



Pennsylvania Department of Human Services

GUIDANCE ON PAYMENT FOR NEWLY COVERED ABORTION SERVICES DURING THE INTERIM PERIOD

September 25, 2026

This guidance from the Department of Human Services (“Department”) is addressing the payment for medically necessary abortion services by the Medical Assistance (“MA”) program and the Children’s Health Insurance Program (“CHIP”) that are not abortion services already covered pursuant to 18 Pa. C.S. § 3215(c).¹ For purposes of this guidance document, the abortion services being addressed will be referred to as “newly covered abortion services.”

Compensability

For individuals enrolled in the Department’s **Fee-for-Service (“FFS”) program**: The newly covered abortion services will be considered a compensable service² by the Department on the date that the Department’s systems to process the newly covered abortion service claims are operational.

For individuals enrolled in the Department’s **managed care programs (Physical Health HealthChoices, Community HealthChoices, and the Children’s Health Insurance Program (CHIP))**: The newly covered abortion services will be considered a compensable service³ by the Department on the date that the Managed Care Organizations’ (“MCOs”) systems to process the newly covered abortion service claims are operational.

From the date that the Department considers the newly covered abortion services to be compensable and going forward, MA- and CHIP-enrolled providers (“providers”) are prohibited from charging MA- and CHIP-enrolled recipients (“recipients”) for the newly covered abortion services or accepting supplementary payments from third parties.

¹ See *Allegheny Reprod. Health Ctr. v. PA DHS*, 358 A.3d 800, 826 (Pa. Cmwlth. 2026).

² For purposes of 55 Pa. Code §§ 1101.63 and 1101.63a.

³ *Id.*

Obligation to Reimburse Recipients During the Interim Period

The **interim period** is the time between September 28, 2026,⁴ and the date that the newly covered abortion services are considered compensable.

For **newly covered abortion services provided during the interim period**: Providers can continue to receive payment for the services from recipients and/or third parties but must retroactively reimburse recipients once the newly covered abortion services are considered compensable. This requirement is in recognition of the constitutional rights of recipients to have MA and CHIP provide coverage for the newly covered abortion services during this interim period.

The Department (for FFS claims), MCOs (for managed care claims), and providers will adhere to the following process for advising recipients of the potential for reimbursement, for submitting claims for the newly covered abortion services, and for reconciling payments received for the newly covered abortion services:

- **During the interim period**: Prior to the provision of the newly covered abortion service to recipients who are paying for the service, providers must: (1) advise recipients of the potential for future reimbursement of the payment for the service and (2) ask for contact information to effectuate reimbursement.
- **Date systems become operational**: The Department will advise providers, via an MA Bulletin, of the date that the Department's and the MCOs' respective systems are able to process the claims, as well as instructions for billing for the newly covered abortion services. Providers cannot accept payment from a recipient (or a third party on behalf of the recipient) as of this date and going forward. Instead, they must submit claims to the Department or to the MCO in accordance with regular practices.
- **Obligations for retroactive billing**: The Department and the MCOs will notify providers of a window of time to submit all claims for the newly covered abortion services provided to recipients during the interim period. For purposes of this guidance document, this process will be referred to as "retro-bill."
 - For newly covered abortion services provided to a recipient but **paid for in whole by third parties**: providers cannot retro-bill.

⁴ On Friday, September 25, 2026, the Pennsylvania Supreme Court declined to reinstate the automatic supersedeas. Order, *Allegheny Reprod. Health Ctr. v. Pa. DHS*, No. 34 MAP 2026 (Pa. Sept. 25, 2026).

- For newly covered abortion services provided to a recipient and **paid for in whole by the recipient**: the provider must retro-bill.
- For newly covered abortion services provided to a recipient and **paid for in part by the recipient and in part by third parties**: the provider must retro-bill and must reduce the billed amount by the amount paid by the third parties.
- **Payment for newly covered abortion services provided during the interim period**: The Department and the MCOs will pay the providers within 45 days of receiving a clean claim.
- **Obligation to reimburse recipients**: Within 30 days of receiving payment from the Department or the MCOs for a newly covered abortion service provided during the interim period, providers must reimburse the recipient who paid for the service.
 - Should providers be unable to reimburse a recipient after making good faith efforts to do so (“good faith effort” is described [below](#)), providers must, within 90 days of receiving payments from the Department or the MCOs, submit a new claim to the Department or the MCO that (1) voids the original claim and (2) bills the service amount minus the amount paid by the recipient. The Department or the MCO will then deduct the overpayment from future payments (i.e., make a claims adjustment).
- **Obligation to return any net total payment in excess of the MA or CHIP payment**. Under no circumstances can a provider that retro-bills MA or CHIP for a newly covered abortion service retain a total net payment (from MA or CHIP, the recipient, and a third party) that exceeds the MA or CHIP payment for that service. Any provider who receives total payment in excess of the MA or CHIP payment must, within 90 days of receiving payments from the Department or the MCOs, submit a new claim to the Department or the MCO that (1) voids the original claim and (2) bills an amount reduced such that the provider’s total net payment is equal to the MA or CHIP payment for the service. The Department or the MCO will then deduct the overpayment from future payments (i.e., make a claims adjustment).

This process is summarized by the chart on the following page.

Payment	Provider obligations	
Third parties paid in whole for the newly covered abortion service during the interim period	Provider cannot retro-bill MA/CHIP	
Recipient paid in whole for the newly covered abortion service provided to the recipient during the interim period	Provider <u>must</u> retro-bill MA/CHIP for the service, then →	Provider can reimburse recipient Within 30 days of receiving MA/CHIP payment, provider must reimburse the recipient the full amount paid by the recipient.
		Provider cannot reimburse the recipient after good faith efforts Within 90 days of receiving MA/CHIP payment, provider must submit a new claim to the Department or the MCO voiding the original claim and billing the service amount minus the amount paid by the recipient. The Department or the MCO will then deduct the overpayment from future payments (i.e., make a claims adjustment).
Recipient and third parties each paid in part for the newly covered abortion service provided to the recipient during the interim period	Provider <u>must</u> retro-bill MA/CHIP for the service minus the amount paid by third parties, then →	Provider can reimburse recipient Within 30 days of receiving MA/CHIP payment, provider must reimburse the recipient the full amount paid by the recipient.
		Provider cannot reimburse the recipient after good faith efforts Within 90 days of receiving MA/CHIP payment, provider must submit a new claim to the Department or the MCO voiding the original claim and billing the service amount minus the amount paid by the recipient. The Department or the MCO will then deduct the overpayment from future payments (i.e., make a claims adjustment).

Good Faith Efforts

“Good faith efforts” by providers means completing one of these options. Providers must maintain documentation of each attempt to contact the recipient, including the date, method of contact, and outcome of the attempt.

Option 1: Prior to the provision of the newly covered abortion service to a recipient who is paying for the service, the provider must give the recipient a form on which the recipient can provide their preferred contact method(s). The form must offer the recipient space to provide a phone number, email address, and mailing address, and offer the recipient the options of a phone call, a text message, an email, a letter, or another method as identified by the recipient.

The provider must attempt to comply with all of the recipient’s preferred method(s) at least three (3) times on three (3) different days. If the preferred method is a phone call, text message, email, or letter, the provider must follow the respective instructions under Option 2.

Option 2: The provider must:

- **Telephone** the recipient using the last known phone number in the possession of the provider at least three (3) times on three (3) different days. To the extent that there is an ability to leave a voice message, the provider must leave a voice message advising of the potential for reimbursement and with instructions on how to return the phone call and provide at least seven (7) days to return the call from the last left voice message; and
- **Text** the recipient using the last known phone number in the possession of the provider at least three (3) times on three (3) different days. The text must advise of the potential for reimbursement and with instructions on how to contact the provider for further information, and provide at least seven (7) days for the recipient to make contact from the date of the last left text; and
- **Email** the recipient using the last known email address in the possession of the provider, if available. The email must provide clear instructions on actions the recipient should take to seek reimbursement, and provide at least seven (7) days from the date of email for the recipient to respond; and
- **Mail** a letter via U.S. Mail to the last known address of recipient in the possession of the provider with clear instructions on actions the recipient should take to seek reimbursement, and provide at least twenty-one (21) days from the date of mailing for the recipient to respond.

Frequently Asked Questions

1. Who can providers contact with questions about this guidance?

Laina Auletta, Director of the Bureau of Fee for Service Programs, Office of Medical Assistance Programs (OMAP) (lauletta@pa.gov).

2. If an MA recipient has Medicaid as a secondary payer and the patient's primary doesn't cover abortion services, would their Medicaid kick in to cover the newly covered abortion services?

Yes. The MA Program is the payor of last resort. All other insurance coverage must be exhausted before billing MA. Providers may bill MA if the payment from other insurance coverage is less than the MA fee for the service, or for unsatisfied deductible or coinsurance amounts. The MA Program will pay up to the maximum allowable MA fee.

3. What if an MA or CHIP recipient is unable to produce their Medicaid or CHIP card?

For recipients enrolled in MA, providers should use Pennsylvania Medicaid's [Eligibility Verification System](#). For individuals enrolled in CHIP, providers should call the recipient's CHIP MCO to verify eligibility.

4. Can providers retro-bill for all relevant and billable claims associated with the newly covered abortion service provided during the interim period?

Yes. MA and CHIP-enrolled providers that are eligible to provide these services may bill for the newly covered abortion service provided during the interim period.

5. During the interim period, what should a provider do if it receives payment from both a third party and the recipient, such that the total payment exceeds the MA or CHIP rate?

The provider must make good faith efforts to reimburse the recipient for the amount they paid. If the remaining payment from a third party exceeds the MA or CHIP rate, then the provider cannot retro-bill.

6. Does a provider have to do all the good faith efforts listed under Option 2?

Before a provider can keep money paid by a recipient, the provider must attempt all methods of contact listed under Option 2. But providers can choose how to sequence the

outreach. Providers do not have to do all methods if one method results in the successful reimbursement of the recipient.

7. What should a provider do if it mails a reimbursement check to a recipient, but the check is not cashed?

A reimbursement check that is not cashed by the recipient within 90 days of the provider mailing the check to the address provided by the recipient constitutes an inability to reimburse by a provider after making good faith efforts to do so. Within 120 days after mailing the check, the provider must submit a new claim to the Department or the MCO that (1) voids the original claim and (2) bills the service amount minus the amount paid by the recipient. The Department or the MCO will then deduct the overpayment from future payments (i.e., make a claims adjustment).

8. How should providers bill if a recipient wants both a newly covered abortion service (state-only funded) and another covered service for which there is a federal match (e.g. contraception)?

During the interim period, claims for which there is a federal match should be billed in accordance with current practices, while claims for the newly covered abortion services should be retro-billed in accordance with this guidance.

After the interim period, claims for which there is a federal match should be submitted to DHS or the appropriate MCO for payment. In other words, claims for which there is a federal match (i.e. Medicaid-covered services) should be submitted separately from claims for newly covered abortion services.

9. Can the provider bill MA or CHIP for everything associated with the newly covered abortion services (e.g., ancillary services, facility fees)?

DHS and MCOs will pay for medically necessary services as set forth in the fee schedule. Administrative expenses such as equipment, materials (including materials for anesthesia), supplies and drugs related to the procedure and ancillary personnel are included in the MA or CHIP payment to the facility.

10. To bill abortion services for which there is a federal match (listed in 18 Pa. C.S. § 3215(c)) during the interim period, do providers have to do anything different?

No.