Medicaid Managed Care Model Provisions: Access to Reproductive Health Services

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Introduction

The National Health Law Program has focused on the legal provisions governing Medicaid managed care for nearly three decades. The Medicaid program has changed significantly and now requires millions of older people, people with disabilities, and those with Limited English Proficiency to enroll in managed care. Yet, the regulations have not been updated for more than a decade and no longer reflect the needs of the covered populations, or current clinical practices and technological capabilities. Moreover, the regulations do not reflect the barriers facing beneficiaries who seek reproductive health services. To help address these deficiencies, NHeLP has developed a complete set of modernized model federal regulations.[1]

To focus advocates on areas that were significantly updated, NHeLP has prepared a series of issue briefs featuring selected model provisions governing six aspects of Medicaid managed care: beneficiary grievances and appeals, enrollment and disenrollment, network adequacy, accessibility, reproductive health services, and quality and transparency (forthcoming). We encourage policy makers and advocates to use these model provisions to update existing regulations, policies, and managed care contracts.

Topic #5: Access to Reproductive Health Services

Background on Reproductive Health Services in Medicaid Managed Care

In 2009, over 22.4 million women were enrolled in Medicaid, and 63 percent of these women were of childbearing age.[2] Moreover, data indicates that almost three quarters of Medicaid beneficiaries receive their health services through a managed care plan.[3] Both Medicaid enrollment and states' use of Medicaid managed care are expected to increase. Nearly all newly eligible individuals enrolled in the Medicaid expansion will be in managed care plans. This means that even more women will receive reproductive health services through a Medicaid managed care plan in the future.

Medicaid covers a range of reproductive health services. States must cover family planning services

and supplies for categorically needy beneficiaries, as well as pregnancy services for all beneficiaries.[4] The scope of coverage for these services varies among states. In addition, states must cover abortion services when the pregnancy is the result of rape or incest, or when the pregnancy endangers the life of the woman.[5] A number of states, however, cover abortion services in a wider range of circumstances with state funds.

In most managed care arrangements, beneficiaries obtain services from a specific network of providers. This can present a unique set of problems for women who seek reproductive health services, in part due to an increase in the number of managed care plans, providers, and facilities that refuse to provide particular reproductive health services because of religious or moral objections.

Despite having coverage, women enrolled in Medicaid managed care often have trouble accessing reproductive health services. In most managed care arrangements, beneficiaries obtain services from a specific network of providers. This can present a unique set of problems for women who seek reproductive health services, in part due to an increase in the number of managed care plans, providers, and facilities that refuse to provide particular reproductive health services because of religious or moral objections. For example, religious directives prohibit providers at Catholic-sponsored facilities from providing basic services such as contraception, sterilization, and abortion.[6] Even miscarriage management can be compromised by these religious restrictions.[7] For example, Catholic-sponsored facilities may prevent providers from providing medically necessary treatment to a woman who is having a miscarriage as long as there is a fetal heartbeat.[8]

Catholic-sponsored health systems have grown substantially in recent years – as of 2011, 10 of the 25 largest health systems in the United States were Catholic-sponsored.[9]

Federal law does contain provisions designed to protect Medicaid beneficiaries who seek covered reproductive health services. For example, family planning services and supplies are a mandatory Medicaid benefit. Under the "freedom of choice" provisions, beneficiaries have the right to see any Medicaid family planning provider in- or out-of-network, and managed care plans cannot impose an extra cost on beneficiaries if that provider is out-of-network.[10] In addition, managed care plans must provide women with direct access to an in-network women's health specialist for "routine and preventive health care services."[11] Nevertheless, serious problems persist.

[M]anaged care plans must provide women with direct access to an in-network women's health specialist for "routine and preventive health care services."

Recurring problems: Managed care enrollees encounter barriers to accessing covered reproductive health services. For example:

- At enrollment, beneficiaries may not have the choice of a managed care plan that provides all covered reproductive health services.
- Pregnant women do not have the right to opt out of enrollment in managed care to maintain continuity of care with a trusted fee-for-service Medicaid provider.
- Managed care plans fail to create adequate provider networks for reproductive health services, leaving beneficiaries without access to these services. In establishing and maintaining their networks, many plans do not account for providers who refuse to offer certain covered services due to religious or moral objections. As a result, plans assemble networks that appear to have sufficient numbers of OBGYNs and other women's health specialists, but do not provide adequate access to all covered reproductive health services.
- When transitioning into or out of managed care or between managed care plans, beneficiaries find it difficult to obtain reproductive health services.
- Women are not guaranteed access to all covered reproductive health services without a referral from their primary care provider. Plans that require a referral for certain reproductive health services create an unnecessary barrier for women whose primary care provider is not an OBGYN or other women's health specialist, or who refuses to make a referral.
- Some plans impose medical management techniques such as prior authorization for family planning services and supplies. This can delay access to contraceptive services and cause unintended pregnancy.
- Many plans do not provide an expedited prior authorization decision for beneficiaries who need time sensitive reproductive health services such as abortion. In certain circumstances, the standard timeframe precludes beneficiaries from receiving these services at all.

The model provisions address these problems by:

- Requiring states to give Medicaid beneficiaries a choice between at least two managed care plans, one of which must provide the full range of reproductive health services covered in the state plan, to the extent the services fall within the scope of services covered under the contract.
- Creating a process for pregnant women who are receiving fee-for-service Medicaid to opt out of enrollment in managed care when necessary to ensure continuity of care.
- Requiring managed care plans, in establishing and maintaining their networks, to account for the number of providers who offer a full range of covered reproductive health services, including high risk pregnancy care, family planning services and supplies, and abortion. In addition, the model provisions require that Medicaid managed care plans contract with Essential Community Providers. Essential Community Providers serve predominantly low-income, medically underserved individuals and include Title X family planning clinics.
- Obligating managed care plans that contract with providers who refuse to provide a full range of reproductive health services to take additional steps to ensure that enrollees have access to

covered services in-network. For example, plans must ensure that a protocol is in place to allow enrollees to obtain covered services when a primary care provider will not or cannot make a referral for services. If particular services are still not available in-network, plans must provide access to the services out-of-network at no additional cost to the enrollee.

- Mandating that if a plan does not cover certain services due to a religious objection, the plan must inform enrollees about which services are excluded and how to obtain information about accessing those services.
- Mandating that states arrange for beneficiaries to receive out-of-network services when moving into or out of managed care or between managed care plans, if certain circumstances exist. For example, states must arrange for a service when it is not available in-network.
- Requiring managed care plans to provide female enrollees, including adolescents, with direct access to an in-network women's health specialist for covered women's health services.
- Prohibiting plans from requiring prior authorization for family planning services and supplies and for family planning-related services.
- Requiring managed care plans to provide an expedited prior authorization decision when a provider indicates or the plan determines that the enrollee is in need of time sensitive services.

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Select Medicaid Managed Care Provisions – Access to Reproductive Health Services

Note: As mentioned above, NHeLP developed a comprehensive set of modernized model federal regulations. Most of the federal regulations have some impact on access to reproductive health services. Included below are the model provisions that are both specific to reproductive health services and significantly different from the current federal regulations. For more information about the remaining model provisions, see Topic #1 through Topic #4 in this series.

Definitions

Prepaid Managed Care Plan (PMCP): A Medicaid managed care organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP), as defined by 42 C.F.R. § 438.2.

Primary Care Case Manager (PCCM): A physician, entity employing physicians, or (at state option) another health care practitioner that contracts with a State to provide case management services, as defined by 42 C.F.R. § 438.2.

Section One: Information requirements

(a) *Terminology.* As used in this section, the following terms have the indicated meanings:
Enrollee means a Medicaid beneficiary who is currently enrolled in a PMCP or PCCM in a

given managed care program.

Potential enrollee means a Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific PMCP or PCCM.

(b) *Information for potential enrollees.*

(1) The State or its contracted representative must provide the information specified in paragraph (b)(2) of this section to each potential enrollee as follows:

(i) At the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program;

(ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available PCMPs or PCCMs; and

(iii) By making the information available through a website that is accessible to the public.

(2) The information for potential enrollees must include the following:

(i) Information specific to each PCMP or PCCM program operating in potential enrollee's service area including:

(A) Benefits covered.

(B) Cost sharing, if any.

(C) Service area.

(D) Provider information including:

(i) Names, locations, telephone numbers of, and non-English language spoken by current contracted providers and

(ii) Identification of current contracted providers and indication of whether they are accepting new patients.

For PCMPs, this includes at a minimum information on primary care physicians, specialists, and hospitals.

(E) Benefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a counseling or referral service that the PCMP or PCCM does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service. The PCMP or PCCM must inform potential enrollees where and how to obtain this information from the State.

(F) The State's strategy for assessing, reviewing, and improving the quality of managed care services offered by MCOs and PIHPs as set forth in § 438.202(a).

(c) *General information for all enrollees of PCMPs and PCCMs.* Information must be furnished to PCMP and PCCM enrollees as follows:

(1) The State, its contracted representative, or the PCMP or PCCM must provide the following information to all enrollees:

(i) How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that the PCMP or PCCM does not cover because of moral or religious objections, the PCMP or PCCM must inform enrollees that the services are not covered. The State must provide information on how and where to obtain the service and the PCMP or PCCM must inform enrollees how they can to obtain information from the State about how to access those services.

(2) In addition to furnishing the information described in this subsection directly to enrollees, the State, its contracted representative, and the PCMP or PCCM (as applicable) must post the information on a website that is accessible to the public.

Section Two: Choice of PCMPs and PCCMs

(a) *General rule.* Except as specified in paragraphs (b) and (c) of this section, a State that requires Medicaid beneficiaries to enroll in a PMCP or PCCM must give those beneficiaries a choice of at least two entities. At least one of those entities must cover the full range of reproductive health services covered in the State plan, to the extent that reproductive health services fall within the scope of services for which the entity is responsible.

(b) *Exception for rural area residents.*

(1) Under any of the following programs, and subject to the requirements of paragraph (b)(2) of this section, a State may limit a rural area resident to a single PMCP or PCCM system:

(i) A program authorized by a plan amendment under section 1932(a) of the Act.

(ii) A waiver under section 1115 of the Act.

(iii) A waiver under section 1915(b) of the Act.

(2) A State that elects the option provided under paragraph (b)(1) of this section, must permit the beneficiary to choose from at least two physicians or case managers.

(3) As used in this paragraph, "rural area" is any area other than an "urban area" as defined in §412.62(f)(1)(ii) of this chapter.

(c) *Exception for certain health insuring organizations (HIOs).* The State may limit beneficiaries to a single HIO if—

(1) The HIO is one of those described in section 1932(a)(3)(C) of the Act; and

(2) The beneficiary who enrolls in the HIO has a choice of at least two primary care providers within the entity.

(d) *Limitations on changes between primary care providers.* For an enrollee of a single PMCP or HIO under paragraph (b) or (c) of this section, any limitation the State

imposes on his or her freedom to change between primary care providers may be no more restrictive than the limitations on disenrollment under §438.56(c).

(e) *Time allotted for choice of* PMCP and PCCM. When enrollees are given a choice of plans in which to enroll and will be automatically enrolled if they make no selection, they must be allowed at least 45 days to make a plan selection.

Section Three: Exemption from plan enrollment

(a) *General requirements.* In States where mandatory enrollment in Medicaid managed care exists, an eligible recipient who satisfies the requirements in (1), (2), or (3) below, may request fee-for-service Medicaid for up to 12 months as an alternative to plan enrollment, by submitting a request for exemption from plan enrollment to the State agency as specified in (b) below.

(1) An eligible recipient who is an American Indian as specified in §438.56(g), a member of an American Indian household, or chooses to receive health care services through an Indian Health Service facility and has written acceptance from an Indian Health Service facility for care on a fee-for-service basis.

(2) An eligible recipient who is receiving fee-for-service Medicaid treatment or services for a complex medical condition, from any provider who is participating in the Medicaid program but is not a contracting provider of a plan in the eligible recipient's county of residence, may request a medical exemption to continue fee-for-service Medicaid for purposes of continuity of care.

(i) *Complex medical conditions.* For purposes of this section, conditions meeting the criteria for a complex medical condition include, but are not limited to, the following:

(A) An eligible recipient is pregnant.

(B) An eligible recipient is under evaluation for the need for an organ transplant; has been approved for and is awaiting an organ transplant; or has received a transplant and is currently either immediately post-operative or exhibiting significant medical problems related to the transplant. Beneficiaries who are medically stable on post-transplant therapy are not eligible for exemption under this section.

(C) An eligible recipient is receiving chronic renal dialysis treatment.

(D) An eligible recipient has tested positive for HIV or has received a diagnosis of acquired immune deficiency syndrome (AIDS).

(E) An eligible recipient has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer that will continue for up to 12 months or has been approved for such therapy.

(F) An eligible recipient has been approved for a major surgical procedure by the fee-for-service Medicaid program and is awaiting surgery or is immediately post-operative.

(G) An eligible recipient has a complex neurological disorder, such as multiple sclerosis, a complex hematological disorder, such as hemophilia or sickle cell diseases, or a complex and/or progressive disorder not covered in (A) through (D) above, such as cardiomyopathy or amyotrophic lateral sclerosis, that requires ongoing medical supervision and/or has been approved for or is receiving complex medical treatment for the disorder, the administration of which cannot be interrupted.

(H) The recipient is enrolled in a Medicaid home and community-based waiver program under 42 U.S.C. §1915(c) or a State plan option under §1915(i) and enrollment in a plan would jeopardize the recipient's ability to live in the community). Verification of participation in the waiver program or State plan option must be submitted with the disenrollment request by the recipient or the recipient's authorized representative as specified in (h).

(i) A request for exemption from plan enrollment based on complex medical conditions shall not be approved for an eligible recipient who has: (i) Been a enrollee of either plan on a combined basis for more than 180 consecutive calendar days, (ii) A current Medicaid provider that the recipient is seeking to continue care with and was a main source of Medicaid services for the recipient during any time in the previous year who is contracting with another plan available to the recipient, or (iii) Has already begun treatment after the date of plan enrollment.

(3) Except for pregnancy, any eligible recipient granted a medical exemption from plan enrollment shall remain with the fee-for-service provider only until the medical condition has stabilized to a level that would enable the individual to change physicians and begin receiving care from a plan provider without deleterious medical effects, as determined by a recipient's treating physician in the Medicaid fee-for-service program, up to 12 months from the date the medical exemption is first approved by the State agency. A recipient granted a medical exemption due to pregnancy may remain with the fee-for-service Medicaid provider through delivery and the end of the month in which 90 days post-partum occurs.

(4) Any extension to the 12-month medical exemption time limit shall be requested through the State agency no earlier than 11 months after the starting date of the exemption currently in effect. The State agency will notify the recipient 45 days before the expiration of an approved medical exemption and will inform the

recipient how to request an extension. An extension to the medical exemption shall be approved if the eligible recipient continues to meet the requirements of subsection (a)(2).

(b) *Process.*

(1) A request for exemption from plan enrollment or extension of an approved exemption due to a complex medical condition, as specified in (a)(2)(A), shall be submitted to the State agency by the Medicaid fee-for-service provider or the Indian Health Service facility treating the recipient and shall be submitted by mail or facsimile. Request for exemption from plan enrollment or extension of an approved exemption shall not be submitted by the plan.

(2) The State agency (or its agent), shall approve each request for exemption from plan enrollment that meets the requirements of this section. At any time, the State agency may, at its discretion, verify the complexity, validity, and status of the medical condition and treatment plan and verify that the provider is not contracted or otherwise affiliated with a plan. State agency may deny a request for exemption from plan enrollment or revoke an approved request for exemption if a provider fails to fully cooperate with this verification. The State agency must accept the Statement of the treating physician or other qualified provider as true and valid and may not administratively overturn such a determination without evidence that it is not a valid medical exemption request.

Section Four: Continued services to beneficiaries

(a) The State agency must arrange for Medicaid services to be provided out-of-network without delay to any Medicaid enrollee of a PMCP or PCCM when the enrollee moves from fee-for-service to a PMCP or PCCM; from one PMCP or PCCM to another; from another insurance affordability program into Medicaid; or from a PMCP or PCCM to fee-for-service, and –

(1) The service or type of provider (including training, experience, specialization, and linguistic and cultural competency) is not available within the PMCP or PCCM network;

(2) The only plan or provider available to the beneficiary does not, because of moral or religious objections, provide the service the enrollee seeks;

(3) The enrollee's primary care provider or other provider determines that the enrollee needs related services that would subject the enrollee to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network;

(4) For up to 12 months after enrolling into a PMCP or PCCM, the enrollee is completing covered services that, at the time of enrollment into the PMCP or PCCM, the enrollee was receiving from an out-of-network provider, as long as the conditions in

(b) are met;

(5) For the duration of a terminal illness when enrollee is completing covered services that, at the time of enrollment into the PMCP or PCCM, the enrollee was receiving from an out-of-network provider, for a terminal illness. A terminal illness is any incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the effective date of coverage for a new enrollee; or

(6) The State determines that other circumstances warrant out-of-network treatment.

(b) An enrollee shall be entitled to complete covered services with an out-of-network provider as described in (a)(4) and (a)(5) above as long as—

(1) The PMCP or PCCM is determines that the enrollee has seen the provider at least once in the 12 month period immediately preceding the enrollee's enrollment in the PMCP or PCCM;

(2) The provider is willing to accept the higher of contract rates of the PMCP or PCCM, or the State agency's FFS rates; and

(3) The provider meets the applicable professional standards of the PMCP or PCCM such that the provider would qualify to participate in the network of the PMCP or PCCM.

Section Five: Availability of services

(a) *Basic rule.* Each State must ensure that all services covered under the State plan are available and accessible to enrollees of PMCP.

(b) A PMCP may specify the networks of providers from whom enrollees may obtain services if the State and the PMCP ensure that all covered services are available and accessible under the plan. To accomplish this, the State shall ensure that each contracting PMCP meets the following requirements:

(1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. These providers shall include (i) providers of all categories of services listed in §§ 440.10 – 440.140, 440.155, 440.165-167, 440.169-440.185, to the extent those services are covered by the State plan and the PCMP contract, (ii) qualified providers of long term services and supports who meet state licensing, credentialing, or certification requirements, particularly providers of home and community-based long term services and supports; and (iii) a sufficient number and geographic distribution of Essential Community Providers, where available, to ensure reasonable and timely access to a broad range of such providers in the plan's service area. Essential Community Providers are providers that serve predominantly low-income, medically underserved individuals, including providers defined in

section 340B(a)(4) of the Public Health Services Act and § 1927(c)(1)(D)(i)(IV) of the Social Security Act.

(2) In establishing and maintaining the network, each PMCP must account for the following:

(i) The anticipated Medicaid enrollment.

(ii) The expected utilization of services, taking into consideration the characteristics and health care needs, including accessibility needs, of specific Medicaid populations represented in the particular PMCP.

(iii) The numbers of network providers who are not accepting new Medicaid patients.

(iv) The numbers of network providers who provide a full range of covered reproductive health services including high risk pregnancy care, family planning services and supplies, and abortion.

(v) The needs of enrollees for home and community-based long term services and supports, mental health, and substance use services.

(3) If a PMCP contracts with institutions or individual providers who refuse to provide a full range of reproductive health services, the PMCP must also:

(i) Contract with at least one institutional provider and one professional provider within the same geographic area that provides covered services in-network providers refuse to provide;

(ii) If there is no provider in the geographic area that offers the covered services, contract with additional providers in nearby regions and provide transportation services; and

(iii) Ensure a protocol is in place to allow enrollees to obtain covered services when a primary care provider refuses or is unable to make a referral to needed services.

(4) Provides female enrollees including adolescents with direct access to a women's health specialist within the network for covered women's health services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

(5) If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the PCMP must adequately and timely cover these services out of network for the enrollee, for as long as the PCMP is unable to provide them in accordance with § 438.62.

Section Six: Authorization of services

(a) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require—

(1) That the PMCP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the PMCP —

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;

(ii) have in effect mechanisms to implement monitoring and use of person-centered needs assessment, service planning, and service coordination policies and protocols; and

(iii) otherwise take into account the needs of people with special health care needs and chronic conditions when determining authorization periods, including those requiring long term services and supports;

(iv) Consult with the requesting provider when appropriate.

(3) That the PMCP shall not require prior authorization for family planning services and supplies and for family planning related services.

(4) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

(b) *Notice of adverse action.* Each contract must provide for the PMCP to notify the requesting provider, and give the enrollee written notice of any decision by the PMCP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

(c) *Timeframe for decisions.* Each PMCP contract must provide for the following decisions and notices:

(1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—

(i) The enrollee, or the provider, requests extension; or

(ii) The PMCP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(2) *Expedited authorization decisions.*

(i) For cases in which a provider indicates, or the PMCP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, or the enrollee is in need of time sensitive services, the PMCP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition

requires and no later than 3 working days after receipt of the request for service.

(ii) The PMCP may extend the 3 working days time period by up to 14 calendar days

if the enrollee requests an extension, or if the PMCP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

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ENDNOTES

[1] We used the current federal Medicaid managed care regulations found at 42 C.F.R. part 438 as the starting point for developing our comprehensive model provisions. The regulations address state obligations, enrollee rights and responsibilities, quality assessment and improvement, external quality review, grievance systems, certification and program integrity, sanctions, and conditions for federal funding.

[2] KAISER FAMILY FOUND., *The Role of Medicaid and Medicare in Women's Health Care*, 309 JAMA 1984 (2013), *available at* http://jama.jamanetwork.com/article.aspx?articleid=1687586.

[3] *See* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID MANAGED CARE ENROLLMENT REPORT: SUMMARY STATISTICS AS OF JULY 1 2011 1, *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

[4] 42 U.S.C. §§ 1396d(a)(4)(C), 1396a(a)(10)(A), 1396a(a)(C), 1396a(a)(10)(G)(VII); 42 C.F.R. §§ 440.210. 440.220. For more detailed information about covered services for categorically and medically needy beneficiaries, *see* NAT'L HEALTH LAW PROGRAM, THE ADVOCATE'S GUIDE TO THE MEDICAID PROGRAM 4.3 - 4.4(2011), *available at* http://www.healthlaw.org.

[5] *See* CMS, Dear State Medicaid Director (Dec. 28, 1993), (Feb. 12, 1998).

[6] *See* NAT'L HEALTH LAW PROGRAM, HEALTH CARE REFUSALS: UNDERMINING QUALITY CARE FOR WOMEN 17-19 (2010), *available at* http://www.healthlaw.org/issues/reproductive-health/health-care-refusals/health-care-refusals-undermining-care-for-women#.VEhFrslDWeA.

[7] Lori Freedman, et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals,* 98 AM. J. PUB. HEALTH 1774 (2008).

[8] *Id*.

[9] ACLU AND MERGERWATCH, MISCARRIAGE OF MEDICINE: THE GROWTH OF CATHOLIC HOSPITALS AND THE THREAT TO REPRODUCTIVE HEALTH CARE 5 (2013), *available at* https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.

[10] 42 U.S.C. §§ 1396a(a)(23), 1396n(b).

[11] 42 C.F.R. § 438.206(b)(2).