20-1463

In the United States Court of Appeals
for the Second Circuit

Rosalind Bellin, on behalf of herself and all others similarly situated,
Plaintiff-Appellant,

v.

Howard A. Zucker, M.D., J.D., in his official capacity as Commissioner, New York State Department of Health, ElderServe Health, Inc., DBA RiverSpring at Home,
Defendants-Appellees.

On Appeal from the United States District Court
for the Southern District of New York, No. 1:19 CV 5694 (AKH)
Honorable Alvin Hellerstein, U.S. District Judge

BRIEF OF *AMICI CURIAE* NATIONAL HEALTH LAW PROGRAM, CENTER FOR MEDICARE ADVOCACY, AND JUSTICE IN AGING IN SUPPORT OF APPELLANT ROSALIND BELLIN AND REVERSAL

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, *amici curiae* National Health Law Program, Center for Medicare Advocacy, and Justice in Aging disclose that they have no parent corporations and are nonprofit entities that issue no stock. Accordingly, no publicly held corporation owns 10 percent or more of their stock.

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INTEREST OF *AMICI CURIAE*

The *amici* file this brief pursuant to Fed. R. App. P. 29. All parties have consented to its filing.[1]

The National Health Law Program (NHeLP), founded in 1969, protects and advances health rights of low-income and underserved individuals and families. NHeLP advocates, educates and litigates at the federal and state levels to advance health and civil rights in the U.S. NHeLP has worked with the Medicaid program since its inception and has decades of experience working with notice and hearing rights in Medicaid programs and Medicaid delivery systems.

The Center for Medicare Advocacy is a national, nonprofit law organization that provides education, advocacy, and legal assistance to help older adults and people with disabilities access Medicare and necessary health care. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, those in need of long-term care, and individuals who are dually eligible for Medicare and Medicaid. It provides training regarding Medicare and health care rights throughout the country. The Center also advocates on behalf of beneficiaries in

[1] Pursuant to Fed. R. App. P. 29(a)(4)(E), counsel for *amici curiae* states that no counsel for a party authored this brief in whole or in part and no person, other than *amici curiae*, their members, or their counsel made a monetary contribution to its preparation or submission.

administrative and legislative forums and serves as legal counsel in litigation of importance to Medicare beneficiaries and others seeking health coverage.

Justice in Aging's principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of legal aid attorneys and other local advocates, we seek to ensure the health and economic security of older adults with limited income and resources.

Since 1972, Justice in Aging (formerly the National Senior Citizens Law Center) has worked to promote the independence and well-being of low-income older adults, especially women, members of the LGBTQ community, people of color, people with disabilities and people with limited English proficiency. We work to ensure access to public benefit programs that allow low-income older adults to live with dignity and independence. Much of our work involves advocacy for health services and programs, including Medicare and Medicaid. We are concerned about restrictions on access to administrative appeals and the due process rights of older adults who rely on these programs.

SUMMARY OF ARGUMENT

Medicaid is the 55-year old public insurance program for low-income people. It is the largest source of publicly funded health coverage in the United States. Millions of people rely on Medicaid for coverage of services to treat their health

needs, including long term services and supports. The Medicaid program is governed by a detailed statutory and regulatory scheme that sets forth beneficiary rights, eligibility and service coverage, and financial and administrative requirements. These requirements are intended to ensure that beneficiaries receive the services they need and to safeguard expenditure of public funds. Since its inception, the Medicaid Act has recognized that individuals have the right to a fair hearing to challenge denials of eligibility or services. This right is also a bedrock constitutional principle, guaranteed by the Due Process Clause of the Fourteenth Amendment. It is well settled that Medicaid beneficiaries seeking coverage of services have a protected property interest in those services, notwithstanding the fact that the standards governing awards of those benefits incorporate medical judgment.

The Medicaid statute and regulations provide states with flexibility to adapt their programs in different ways, thus the Medicaid program has evolved over the years. One significant way that program has changed is that states now provide most of their services through managed care plans, rather than paying providers on a fee-for-service basis. Many states, including New York, contract with Managed Care Organizations (MCOs), which provide services in exchange for a fixed payment per enrollee. This gives MCOs the incentive to limit costs which, in turn, can lead them to provide less or lower quality care than beneficiaries need.

To guard against this practice, Congress enacted a robust set of protections for the individuals who are to receive care through managed care plans. These protections include a requirement for managed care plans to operate an internal grievance and appeal system through which enrollees can challenge denials or reductions of services. Notably, these internal managed care processes are in addition to the already-existing statutory and constitutional rights to a state fair hearing and were never intended to supplant it. In other words, regardless of whether the individual is enrolled in managed care, they retain their basic constitutional and Medicaid statutory rights to an impartial and meaningful administrative state fair hearing.

In this case, when RiverSpring first denied Plaintiff-Appellant Rosalind Bellin (Ms. Bellin) 16 of the 24 hours of personal care that she requested, it denied her an internal MCO appeal to challenge that determination. After she enrolled, she was told she could not appeal a pre-enrollment decision. Notwithstanding the existence of constitutional, statutory, and regulatory protections designed to prevent wrongful denials of services, the District Court affirmed that decision and also held that she had no right to a state fair hearing to challenge the denial. The State's and MCO's conduct, supported by the District Court's decision, strands Ms. Bellin and other beneficiaries like her in a state-created limbo where they are not afforded their due

process rights. This reasoning undermines the clear intent of Congress and the federal Medicaid agency.

ARGUMENT

I. Introduction

For 55 years, the Medicaid program has provided health coverage to low-income people in the United States. It is the largest public insurer in the country, covering more than 65 million adults and children. March 2020 Medicaid & CHIP Enrollment Data Highlights, Medicaid.gov, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html, (last visited June 26, 2020). New York's Medicaid program is one of the largest in the country, covering 5.3 million people. *Id.* Medicaid beneficiaries, many of whom are over 65 or have disabilities, have no other meaningful access to health insurance or health care services. The program is particularly important for people with chronic needs like Rosalind Bellin, who need long term care services and supports (LTSS) to live safely and independently in their homes.

The vast majority of Medicaid beneficiaries in the U.S. and in New York receive services through Managed Care Organizations (MCOs). Because Medicaid managed care is designed to control costs and save money for states, there are built-in incentives to offer as few services as possible. And, LTSS can be very costly,

which, as discussed below, can cause plans to try to avoid the expense of covering them. The most important safeguards against wrongful denial of services are the robust due process rights and protections imposed by federal law, including the right to challenge denials and delays of services.

New York's system for providing LTSS exacerbates the problematic incentives in managed care. Once found eligible for LTSS, the Medicaid beneficiary is able to select an MCO. Before she enrolls, however, the MCO will determine how many hours of services it will provide to the beneficiary. Appellant's Br. at 16, ECF 30. If the MCO offers fewer services than needed, this can induce beneficiaries not to enroll or, if they do, to accept fewer services than they need. In either situation, the MCO saves money either by limiting coverage of services or avoiding enrolling a high-needs beneficiary.

The District Court's decision would insulate MCOs and the state Medicaid agency from the consequences of this practice by barring access to either an internal MCO hearing or a state hearing when they are partially denied what they requested. This practice thus strands Medicaid beneficiaries in an artificial, state-created limbo that ignores the constitutional, statutory and regulatory provisions designed to ensure that all Medicaid beneficiaries, including those enrolled in MCOs, receive a timely and robust notice and appeal process.

II. History and Background of Medicaid and Managed Care

Medicaid is a cooperative federal-state program governed by federal and state laws and policies, overseen by the U.S. Department of Health and Human Services (HHS), and administered by a "single state agency" responsible for implementation of the program at the state level. 42 U.S.C. § 1396a(a)(5). State Medicaid programs are financed by a combination of federal and state funds; the federal government matches at least 50% of state expenditures for the program. 42 U.S.C. § 1396b. Federal Medicaid statute and regulations set forth the requirements of the program, including program administration, categories of individuals who are eligible, services covered, and rights to notice and opportunity for a hearing. 42 U.S.C. §§ 1396-1396w-5; 42 C.F.R. pts. 430-456. One of the fundamental requirements of the Medicaid program is the right to an opportunity for a hearing when eligibility or services are denied or not acted upon with reasonable promptness. 42 U.S.C. § 1396a(a)(3).

Medicaid is the primary payer for long term care services and supports (LTSS), which provide assistance with activities of daily living, such as eating, dressing, bathing, preparing meals, housekeeping, and medication management. *See* Erica L. Reaves & MaryBeth Musumeci, Kaiser Family Found., *Medicaid and Long-Term Services and Supports: A Primer*,

https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/ (Dec. 15, 2015). States must cover nursing home and home health services and, may also cover rehabilitative, personal care, or private duty nursing services, as well as physical, occupational, and speech therapy for adults. 42 U.S.C. § 1396d(a).[2] States may also obtain approval from HHS to offer waiver programs to provide home and community based services to individuals who would otherwise need the level of care provided in an institution. 42 U.S.C. § 1396n(c). Medicaid is the single largest payer for long term care services in the U.S., covering more than half of all long term care costs. *See* Reaves & Musumeci, *Medicaid and Long-Term Services and Supports: A Primer*; Medicaid.gov, Long Term Services and Supports, https://bit.ly/2VI9Ha5 (last visited July 3, 2020).

States also have options as to how they deliver covered Medicaid services. The Medicaid statute provides beneficiaries the right to obtain services from any enrolled provider. 42 U.S.C. § 1396a(a)(23). At Medicaid's inception in 1965, services were typically covered through fee-for-service, with the Medicaid agency reimbursing health care providers based on claims they submitted for each service rendered. By the early 1980s, states could obtain waivers from HHS that gave them

[2] Children and youth under age 21 are entitled to all medically necessary services listed in the Medicaid statute, regardless of whether they are optional for adults. 42 U.S.C. §§ 1396d(a)(4)(B), 1396d(r).

permission to require beneficiaries, typically families and children, to enroll in MCOs for their care. 42 U.S.C. §§ 1315, 1396n(b).

In 1997, Congress amending the Medicaid Act to allow states to restrict beneficiaries to managed care without requesting a waiver, subject to certain restrictions.[3] Balanced Budget Act of 1997 (BBA), Pub. L. No. 150-33 (1997), (codified at 42 U.S.C. § 1396u-2 (2000)). The statute and regulations define the types of managed care entities that states can employ. Most Medicaid beneficiaries receive services through MCOs, which contract with the single state agency to provide comprehensive Medicaid services in exchange for a fixed per member (capitated) rate. This arrangement is known as a "risk contract," because the MCOs assume the financial risk that services may cost more than the amount of the capitated payment. 42 U.S.C. §§ 1396b(m)(1)(A), 1396u-2(1)(B); 42 C.F.R. § 438.2 The other types of managed care are Primary Care Case Management (PCCM), in which a primary care provider receives a per patient case management fee for services rendered on a fee for service basis, and Prepaid Health Plans, which provide less than a comprehensive range of services on a capitated basis. 42 C.F.R. § 438.2.

[3] States using this statutory authority for mandatory enrollment in managed care cannot require enrollment of children with special needs, Medicare beneficiaries, or Native Americans (unless the Indian Health Service or a tribe acted as a managed care entity). 42 U.S.C. § 1360u-2(a)(2).

Over the years, managed care enrollment has grown dramatically. In 1981, only about 250,000 Medicaid beneficiaries were enrolled in managed care. Medicaid Managed Care, 63 Fed. Reg. 52022 (proposed rule) (Sept. 29, 1998). Now, managed care is the most prevalent delivery system in Medicaid by far. In 2017, more than 54 million people received nearly all of their services from capitated MCOs – 69 percent of all Medicaid beneficiaries. More than $254 billion in public funds were paid to Medicaid MCOs in 2018, with $39 billion paid to MCOs in New York. Kaiser Family Found., State Health Facts, Total Medicaid MCO spending, https://bit.ly/3gvBxOR (last visited June 26, 2020).

State Medicaid agencies are increasingly providing coverage for LTSS through managed care, most often MCOs. Elizabeth Hinton et al., *10 Things to Know About Medicaid Managed Care*, (Dec. 15, 2019), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/. In 2017, twenty four states were operating managed long-term services and supports (MLTSS) programs in which 1.8 million Medicaid beneficiaries were enrolled. Most of these programs served older adults and those with physical disabilities. Medicaid spending for MLTSS more than doubled between 2012 and 2015, and growth is expected to continue. Elizabeth Lewis et al., Truven Health Analytics, *The Growth of Managed Long Term Services and Supports Programs: 2017 Update* at 3-4, (Jan. 29, 2018). New York is a leader in this growing trend,

serving more than 200,000 Medicaid beneficiaries in its Managed Long Term Care (MLTC) programs. *Id.* at 10.

III. Managed Care Beneficiary Protections

Medicaid notice and fair hearing rights are an essential requirement of the program. The statute provides the basic right to an opportunity for hearing before the state agency when a claim for eligibility or services are denied or not acted upon with reasonable promptness. 42 U.S.C. § 1396a(a)(3). Regulations dating back to 1971 flesh out this right, defining the actions that give rise to notice and opportunity for a hearing, specifying contents of the written notice, describing when a hearing is required, and establishing procedures for conducting the hearing. 42 C.F.R. §§ 431.200-.246.

When enacting and implementing the 1997 Medicaid managed care amendments, Congress and HHS recognized that protections were necessary to ensure that people actually receive the services they need and that public funds must actually be spent on health care and services. *See, e.g.*, H.R. Rep. No. H6335-02 (1997) (Conf. Rep.) (remarks by Rep. Dingell praising the "vital improvements" the legislation makes to the Medicaid program to protect consumers); Medicaid Managed Care, 66 Fed. Reg. 6228, 6229 (Jan. 19, 2001) (Final Rule) ("[T]he [Medicaid managed care] rule was developed with a clear emphasis on consumer protections. We have addressed the issues identified by advocates regarding the

rights of Medicaid beneficiaries, particularly vulnerable populations, and how they can be protected as State agencies increasingly replace fee-for-service Medicaid delivery systems with managed care programs.").

Not surprisingly, the Medicaid Act and regulations include a variety of protections and beneficiary rights in managed care delivery systems.

Grievance and appeal. Medicaid MCOs must establish internal grievance procedures that enable beneficiaries to challenge denials of coverage or payment for services and to file grievances about problems that do not give rise to appeal rights. 42 U.S.C. § 1396u-2(b)(4). Federal regulations set forth the scheme that governs the internal appeal process that applies when an enrollee receives an "adverse benefit determination." 42 C.F.R. §§ 438.400-.424. This system provides for an internal appeal, with a further right to access a state fair hearing if a beneficiary is dissatisfied with the results. 42 C.F.R. § 438.402(c).

These requirements complement and do not supplant the basic right that Medicaid beneficiaries to a state hearing when a "claim for medical assistance is denied or not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3). Regulations flesh out this statutory right, specifying that the right is available when an agency takes an erroneous action or denies an individual's claim for covered benefits or services. 42 C.F.R. § 431.220(a)(1). HHS has emphasized that "all [Medicaid] beneficiaries, in including those enrolled in MCOs . . . have access to

the fair hearing process." Medicaid Managed Care, 66 Fed. Reg. 6228, 6341(Jan. 19, 2001) (final rule with comment period); *see also* 63 Fed. Reg. 52022, 52054 ("this proposed regulation . . . would explicitly reflect . . . [the federal agency's] longstanding policy that managed care enrollees are entitled to a hearing in the State fair hearing process . . . We also make clear that . . . an internal grievance policy does not substitute for a right to a State fair hearing.").

Information. Information about the basic features of managed care, services covered, enrollment and disenrollment rights, cost sharing, available providers, and the right to challenge determinations made by MCOs must be made available to Medicaid beneficiaries. State Medicaid agencies have the responsibility for providing information to potential enrollees, while MCOs have obligations to current enrollees. 42 U.S.C. § 1396u-2(a)(5), 42 C.F.R. § 438.10(e)-(g). There is also a restriction on deceptive or fraudulent marketing practices and provision for oversight of marketing activities. 42 U.S.C. § 1396u-2(d)(2); 42 C.F.R. § 438.104.

Enrollment and disenrollment. In mandatory managed care systems such as the one being employed in New York, Medicaid beneficiaries are required to enroll in MCOs and, if they do not select a plan, will usually be auto-enrolled in a plan by default. 42 U.S.C. § 1396u-2(a)(4); 42 C.F.R. § 438.54(c)(2). Congress required that enrollees be able to disenroll from a plan for cause at any time and without cause during the initial 90 day period after receiving notice of enrollment and at least every

12 months. *Id.* § 1396u-2(a)(4)(A); 42 C.F.R. § 438.56. "Cause" can include poor quality of services, moving out of a service area, or lack of access to covered services, including a plan's failure to cover services because of religious or moral objections. 42 C.F.R. § 438.56.

Network adequacy and access to services. Because MCO enrollees are restricted to the plan's network of providers to receive services, it is crucial that the plan ensure that those services are actually available. As an initial matter, states must ensure that their MCOs and other managed care plans have the capacity to serve the expected enrollment, offer an appropriate range of services for enrollees, and maintain a sufficient number, mix, and geographic distribution of service providers. 42 U.S.C. § 1396u-2(b)(4); 42 C.F.R. §§ 438.206-.207. Potential enrollees must be given a choice of at least two managed care plans, with limited exceptions. 42 U.S.C. § 1396u-2(a)(3); 42 C.F.R. § 438.52. The regulations require state agencies to develop and enforce standards to ensure that the MCO's network is adequate, including developing time and distance standards for many types of care, including primary and hospital care, pharmacy, behavioral health, and other specialty care. 42 U.S.C. § 1396u-2(c)(1)(A)(i); 42 C.F.R. § 438.68. States most also arrange for continued services to enrollees when an MCO contract is terminated or the beneficiary is disenrolled for reasons other than ineligibility for Medicaid. 42 C.F.R. § 438.62.

Quality Assurance and Monitoring. States must develop and implement a quality assessment and improvement system that includes standards for access to care, monitoring, and periodic review, consistent with standards developed by HHS. 42 U.S.C. § 1396u-2(c); 42 C.F.R. § 438.310-.370.

These detailed provisions are intended to ensure that managed care delivery systems provide quality services to enrollees and continuity of services to those entering and leaving the managed care system. The District Court's perception that the managed care delivery system can interrupt and curtail individuals' statutory and due process rights is directly at odds with the congressional design.

IV. New York's Atypical Program Exacerbates the Problematic Incentives Inherent in Risk-Based MCO Systems.

It is widely recognized by federal agencies and scholars that risk-based MCOs create incentives to deny care. The federal Medicaid and CHIP Payment and Access Commission (MACPAC), an agency that provides policy and data analysis and makes recommendations to Congress, HHS, and the States, cautioned that "paying MCOs [based on] a set amount per enrollee and not on how much treatment is provided may create incentives to undertreat patients to minimize treatment costs. . . . Capitated plans may also seek to enroll as many healthy patients as possible and discourage participation of disabled or high utilizing enrollees." Medicaid and CHIP Payment and Access Commission, *Managed Care's Effect on Outcomes*, https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/ (last visited

July 3, 2020) (collecting studies); *see also, e.g.*, Ilyana Kuziemko et al., *Do Insurers Risk-Select Against Each Other? Evidence from Medicaid and Implications for Health Reform* at 10, National Bureau of Economic Research (July 2013), https://www.nber.org/papers/w19198.pdf ("Managed care plans under capitation have an incentive to compete for low-cost enrollees and appear unattractive to high-cost enrollees in the hope they will join a competing plan in the next period."). This risk is particularly true with regard to managed LTSS, because of the high and ongoing needs of the population. Reaves & Musumeci, *Medicaid and Long-Term Services and Supports: A Primer* at 9.

For this reason, due process rights are crucial. The Office of the Inspector General of HHS last year announced a review into whether Medicaid MCOs complied with federal requirements when denying access to requested services, noting that the MCO's "contractual arrangement shifts financial risk for the costs of services from the State Medicaid agency and the Federal Government to the MCO, which can create an incentive to deny beneficiaries' access to covered services." U.S. Dep't of Health and Human Servs. Office of Inspector Gen., *Medicaid Managed Care Organization Denials*, https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000370.asp (last visited July 3, 2020).

The structure of New York's Medicaid MLTC system heightens the risks that MCOs will deter or underserve high needs beneficiaries, yet makes it more difficult to challenge MCO coverage decisions. Like all other Medicaid programs that employ MCOs, New York's MLTC MCOs receive a fixed capitated rate for each member. In other words, the payment does not vary based on the services provided. *See* Suppl. Letter to J. Hellerstein, *Bellin v. Zucker,* -- F. Supp. 3d --, 2020 WL 2086009 (S.D.N.Y. 2020), ECF No. 60. Beneficiaries found eligible for Medicaid and LTSS apply to one of the participating MCOs for the home care services they need. After the MCO evaluates them, it determines the amount of services it will provide. Appellant's Br. at 16, ECF No. 30. Unlike the managed care systems in other states, however, the MCO makes a determination of how many hours it will provide *before* an individual is enrolled. Thus, MCOs can effectively deter high-needs beneficiaries from enrolling. Or, if the beneficiary does enroll, the MCO will save money by providing fewer hours of services. Though the State does not limit the number of MCOs to which a beneficiary may apply, this does not help, because any MCO in the system has the same incentive to fully or partially deny services.

Indeed, the concern that allowing MCOs to determine the amount of services in this way would lead to limits has been borne out by a report on fair hearing appeals in New York. According to this report, in the six month period after MCOs began performing assessments for service needs, denials and reductions of home care

services increased by nearly 600 percent. Medicaid Matters NY, *Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by MLTC Plans June-Dec. 2015* at 4 (July 2016). Without the ability to effectively challenge these decisions, beneficiaries have no redress.

V. Ms. Bellin Has Alleged a Valid Due Process Claim

The District Court's dismissal of Ms. Bellin's Fourteenth Amendment Due Process claim disregards the longstanding principle that individuals are protected against deprivations of government benefits without procedural safeguards, including deprivations of benefits offered by public health programs. It also depends on the erroneous premise that Ms. Bellin cannot have a protected property interest in the Medicaid coverage she seeks because MCOs have some amount of discretion in making initial determinations of the amount of personal care services an enrollee receives. *Bellin*, 2020 WL 2086009, at *6. As explained below, the District Court's brief examination of Ms. Bellin's due process claim did not apply the correct analytical framework.

A. It is Well-Settled that Due Process Protections Attach to Public Benefits, Including Those That Involve Medical Judgment.

To state a due process claim, a plaintiff must allege deprivation of a liberty or property interest. *Barrows v. Burwell*, 777 F.3d 106, 113 (2d Cir. 2015). A person's interest in a government benefit is a protected property interest "if there are rules or

mutually explicit understandings that support his claim of entitlement to a benefit and that he may invoke at a hearing." *Perry v. Sindermann*, 408 U.S. 593, 601 (1972). *See also Sealed v. Sealed*, 332 F.3d 51, 56-57 (2d Cir. 2003). The source of the rules or understandings may be formal, such as statutes or regulations, or informal, such as "unwritten common law and informal institutional policies and practices." *Furlong v. Shalala*, 156 F.3d 384, 395 (2d Cir. 1998).

In the public benefit context, a person has a protected property interest if she is entitled to the benefit assuming all enumerated criteria have been met. *Kapps v. Wing*, 404 F.3d 105, 112 (2d Cir. 2015) (because the "award of [home heating] benefits to qualified applicants" was non-discretionary, applicants had a property interest). It is this "legitimate claim of entitlement," as opposed to an "abstract need or desire" for the benefit that forms the basis for a protected property interest. *Bd. of Regents of State Colleges v. Roth*, 408 U.S. 564, 577 (1972). Applicants for benefits, as well as current recipients, may have an interest protected by due process. *Kapps*, 404 F.3d at 112. Because individuals who meet the eligibility requirements for programs such as Medicaid, Medicare, and Social Security cannot be denied covered benefits, those individuals are consistently afforded constitutional due process protection. *Id.* at 113 ("Social welfare benefits have long been afforded constitutional protection as a species of property protected by the federal Due Process Clause.") (citing *Goldberg v. Kelly*, 397 U.S. 254, 262 & n.8 (1970)).

Furthermore, courts have consistently found or assumed a protected property interest in benefits governed by standards that *necessarily* incorporate medical judgment, including Social Security Disability Insurance, Medicare, and Medicaid. *E.g.*, *Mathews v. Eldridge*, 424 U.S. 319, 332, 336 (1976) (Social Security disability benefits dependent on a finding of medical impairment constitute a protected property interest); *Catanzano by Catanzano v. Dowling*, 60 F.3d 113, 115, 120 (2d Cir. 1995) (due process protections applied to determinations of eligibility for and amount of Medicaid home health services); *Kraemer v. Heckler*, 737 F.2d 214, 222 (2d Cir. 1984) (same for Medicare coverage of physical therapy); *Gray Panthers v. Schweiker*, 652 F.2d 146, 166-67 (D.C. Cir. 1980) (same for Medicare claims of less than $100); *see also Russell v. Dunston*, 896 F.2d 664, 668 (2d Cir. 1990) (New York State disability retirement benefits dependent on proving permanent disability were "a constitutionally protected property interest for purposes of Section 1983.").

The District Court nonetheless departed from the historic treatment of due process rights in public benefit programs and held that simply because the regulations governing personal care services "leave room for discretion" and "require medical judgment" on the part of the MCOs, Ms. Bellin could have no protected property interest. *Bellin*, 2020 WL 2086009, at *6. By this reasoning, *no* benefit involving medical judgment could be afforded due process protections. As

demonstrated by cases such as *Eldridge*, *Catanzano*, and *Kraemer*, however, that is not correct.

B. The District Court's "Protected Property Interest" Analysis Was Incorrect.

As this Court has recognized, the standard for determining whether a protected property interest exists is whether the relevant statutes, regulations, or other guidance "*meaningfully channel[]* official discretion by mandating a defined administrative outcome." *Barrows*, 777 F.3d at 113-14 (internal quotations marks omitted) (quoting *Sealed*, 332 F.3d at 56) (emphasis added). By the plain terms of that standard, elimination of discretion is not required. Rather, courts have examined "two entirely distinct uses of the term discretion" within the standard: (1) whether substantive predicates govern official decision-making, and (2) whether an outcome is mandated assuming the enumerated criteria have been met. *Bd. of Pardons v. Allen*, 482 U.S. 369, 375 (1987); *see also Sealed*, 332 F.3d at 56.[4] Discretion is permissible in the first inquiry, *i.e.*, the application of criteria. It is only where conferral of a benefit itself is discretionary, *i.e.*, if the benefit may be denied *even if the plaintiff satisfies all relevant criteria*, that there is no property interest for due process purposes. *See, e.g. NB ex rel. Peacock v. District of Columbia*, 794 F.3d 31,

[4] As noted by Ms. Bellin, the Supreme Court and this Court have applied the analysis for liberty interests, as in *Allen* and *Sealed*, to property interests. Appellant's Br. at 42, ECF No. 30.

41-42 (D.C. Cir. 2015) (finding Medicaid beneficiaries had property interest in prescription drug coverage where government retained no discretion to deny claims for which coverage conditions were met).

Thus, contrary to the District Court's presumption, the mere presence of discretion in determining whether criteria are met does not negate a protected property interest. *See, e.g.*, *Ciambriello v. County of Nassau*, 292 F.3d 307, 314-15 (2d Cir. 2002) (finding property interest in a position that required assessing employee's "ability" and "adaptability"); *Parks v. Watson*, 716 F.2d 646, 657 (9th Cir. 1983) ("[A] determination as to whether the public interest will be prejudiced, while obviously giving a certain amount of play in the decisional process, defines an articulable standard" and gives rise to a property interest).

The District Court also mischaracterized *Alexander v. Azar*, 370 F. Supp. 3d 302 (D. Conn. 2019). *See Bellin*, 2020 WL 2086009, at *6. That opinion does not stand for the proposition that any amount of discretion in determining whether enumerated criteria have been met precludes the existence of a property interest. On the contrary, the *Alexander* court explicitly stated that "incorporation of discretion into a legal standard does not necessarily prevent the standard from creating an interest protected by the Due Process Clause." 370 F. Supp. 3d at 316. It went on to examine whether Medicare beneficiaries could be denied inpatient hospital coverage assuming they *did* meet the relevant criteria. *Id.* at 316-19; *see also Alexander v.*

Azar, -- F. Supp. 3d --, 2020 WL 1430089 at *28, (D. Conn. Mar. 24, 2020), appeal filed May 22, 2020 (No. 20-1642).

In this case, Ms. Bellin's allegations address both forms of discretion contained in the "meaningful channeling" standard, particularly when all reasonable inferences are drawn in her favor. First, the governing statutes and regulations place substantive limits on MLTCs in making initial determinations of the appropriate amount of personal care services. *See* Appellant's Br. at 49-57, ECF No. 30 (describing detailed, multi-step analysis that must be conducted to determine a medically necessary level of personal care services). The provisions cited by Ms. Bellin likewise set forth articulable standards that an enrollee may invoke at a hearing. *Perry*, 408 U.S. at 601. For instance, an enrollee could argue that additional hours of personal care services are required to "maintain[] the patient's health and safety in his or her own home." 18 N.Y.C.R.R. § 505.14(a)(1); *see also id.* § 505.14(a)(4) (specific factors to be considered for 24-hour care). *Cf. Catanzano*, 60 F.3d at 115 (due process protection applied to determinations of "how much home health care is medically necessary and whether that care, if any, can be provided safely in the home."). Moreover, enrollees may appeal the number of personal care hours in MLTC determinations that are made *after* initial, pre-enrollment determinations. *See* JA194 (Fair Hearing decision stating enrollee has recourse to hearing upon denial of a request for additional hours). This shows that there must be

a standard for the sufficiency of personal care services that can be invoked in a hearing and that gives rise to a property interest.

Second, the statutes and regulations mandate the conferral of personal care services for which one is found eligible. Appellant's Br. at 43-49, ECF No. 30 (citing, *inter alia*, Soc. Serv. L. § 365-a(2) (mandating that medically necessary services "shall" be paid by Medicaid); 18 N.Y.C.R.R. § 505.14(a)(5) ("personal care services *shall*…be provided in accordance with the following standards) (emphasis added); *see also* 42 U.S.C. § 1396a(a)(8) (medical assistance "*shall be furnished* with reasonable promptness *to all eligible individuals*") (emphasis added). Notably, no provision allows MLTCs to deny services to qualified individuals, or to grant fewer personal care hours than those for which an enrollee qualifies. *See NB*, 794 F.3d at 41.

In short, the District Court departed from the established treatment of due process rights in public benefit programs and conflated two meanings of "discretion" in the "meaningful channeling" standard. Accepting Ms. Bellin's allegations as true and drawing reasonable inferences in her favor, the District Court should have concluded that she plausibly alleged a due process claim. And, to the extent that factual disputes exist (*compare, e.g.*, Mar. 27, 2020 letter of State Defendant (Doc. 57) at 2 *with* amended Mar. 27, 2020 letter of Plaintiff Rosalind Bellin (Doc. 60) at

5), those differences should be resolved only after an opportunity for discovery on the topic of how determinations are made in practice. *Barrows*, 777 F.3d at 115.

CONCLUSION

For the foregoing reasons, *amici* ask the Court to affirm the opinion of the District Court.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font. I certify that the foregoing brief complies with the requirements of Fed. R. App. P. 32(A)(7)(B) and 29(a)(5), and that the total number of words in this brief is 5,518 according to the count of Microsoft Word, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

/s/Martha Jane Perkins
Martha Jane Perkins

CERTIFICATE OF SERVICE

I certify that on July 8, 2020, I served the counsel of record in this case by electronically filing the foregoing brief with the Clerk of the Court using the ECF/CM system.

/s/Martha Jane Perkins
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