortion and not an induced abortion. Here is a sample protocol.

Title X funding is used for family planning services, which do not include EPL care. You may provide this care as a recipient of Title X funding, but it cannot be supported or paid for with Title X funding.

4. Our administrators are worried about increased security risks if we provide abortions. What can I tell them?

Health centers already deal with issues of patient and staff security on a regular basis. For example, you see patients with mental health concerns, substance use disorders, and issues of domestic violence. All health centers should have good security protocols in place for the protection of patients and staff. Some states have laws in place that protect health care facilities, clinicians, and/or patients from anti-abortion violence. RHAP may be able to refer you for a security consultation or resources to ensure that the protocols in place are appropriate.

5. Why should our health center provide abortion services when we can refer our patients to Planned Parenthood or another clinic?

Your patients count on you for quality primary health care services. There are many reasons why early abortion services are important for the health of your patients:

- You are a known and trusted health care system/health care provider. This familiarity means your patients trust you with their health care and may feel more comfortable than going to an unknown, unfamiliar place.
- Providing abortion care at your health center enhances continuity of care. Every time a referral is made to another system, some of your patients may fall through the cracks. Continuity means better care for your patients and ensures they receive care in the full context of their medical and social needs.
- At many high-volume abortion clinics, patients may deal with protesters or harassment.
- Some patients have complex feelings about having an abortion. Being able to talk it through with their own clinician, without judgment and with support and understanding, can make all the difference.
- Referral to an independent abortion clinic could require additional appointments, time off work, coordination, and travel for your patient, delaying needed care. Delays in abortion care can lead to greater costs for the patient, slightly higher risks of complications, and greater stress on the patient. These delays will be compounded as many patients in states that ban abortion care will likely travel to states where abortion care is legal. Creating more access points in primary care can alleviate this stress on independent abortion clinics.
- By providing abortion care as an integrated part of primary health care, you are increasing access to this care. You are providing dignity and enhancing bodily autonomy for all people, especially for those with the greatest barriers and costs to accessing abortion care. Abortion in primary care decreases the marginalization and stigmatization of patients who need this service and the clinicians who provide it.

6. Our administration is somewhat supportive of adding abortion care, but they say that the Board will never allow it. What can we do?

Not all health centers allow their Board to determine their scope of services. Many health centers believe these decisions are medical and are best left in the hands of the medical director of the health center. Make sure that, if you hear that the provision of abortion services is to be debated by the Board, that it is a usual and customary practice for the Board to be determining the scope of the medical care. Did they go to the Board when colposcopy services were added? Or is this just an anti-choice or ambivalent administrator putting up roadblocks?

However, if the decision to provide abortion care does go to your Board, it is important that clinicians' and patients' voices be heard. RHAP can help you make a very compelling presentation to your Board about why your patients need this service. This kind of presentation should also incorporate values clarification (see this resource from

RHAP). Values clarification can help address anxiety around change, identify and dispel myths, and separate personal beliefs from professional responsibilities in medicine.

It is important to research your Board and find out who the members are. You can work with your health center's CEO, or other leaders, to do a power map to help you understand who is on the Board and who can be your allies. FQHC guidelines require that the Board be made up of community representatives, including patients. It will take some legwork, but you should find someone who knows a Board member who can become an ally and help you make a presentation to the Board about why abortion care is so critical to your community.

If there is significant resistance from those in positions of power that determine your health center's scope of services, consider starting to integrate other new reproductive health services – like full-scope contraception or EPL care. Consider starting with medication abortion before aspiration abortion. These steps may help get Leadership on board and set the stage logistically for offering comprehensive early abortion care later on.

7. Can our nurse practitioner provide medication abortion? How about our midwives and physician assistants?

In many states, advanced practice clinicians (APCs: physician assistants, nurse midwives, and nurse practitioners) can provide abortion. Visit the Guttmacher Institute for updated information on abortion legislation, including Physician-only laws. Contact RHAP at program@reproductiveaccess.org for information about the status of APC scope of practice in your state. Learn more at the abortion provider toolkit website.

8. Some staff may be uncomfortable with abortion. How can I raise the issue of providing abortions at our health center to get a better sense of how staff feel?

Clinicians who want to add abortion care services to their health center's practice often wonder how to discuss this subject with staff and colleagues whose views on abortion are unknown. There is no one best way to do this, it depends on the culture of your health center, your relationship with your colleagues, and the types of opportunities available for you to have these discussions. There are many ways to approach this:

- Bring up the subject in the context of a case discussion. The ideal case involves a patient well known to the staff who clearly needs an abortion – so much so that anyone but the most dogmatic "anti" would understand their need – but faces difficulty in getting the procedure done elsewhere. "If only they had been able to obtain this service from their own clinician, in the privacy and trust of their clinician's office." Once the conversation has started, involving the entire staff in values clarification exercises is often extremely helpful. You can find samples on the RHAP website:

    - Staff Attitude Survey
    - Values Clarification Workshop

- Discuss abortion care delivery in the context of reproductive autonomy and justice, family planning, the concept of helping all people to have children when and how they feel is best for them, and your health center's commitment to primary care. Ask staff members: what do our patients do when faced with an unwanted pregnancy? How do we counsel them, and where do we refer them? How might this process change if we offered abortion care here?
- Educate staff to the reality of the abortion provider shortage, heavily restrictive state laws, and the potential impact of primary care abortion provision for patients.

- Discuss the lack of access to legal abortion care in states where abortion is banned. This lack of access may lead to increased stress on your local abortion clinics with many patients traveling out of state for care. Your practice can help alleviate some of that excess demand by caring for your own patients within your health center.

Some tips for navigating these conversations:

- Acknowledge that people on both sides of this issue have strong feelings.
- Give staff members an opportunity to ask questions. Sometimes abortion stigma is exacerbated by misinformation. Clinical and non-clinical staff may benefit from learning the basics about what abortion is and how it works.
- Allow staff members to talk about how they feel and demonstrate respect for powerful feelings, even if they are hard to understand. Our experience shows that even those who may not support abortion are more likely to be involved if their feelings, beliefs, and concerns are acknowledged and respected early on.
- Use gender-inclusive language. Non-binary and transgender people also seek abortion care.
- And, very important: Help staff to stay focused on the needs of patients!

9. Our administration doesn't want our health center to be known as an "abortion provider." If we introduce abortion care, how can I let my patients know about the availability of services without advertising?

When you take a sexual history of a new patient, or when you are doing an annual exam, you no doubt ask about contraceptive practices and sexual and reproductive health needs. It is quite natural to say something along the lines of, "As you know, contraception fails sometimes. If you ever have an unplanned pregnancy, you can make an appointment with me so that we can discuss *all* of your options. We can provide you with whatever care you may need."

While office visits are short, patients often sit in the exam room for 10 or 15 minutes waiting for the clinician. Consider putting up pro-choice posters along with all the other informational posters or patient-friendly artwork on the walls of your exam room. You can also place bumper stickers and buttons on your bulletin boards with slogans such as "Ask me about abortion" or "Abortion is essential health care." You can also keep RHAP's abortion themed zines in your exam room for patients to read while they wait for you.

10. What can I tell our billing department about coding for medication abortion?

Accurate coding for medication abortion can vary from payor to payor. They should check with individual payors to determine the appropriate CPT codes to use to ensure reimbursement. The Mifeprex® website has helpful state specific information on private insurance and Medicaid coverage and reimbursement that can be accessed here: Mifeprex State Payer Policies. You can review our billing guides on medication abortion and procedural abortion for more information on these codes. You'll also need to review mifepristone ordering information. If you'd like more guidance, contact RHAP, and we can put you in touch with billing experts.

11. Where can our staff get trained to provide medication abortion?

Though special certification is not required to prescribe mifepristone and misoprostol, clinical training is necessary, just as it would be for any clinical care you provide. RHAP can help organize a virtual or in-person CE Medication Abortion Training for your staff on the clinical elements of providing medication abortion care. TEACH also offers a self-paced, virtual medication abortion training for CME credit. NAF members have access to online CE courses on abortion care. You can also watch video lectures through Innovating Education. Contact RHAP at program@reproductiveaccess.org for other options.

12. We don't have an ultrasound machine. Does this mean we can't provide abortion services?

While many clinicians are trained to use an ultrasound machine, it is not essential to providing high quality abortion care. In fact, RHAP and other major organizations like NAF, and Society of Family Planning endorse an "ultrasound only as needed" protocol. You can review RHAP's protocol on our website. The majority of patients will not need an ultrasound, but you should have access to a nearby ultrasound service for those times when the need does arise. It is important to make sure that the sonographers are sensitive and respectful to your patients and do not make assumptions that the patient is happy to be pregnant. Consult RHAP's website to review additional protocols and join the Reproductive Health Access Network to be part of a community of like-minded clinicians who can help support and mentor you on providing the latest evidence-based, person-centered care.

13. How expensive is it to provide an abortion? Will our patients be able to afford it?

Costs to the health center are minimal. The mifepristone pill costs around $50-$90 per pill. Beyond that, the other medications that are needed for medication abortion – misoprostol, pain medicine (ibuprofen or acetaminophen), and anti-nausea medicine (like promethazine – are very inexpensive. For an MVA, there are no direct costs once the MVA supplies are purchased. For more information about how to bill out the office visits while keeping abortion expenses and revenues appropriately separated from federally-funded services, see our Billing Guide and Guidelines for General Ledger Record Keeping.

If you work at an FQHC, your site probably has a sliding fee scale for uninsured patients. This sliding scale is partially supported with federal funding so it cannot be used for abortion care, unless your health center has identified a separate funding stream to underwrite abortion care.

As part of your planning process, it is important to review your health center's payor mix. Commercial insurance usually covers abortion care. In some states, Medicaid also covers abortion care (though work in some states may need to be done to ensure FQHCs have an appropriate mechanism to bill abortion Medicaid visits). Contact RHAP at program@reproductiveaccess.org for more information. Abortion funds also provide financial support to uninsured and underinsured people seeking abortion care.

14. I've been told that I am not even allowed to counsel patients on abortion or refer for abortion because of our FQHC status. Is this true?

No. As an FQHC, you are allowed to counsel patients on all pregnancy options, including abortion, and refer for abortion if that is what a patient elects. There is nothing in the Section 330 statute, implementing regulations, or any HRSA policy that prohibits or otherwise restricts referrals of patients for abortions that do not fit within the Hyde amendment. This DOJ memo references referrals on page 2, "Reading the Hyde Amendment to reach any expenditure that could be said to cause an abortion would have the potential to sweep in activities that have never been understood to violate the Amendment or analogous restrictions, such as non-directive counseling and referrals, see 42 C.F.R. § 59.5(a)(ii); 86 Fed. Reg. 56,144, 56,150 2 (Oct. 7, 2021)."

During the Trump administration, there were restrictions on referrals and options counseling for recipients of Title X funding, but those have since been reversed. Here is HHS's official announcement of the reversal of 2019 Trump-era restrictions on Title X sites. Current Title X regulations state that Title X providers must "offer pregnant clients the opportunity to be provided information and counseling regarding each of the following options: prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination. If requested to provide such information and counseling,

provide neutral, factual information and nondirective counseling on each of the options, and, referral upon request, except with respect to any option(s) about which the pregnant client indicates they do not wish to receive such information and counseling."