



What Makes Medicaid, Medicaid? – Consumer Protections and Due Process

By [Kim Lewis](#) and [Wayne Turner](#)

Key takeaways

- Medicaid is designed to ensure that low income and underserved persons can fully access needed medical assistance
- Constitutionally protected due process rights allow Medicaid enrollees to challenge unlawful denials of coverage and care
- Medicaid consumer protections, grievances, and appeals processes help improve quality and access to care
- 88% of enrollees are satisfied with their health coverage under the ACA's expansion of Medicaid to low income adults according to HHS
- Drastic funding cuts through per capita caps or block grants would undermine the Medicaid program and important consumer protections

Discussion

Nearly 75 million people rely on health services and benefits provided by Medicaid, the federal-state health program serving low income individuals and families.¹ Although a state's participation is voluntary, once a state chooses to participate in the program, it must comply with federal statutory and regulatory requirements.²

The Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) is responsible for administering Medicaid and ensuring state compliance with federal requirements. However, CMS' formal oversight has not been an

adequate means of ensuring that states comply with the requirements set forth in the Medicaid statute and regulations, primarily because of the limited range of enforcement mechanisms available to CMS and HHS, but also due to the reluctance of some administrations.

To help ensure enrollees have full access to quality health care, Medicaid provides important consumer protections and due process rights, many of which are enforceable through legal action. However, these rights and protections which are now threatened under proposals to severely cut funding for this life-saving program by imposing per capita caps and block grants on states amid promises to provide states with greater “flexibility.”³ Republican proposals to impose per capita caps through the budget reconciliation process would cut \$880 billion from Medicaid over ten years, according to the Congressional Budget Office (CBO).⁴

1. General Medicaid protections help ensure coverage and access to services

Congress mandated the inclusion of certain benefits and services states must offer in their Medicaid programs.⁵ However, it did not explicitly define the minimum level of each service to be provided. Instead, Congress, through the Medicaid Act, required states to establish reasonable standards, comparable for all eligibility groups, for determining the extent of medical assistance.⁶ These standards must be consistent with the objectives of the Medicaid Act.⁷ While enforcing these rights often only happens through a legal challenge in the courts, these consumer protections are key features to the Medicaid program.

Amount, Duration and Scope of Benefits

Federal Medicaid regulations require that the services be “sufficient in amount, duration and scope to reasonably achieve their purpose.”⁸ These rules also require that states not “arbitrarily deny or reduce the amount, duration, or scope of such services to an otherwise eligible individual solely because of the diagnosis, type of illness or condition.”⁹

There is no concrete rule as to what constitutes a sufficient amount of services, and states have a lot of leeway about how they impose limits on services. It is generally understood to mean that all medically necessary treatment within a covered service area must be covered, that service must be covered in an amount sufficient to achieve its intended purpose (meets most people’s need for that service), and particular illnesses cannot be singled out for restricted coverage. States must also use reasonable standards in administering their Medicaid program, meaning that they cannot have policies or practices that arbitrarily deny a particular service or item within a category of benefits, such as durable medical equipment. All these consumer protections are critical to ensure beneficiaries have access to services that are medically necessary.

Comparability

Medicaid benefits must not only be “sufficient” in amount, duration, and scope, they must also be comparable. Generally, states must ensure that services available to categorically needy beneficiaries are not less in amount, duration, and scope than those services available to medically needy beneficiaries.¹⁰ Additionally states are required to provide services equal in amount, duration and scope for all beneficiaries within the categorically needy and medically needy groups respectively.¹¹ Some exceptions exist, for example, children are entitled to receive additional services.¹² A state may also operate a home and community-based services program for people with disabilities under a Medicaid waiver program which can provide additional services.

Essentially, comparability is about fairness: one person who has the same type of needs as another person should be able to access the same services. Comparability does not require states to provide any particular service, but requires the state to provide the services it offers in a manner that does not deny it to individuals who have the same types of needs. Some states have been found by courts to violate this requirement when they arbitrarily provide a service or benefit to one individual or group of individuals but do not provide the service or benefit to another group with a similar need (e.g. blind individuals, but not individuals with another disability).¹³

Reasonable promptness

The Medicaid Act requires that state "medical assistance . . . be furnished with reasonable promptness to all eligible individuals."¹⁴ Federal regulations direct state agencies to determine an applicant's eligibility for Medicaid within forty-five days of the date of application and to "[f]urnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures."¹⁵ This requirement arises both in the state's obligation to determine Medicaid eligibility of an applicant in a timely manner and in the duty to provide services or benefits to a beneficiary on the Medicaid Program. For example, if a state (or county) fails to determine individuals' eligibility for Medicaid in a timely manner (i.e. 45 days for most applicants) due to a backlog of applications in the system, that delay would very likely violate the state's obligation to furnish assistance with reasonable promptness.

In the case of services or benefits, the existence of a waitlist for beneficiaries to access to a particular service due to a lack of providers available to provide services would likely violate their right to get medically necessary services in a reasonable prompt time frame. Other similar examples that could violate the reasonable promptness standard are a cap on services, or state imposing an arbitrary waiting period before a beneficiary can get a particular service. If a state fails to determine Medicaid eligibility or provided

needed services with reasonable promptness, enrollees can appeal (See Section 3 below on Medicaid due process).

Statewideness

Another consumer protection provision of the Medicaid law is the requirement that a state plan for medical assistance “shall be in effect in all subdivisions of the state, and if administered by [political subdivisions], be mandatory upon them.”¹⁶ The state Medicaid plan must be continuously in operation throughout the state.¹⁷ In general, states are required to make their Medicaid benefits available to all eligible individuals, regardless of the location of their residence within the state. This requirement does not mean that a Medicaid provider must offer the services throughout the state, but rather that services covered under the Medicaid state plan be available throughout the state. So, for example, a state can contract with a managed care plan to serve a particular population, or beneficiaries residing within a particular region of the state and not serve beneficiaries outside of that population or region of the state.

This rule applies to both mandatory and optional benefits. For example, a state that covers optional prescription drugs must make that benefit available in both rural and urban areas of the state. There are exceptions to this general rule, as states are allowed to limit coverage of some services (e.g. “targeted” case management services) to a particular subpopulation of Medicaid beneficiaries or to particular geographic areas within the state. Similarly, certain Home and Community Based waiver services can be restricted to certain target populations residing in particular areas within the state or to beneficiaries that meet certain qualifications. States may also obtain waivers of this “statewideness” requirement to conduct demonstrations.¹⁸

Free choice of provider

Any individual eligible for Medicaid may obtain Medicaid services from any institution, agency, pharmacy, person or organization that is qualified to furnish the services and willing to furnish them.¹⁹ This provision is often referred to as the “any willing provider” or “free choice of provider” provision. This important consumer protection allows Medicaid beneficiaries to seek care and services from a Medicaid provider that they elect that as long as such provider is willing to provide these services (and accept them as a patient). There is an exception for beneficiaries enrolled in certain managed care plans (to permit such plans to restrict beneficiaries to providers in the managed care plan’s network), except that such plans cannot restrict free choice of family planning providers, even if the plan otherwise restricts enrollees’ coverage to a network of providers.²⁰ The provider must also meet Medicaid qualifications or standards set forth by the state.

Additionally, when invoking standards that are validly related to a provider’s “qualifications,” the “free choice of provider” provision ensures that a state may not deny Medicaid beneficiaries the right to see the provider of their choice unless there is a sufficient basis.²¹ In other words, states cannot set unreasonable standards to unfairly target certain providers. A state’s action against a provider affecting beneficiary access to the provider must be supported by evidence of fraud or criminal action, material non-compliance with relevant requirements, or material issues concerning the fitness of the provider to perform covered services or appropriately bill for them.²² Taking such action against a provider without such evidence would not be in compliance with the free choice of provider requirement. If a state does not have evidence supporting its finding that a provider failed to meet a state standard, that provider remains “qualified to furnish” Medicaid services.²³

The “free choice of provider” provision is specific with respect to the free choice of family planning providers. States may not deny qualification to family planning providers, or take other action against qualified family planning providers, that impedes beneficiaries access to those providers—whether individual providers, physician groups, outpatient clinics or hospitals—solely because they separately provide family planning services or the full range of legally permissible gynecological and obstetric care, including abortion services (as permitted by state and federal law), as part of their scope of practice.²⁴ This is a critical protection for beneficiaries who want the right to see providers who may provide the full range of family planning services (e.g. contraception or abortion services) that a state does not support, such as Planned Parenthood. The “freedom of choice” principle is critical for beneficiaries who want to receive care from a provider with whom they are comfortable, is familiar with their health history, and can provide immediate and time-sensitive care.

Single state agency

The single state agency requirement serves an as important accountability protection for enrollees. In ruling that the state, not a Medicaid managed care company, was ultimately responsible for meeting federal requirements, the 4th Circuit concluded, “One head chef in the

A state plan must specify a single state agency established or designated to administer or supervise the administration of the Medicaid state plan.²⁵ That agency must have legal authority to administer or supervise the administration of the plan and make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan. For an agency to qualify as the Medicaid agency, it must not delegate, to other than its own officials, authority to exercise administrative discretion in the administration or supervision of the plan, or issue policies, rules and regulations on program matters.

Medicaid kitchen is enough.”

K.C. v. Shipman, 716 F.3d 107, 119 (4th Cir. 2013)

The authority of the Medicaid agency must not be impaired. If any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies or offices performing services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the applications of policies, rules, and regulations issued by the Medicaid agency.

2. Consumer protections in Medicaid managed care

Nearly 77% of Medicaid beneficiaries receive services through some type of managed care arrangement.²⁶ Most Medicaid beneficiaries are enrolled in capitated managed care plans, including Managed Care Organizations (MCOs), which receive a fixed per-member, per-month “capitated” fee, regardless of how many services an enrollee may actually need. MCOs incur a loss if the cost of providing services exceeds the capitated payment. But if enrollees use fewer services, the plan keeps the excess payment. Because managed care companies have a financial incentive to deny care, federal law and newly updated regulations provide an important array of consumer protections for enrollees.

General enrollee rights and patient protections

The right to participate in one’s own healthcare is a fundamental right in any health care situation, given the personal nature of such decisions.

Federal law establishes standards and rights to protect enrollees in Medicaid managed care plans, including the right to:²⁷

- Be treated with respect and dignity;²⁸
- Have timely access to services, including specialists;²⁹

- Receive information on risks, benefits, and consequences of treatment options, or non-treatment;³⁰
- Participate in decisions regarding his or her health, including the right to refuse treatment.³¹

Right to enroll and disenroll

States that require beneficiaries to enroll in Medicaid managed care must, with limited exceptions, provide each enrollee a choice between at least two managed care plans.³² To help them make an informed choice when choosing a plan, Medicaid agencies must make information about the plans, and enrollee rights, available to potential enrollees.³³ Plan information includes:

Covered benefits	Plan performance indicators	Procedures for obtaining prior authorization of services
Searchable provider directories	Any cost sharing (co-pays or co-insurance)	Information on grievance and fair hearing procedures
Prescription drug formularies	Information on enrollee rights	Information on the accessibility of providers and facilities ³⁴

Information on plan providers and services can help managed care enrollees select the plan that best suits their needs. Moreover, enrollees may disenroll from a plan within 90 days of initial enrollment, or later for cause, such as poor quality or lack of access to care.³⁵ The right to choose between managed care plans and to disenroll helps safeguard consumers from poor performing plans, and provide an incentive for plans to better serve enrollees.

Right to reproductive health care

MCOs are responsible for providing enrollees with a handbook listing the benefits that are provided directly by the state. Enrollees must be informed of “[t]he extent to which, and how [they] may obtain benefits, including family planning services and supplies from out-of-network providers.”³⁶ In addition, the federal regulations require managed care entities to clarify that enrollees cannot be required to obtain a referral before seeing a family planning provider.³⁷

When a plan refuses to cover a counseling or referral service due to a moral or religious objection, the plan must inform enrollees how and where to obtain information from the

state about how to access the service. Because enrollees are accustomed to seeking and receiving information about covered benefits from their plan this requirement will help ensure that enrollees have the information needed to access services that their plan refuses to cover.³⁸

Beneficiary support system

The federal regulations require states to create an important new beneficiary support system that “provides support to beneficiaries both prior to and after enrollment” into managed care.³⁹ This new system promises to support older adults that struggle to navigate the complexities of managed care.

Specifically, the beneficiary support system must provide independent choice counseling (for example, helping a senior select the best plan for her), assistance in understanding managed care, and special support for individuals using or interested in using long-term services and supports (LTSS). The beneficiary support system must outreach to beneficiaries and be accessible, including via auxiliary aids and services.⁴⁰ For individuals using or interested in LTSS, the beneficiary support system must be an access point for complaints, provide education on appeal and grievance rights, provide assistance with appeal and grievances processes, and help identify and resolve systemic LTSS problems.⁴¹

Right to file grievances

States must ensure that managed care companies establish grievance procedures and systems.⁴² Grievance means an expression of dissatisfaction about any matter other than an action.⁴³ The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO level and access to the state fair hearing process. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights.

“Because of the pecuniary incentives that MCOs have for denying, suspending, or terminating care [...] enrollees need strong due process protections to protect themselves from inappropriate denials of health care.”

Daniels v. Wadley, 926 F. Supp. 1305

(M.D. Tenn. 1996).

Appeals, discussed in Section 3 below, means a request for review of an action, which is a denial, limited authorization, reduction, termination, or suspension of a service; a denial of payment for a service; a failure to provide services in a timely manner; or failure of an MCO to act within required timeframes.

States must collect and report data on grievances and appeals as part of an annual managed care program assessment.⁴⁴ Information on grievances, appeals, disenrollment, and other key protections in Medicaid managed care can help identify problem areas, best practices, and lead to overall improvements in the program.

3. Medicaid applicants and beneficiaries have due process rights

One of the most important consumer protections of the Medicaid Program are the rights of applicants and beneficiaries to receive a notice and obtain a hearing when benefits are denied, terminated or reduced. It has long been recognized that Medicaid enrollees have a property interest in Medicaid benefits.⁴⁵ Because they have a property interest, Medicaid applicants and beneficiaries right to benefits are protected by the Due Process Clause of the U.S. Constitution.⁴⁶ The two fundamental elements of these constitutionally required protections are the right to adequate *notice* of the state Medicaid agency's actions and a meaningful opportunity to seek a *hearing* to review (called an "appeal") the state's actions or decisions. These rights were articulated by the U.S. Supreme Court in its landmark decision of *Goldberg v. Kelly*.⁴⁷ In *Goldberg*, the Court acknowledged that beneficiaries rely on programs like Medicaid to meet basic needs, without any other options, and therefore beneficiaries are entitled to effective notice and pre-termination hearing when these benefits are being terminated.

Adequate notice of state Medicaid agency actions

The notice must be reasonably calculated, under all the circumstances, to inform the individual of the action being taken and to convey information regarding the right to appeal. Written notice of appeal rights is required at the time of an application for benefits and any time the state agency takes an action that affects a person's right to benefits or services. All notices must advise the individual of the right to a hearing, describe the method for requesting a hearing, and explain that the individual may represent herself or be represented by legal counsel, a relative, a friend, or another spokesperson.⁴⁸ State agencies must also advise applicants and beneficiaries about legal services agencies or other sources of representation.⁴⁹ Written notices of appeal rights should also contain a translation in a language understood by individuals who are limited English proficient and the information must be accessible to individuals with disabilities.⁵⁰

If a state Medicaid agency intends to terminate, suspend or reduce an individual's Medicaid eligibility or covered services, the agency must provide a notice that describes the adverse action the state Medicaid agency intends to take, the reasons for the intended action (including both the legal support and the factual basis), the specific regulations or law that support or require the action, the individual's right to request a hearing, and the circumstances under which the person can receive continued benefits (sometimes called "aid paid pending") pending the outcome of the appeal if a hearing is requested.⁵¹ For intended actions, the state agency generally must send the notice to the beneficiary at least 10 days before the date of the action, except in limited circumstances.⁵² These same obligations apply to a Medicaid managed care plan that denies, terminates or reduces benefits or services to an enrollee of the plan.⁵³

Right to obtain a hearing through an appeal

The federal Medicaid Act and implementing regulations requires states to provide the opportunity for a state fair hearing to any individual whose claim for benefits is denied or not acted upon with reasonable promptness.⁵⁴ The administrative agency hearings in the Medicaid appeals system are known as "fair hearings." Generally speaking, there are two types of the Medicaid issues that can be considered at these hearings: (1) Medicaid eligibility - appealing the state agency's decision to deny or terminate eligibility for the Medicaid program, and (2) Medicaid benefits – appealing the Medicaid state agency or a managed care plan's decision to deny, suspend, terminate or reduce benefits or services. These rights apply to actions affecting both mandatory and optional Medicaid services.

An individual must be allowed a reasonable time to request a hearing, within a reasonable period of time established by the state agency, not to exceed 90 days from the date that the notice of action is mailed.⁵⁵ The hearing can be requested via the internet, by telephone, mail, in person, or through other commonly available electronic means.⁵⁶ The agency can require the request to be in writing. State agencies may not limit or interfere with an individual's freedom to request a hearing.⁵⁷

If the individual requests a hearing, he or she must generally be given recourse to the hearing process. Federal regulations provide an exception for automatic changes in coverage due solely to a change in state or federal law. In these instances, the state agency must provide notice of the change but not a fair hearing.⁵⁸

Applicants, beneficiaries and their representatives have several important procedural rights associated with state fair hearings. Prior to the hearing, the individual must have an opportunity to examine his or her case file, as well as all policies and documents that form the basis for the decision.⁵⁹ The hearing must be fair, meaning that it must occur at a —reasonable time, date and place and be conducted by an impartial hearing officer.⁶⁰

State Medicaid agencies must also secure an interpreter for beneficiaries with limited English proficiency.⁶¹ If the hearing involves medical issues such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision, and if the hearing officer considers it necessary to have a medical assessment other than that of the individual involved in making the original decision, such a medical assessment must be obtained at agency expense and made part of the record.⁶² The hearing must provide the individual with an opportunity to bring witnesses, establish all pertinent facts and circumstances, present an argument without interference, and confront and question any adverse witnesses.⁶³

An individual can also request and obtain an expedited fair hearing if the time otherwise permitted for a hearing could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function.⁶⁴ The right to present evidence does not necessarily extend to presenting the evidence to the hearing officer in person. More states now provide telephonic hearings as a routine matter and an individual may need to request a hearing in person if they believe that is necessary or preferable.

The hearing decision must be based solely on the legal rules and evidence presented at the hearing.⁶⁵ The hearing decision must be provided in writing to the claimant, within 90 days of the date of the request for a hearing, and it must summarize the facts and identify the regulations supporting the decision, as well as inform the individual of any additional administrative or court review that is available.⁶⁶

Right to continuing benefits pending the appeal

One additional critical consumer protection that beneficiaries have who are currently receiving services is the right to request that the services continue during an appeal, until a hearing decision is issued. This is also called "aid paid pending" or "continued benefits."⁶⁷ To exercise this right, the beneficiary must request a hearing *before* the date of the Medicaid state agency's (or Medicaid managed care plan's) intended action, within the 10-day advance notice period.⁶⁸

However, continuing benefits during an appeal is not available if the sole issue at the hearing is a change in the federal or state law or policy, as opposed to issues of fact or judgment such as the proper application of state law or policy to the facts of an individual's case.⁶⁹ For example, if the federal and state law were to change and no longer provide Medicaid benefits for people with incomes above a certain income amount, continued benefits would not be available because the termination of benefits resulted from a change in federal law. But if the person has facts to support the

argument that he or she is still eligible for Medicaid, despite the change of federal or state law, then the individual would be entitled to a hearing.

After the 10-day advance notice period expires, a beneficiary still may ask for a hearing, until the expiration of the time period to do so, but the state agency may implement its decision to reduce or discontinue services while the appeal is pending. The state agency may reinstate and continue services until a hearing decision is issued, if a beneficiary requests a hearing within 10 days after the date of action.⁷⁰ Services also must be reinstated if the state agency takes action without issuing the required notice.⁷¹ If a beneficiary receives continued services while the appeal is pending, and the state agency's decision ultimately is upheld at the hearing, the Medicaid agency may be allowed to recover costs of continued benefits from the beneficiary.⁷²

Conclusion

For more than 50 years, the Medicaid program has helped ensure that low income and underserved persons can obtain medically necessary services and benefits, and, if needed, challenge unlawful coverage denials.

The due process protections of notice and fair hearing are guaranteed under the U.S. Constitution and cannot be eliminated by legislation. However, pending legislative proposals threaten to undermine Medicaid protections and, ultimately, reduce or eliminate coverage and access to care. For example, Republican governors seek the authority to freeze eligibility and enrollment, limit prescription drug coverage, and end mandatory services such as the enhanced benefits for children (Early and Periodic Screening, Diagnostic and Treatment), and eliminate program requirements such as statewide and comparability.⁷³

The Republican reconciliation bill (American Health Care Act) to repeal the Affordable Care Act, and impose Medicaid per caps or block grants, similarly proposes to end requirements for comparability, amount, duration and scope, and statewide. ⁷⁴ Newly confirmed HHS Secretary Tom Price and CMS Director Seema Verma outlined their plan to provide greater flexibility to states in Section 1115 demonstration projects, and to review the recently updated regulations on Medicaid managed care.⁷⁵ Moreover, legislation to fundamentally alter Medicaid's financing structure is part of the current Republican leadership's broader agenda to dismantle the Medicaid program as we know it, leaving up to 24 million people without any health coverage.⁷⁶

ENDNOTES

¹ Ctr's. for Medicare & Medicaid Serv's., MEDICAID AND CHIP APPLICATION, ELIGIBILITY DETERMINATION, AND ENROLLMENT REPORT (Dec. 2016) available at <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>.

² 42 U.S.C. § 1396a.

³ See e.g., Letter from John Kasich, Gov. of Ohio, et.al, to Senate Majority Leader Mitch McConnell and House Speaker Paul Ryan, March 16, 2017, available at http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=S_gEqkALBFY%3d&tabid=160.

⁴ CBO, COST ESTIMATE - AMERICAN HEALTH CARE ACT BUDGET RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEES ON WAYS AND MEANS AND ENERGY AND COMMERCE (March 9, 2017) available at <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf>.

⁵ NHeLP, *What Makes Medicaid, Medicaid? Services* (March 1, 2017) available at

<http://www.healthlaw.org/publications/browse-all-publications/what-makes-medicaid-medicaid-services>

⁶ 42 U.S.C. § 1396a(a)(17). See S. Rep. No. 89-404 (1965), reprinted in 1965 U.S.C.C.A.N. 1943, 1986 ("Congress intended medical judgments to play a primary role in determining medical necessity. . . . The Committee's bill provides that the physician is to be the key figure in determining utilization of health services -- and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs, and treatments, and determine the length of stay."

⁷ *Id.*

⁸ 42 C.F.R. § 440.230(b).

⁹ 42 C.F.R. § 440.230(c).

¹⁰ 42 C.F.R. § 440.240(a).

¹¹ 42 C.F.R. § 440.240(b).

¹² See 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r)(Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards.

¹³ Some examples of violating this requirement include: providing orthopedic shoes and compression stockings to some people who needed them, but not to others; providing more items of durable medical equipment to blind individuals than to others individuals with disabilities even though they had equivalent need for the equipment; limiting prescriptions to people living in the community but not for those living in institutions.

¹⁴ 42 U.S.C. § 1396a(a)(8).

¹⁵ 42 C.F.R. §§ 435.912, 435.930.

¹⁶ 42 U.S.C. §1396a(a)(1); 42 CFR § 431.50.

¹⁷ *Id.*

¹⁸ Sec. 1115 of the Social Security Act; see also NHeLP, *Health Advocate: Section 1115 Waivers: More than Meets the Eye*; available at <http://www.healthlaw.org/issues/medicaid/waivers/health-advocate-section-1115-waivers-more-than-meets-the-eye>.

¹⁹ 42 U.S.C. §1396a(23); 42 CFR § 431.51

²⁰ *Id.* at § 1396a(a)(23)(B); 42 C.F.R. § 431.51(b)(1); 42 C.F.R. Part 438.

²¹ State Medicaid Director Letter # 16-005 (Apr. 19, 2016).

²² *Id.*

²³ *Id.*

²⁴ *Id.*

²⁵ 42 U.S.C. §1396a(a)(5) 42 C.F.R. § 431.10.

²⁶ Kaiser Family Foundation, State Health Facts (2014) available at <http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

²⁷ 42 C.F.R. § 438.10(f)(6)(iii).

²⁸ *Id.* § 438.100(b)(2)(iii).

²⁹ *Id.* §§ 438.206, 438.208.

³⁰ 42 C.F.R. §§ 438.100; 438.102.

³¹ 42 C.F.R. 438.100(b)(2)(iv).

³² 42 U.S.C. § 1396u-2(a)(3)(A); 42 C.F.R. § 438.52(a). In rural areas, states can require enrollment in just a single managed care entity; however, that plan must provide consumers a choice of more than one physician or case manager. 42 U.S.C. § 1396u-2(a)(3)(B); 42 C.F.R. § 438.52(b). Certain county-operated plans, such as those operated under the MediCal program in California, also do not have to offer a choice in MCOs. See 42 U.S.C. § 1396u-2(a)(3)(C); 42 C.F.R. § 438.52(c).

³³ See generally 42 C.F.R. § 438.10.

³⁴ *Id.*

³⁵ 42 C.F.R. § 438.56.

³⁶ 42 C.F.R. § 438.10(f)(6)(vii).

³⁷ 42 C.F.R. § 438.10(g)(2)(vii).

³⁸ 42 C.F.R. § 438.10.

³⁹ 42 C.F.R. § 438.71(a).

⁴⁰ 42 C.F.R. §§ 438.71(b)(1) and (c).

⁴¹ 42 C.F.R. § 438.71(d).

⁴² 42 C.F.R. § 438.228.

⁴³ 42 C.F.R. § 438.400(b).

⁴⁴ 42 C.F.R. §§ 438.66(b)(2), (e)(2)(v).

⁴⁵ See generally *Bd. of Regents v. Roth*, 408 U.S. 564, 577 (1972).

⁴⁶ See U.S. Const., amend. XIV, § 1.

⁴⁷ 397 U.S. 254 (1970) (holding that when welfare benefits are terminated, the beneficiary has due process rights to an effective notice and pre-termination hearing); see also 42 C.F.R. § 431.205(d).

⁴⁸ 42 C.F.R. § 431.201; 42 CFR 435.917.

⁴⁹ CMS State Medicaid Manual, § 2900.3, available at <https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

⁵⁰ 42 C.F.R. § 431.206(e).

⁵¹ 42 C.F.R. §§ 431.201; 431.210.

⁵² 42 C.F.R. § 431.211.

⁵³ 42 C.F.R. §§ 438.404; 438.420.

⁵⁴ See 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200-431.250; 42 C.F.R. § part 438 (complaint procedures for managed care systems); see also *Id.* at § 431.205(d) (explicitly requiring hearing system to meet *Goldberg* standards).

⁵⁵ 42 C.F.R. § 431.221.

⁵⁶ *Id.*

⁵⁷ *Id.* at § 431.221(b).

⁵⁸ 42 C.F.R. § 431.220(b).

⁵⁹ 42 C.F.R. § 431.242.

⁶⁰ 42 C.F.R. § 431.240.

⁶¹ CMS State Medicaid Manual, § 2902.9, available at <https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

⁶² *Id.*

⁶³ *Id.*

⁶⁴ 42 C.F.R. § 431.224(a).

⁶⁵ 42 C.F.R. § 431.244(a).

⁶⁶ *Id.* at § 431.244(d).

⁶⁷ 42 C.F.R. §§ 431.230; 438.420

⁶⁸ *Id.*

⁶⁹ *Id.*; *See also* § 431.231.

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² 42 C.F.R. §§ 431.210; 431.230.

⁷³ *See Governors' Letter, supra* note 4, at 7-8.

⁷⁴ American Health Care Act of 2017, H.R. 1628, Managers Amend. #5 offered by the Hon. Greg Walden and Kevin Brady (Mar. 20, 2017).

⁷⁵ Letter from HHS Sec. Tom Price and CMS Administrator Seema Verma to Governors, Mar. 15, 2017, at 2, available at <https://www.hhs.gov/sites/default/files/sec-price-cms-admin-verma-ltr.pdf>.

⁷⁶ Jeff Stein, Vox, The GOP's "three-pronged" health care strategy, explained (Mar. 16, 2017) available at <http://www.vox.com/policy-and-politics/2017/3/16/14921772/three-prongs-gop-health-care>; CBO, *supra* note 5.