In the
United States Court of Appeals
For the Second Circuit

August Term, 2024

(Argued: March 19, 2025 Decided: May 21, 2026)

Docket No. 24-341

ROSALIND BELLIN,

Plaintiff-Appellant,

–v.–

JAMES V. MCDONALD, IN HIS OFFICIAL CAPACITY AS COMMISSIONER, NEW YORK STATE DEPARTMENT OF HEALTH, ELDERSERVE HEALTH, INC., D.B.A. RIVERSPRING AT HOME,

Defendants-Appellees.[*]

B e f o r e :

CALABRESI, CARNEY, and KAHN, *Circuit Judges*.

[*] Pursuant to Federal Rule of Appellate Procedure 43(c)(2), the Clerk of Court is directed to amend the caption as reflected above. The originally named State Defendant was Howard A. Zucker, the former Commissioner of the New York State Department of Health. James V. McDonald is the current Commissioner.

Plaintiff-Appellant Rosalind Bellin appeals from a judgment of the United States District Court for the Southern District of New York (Hellerstein, *J.*) entered for Defendants-Appellees James McDonald, the Commissioner of the New York State Department of Health, and ElderServe Health, Inc., in Bellin's challenge to the appeals procedures afforded to those seeking 24-hour at-home, long-term care covered by New York State's Medicaid program.

New York covers the cost of in-home personal care services for Medicaid recipients who need assistance with everyday activities like bathing, preparing food, and walking. Some New Yorkers require only a few hours of assistance a day while others need around-the-clock care. To provide assistance, the State partners with private entities to evaluate the personal care needs of Medicaid recipients and offer them a plan of care that matches their needs. Under the State's rules, offerees have no immediate right to appeal the particular level of personal care services that they are initially offered. Instead, they must first enroll in the offered plan and then request a change in services. If the request is denied, the enrollee may appeal.

Bellin, who sought 24-hour care, was barred by these rules from appealing the initial offer she received of eight hours of daily care. She then brought this suit, challenging the State's procedures under the Fourteenth Amendment's Due Process Clause. At summary judgment, the District Court concluded that she had no cognizable property interest in 24-hour long-term care services and that, without such a property right, she was not entitled to the procedural due process protections she claimed. On *de novo* review, we disagree with the District Court that Bellin lacked a protected property interest. The laws, regulations, policies, and practices governing the determination whether a Medicaid recipient requires 24-hour personal care services substantially channel the assessor's discretion, so as to generate a property interest for qualifying recipients. That property interest, in turn, triggers procedural due process protections for the recipients. We nonetheless conclude, however, that as a matter of constitutional due process, New York's appeals procedures adequately protect that property right. We therefore affirm the District Court's grant of summary judgment to Defendants on this alternative ground.

AFFIRMED.

AYTAN Y. BELLIN, Katsky Korins LLP, New York, NY (Nina Keilin, New York, NY, *on the brief*), *for Plaintiff-Appellant Rosalind Bellin*.

MARK S. GRUBE, Senior Assistant Solicitor General (Barbara D. Underwood, Solicitor General, Ester Murdukhayeva, Deputy Solicitor General, *on the brief*), *for* Letitia James, Attorney General of the State of New York, *for Defendant-Appellee James V. McDonald*.

Sarah Michelle Gilbert, Mara R. Lieber, Crowell & Moring LLP, New York, NY, *for Defendant-Appellee ElderServe Health, Inc*.

CARNEY, *Circuit Judge*:

Plaintiff-Appellant Rosalind Bellin appeals from a judgment of the United States District Court for the Southern District of New York (Hellerstein, *J.*) entered for Defendants-Appellees James McDonald, the Commissioner of the New York State Department of Health, and ElderServe Health, Inc., d/b/a RiverSpring at Home (RiverSpring), in Bellin's challenge to the appeals procedures afforded to those seeking 24-hour at-home, long-term care covered by New York State's Medicaid program.

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AFFIRMED.

BACKGROUND

I. New York's Medicaid program

A complex web of federal and state laws, regulations, and policy directives governs the provision of long-term, at-home health care under Medicaid. We first supply an overview of how New York's Medicaid program delivers at-home care services to eligible New Yorkers. To provide a framework for our later analysis of whether qualifying Medicaid recipients in New York have a property interest in 24-

[1] Bellin's related appeal of the District Court's order denying her motion for class certification is dismissed as moot.

hour at-home care, we then explain the State's process for determining whether a Medicaid recipient is eligible for at-home care and, if so, what level of care they require. Finally, we canvass the State's existing procedures for appealing plan-of-care decisions to ground our discussion of the adequacy of those procedures.

A. Overview of covered at-home care services

The State covers the cost of at-home care for Medicaid recipients who require assistance with the tasks of daily living. N.Y. Soc. Serv. Law § 365-a(2)(e). New York law broadly defines covered at-home care, which it terms "personal care services," as "assistance with nutritional and environmental support functions and personal care functions" that are "medically necessary for maintaining an individual's health and safety in his or her own home." N.Y. Comp. Codes R. & Regs. (N.Y.C.R.R.) tit. 18, § 505.14(a)(1).[2]

Covered personal care services take a variety of forms depending on an individual's needs. As relevant here, New York regulations authorize the provision of two broad categories of personal care services. First, they authorize the provision of part-time personal care services for individuals who require help with scheduled tasks such as meal preparation or bathing. Second, they authorize the provision of 24-hour personal care services for individuals who require around-the-clock assistance with scheduled tasks or with unscheduled needs like toileting. § 505.14(a)(2), (a)(4). The latter category of care entails either a 24-hour live-in aide or multiple aides working in shifts over a 24-hour period. *Id.*

New York's Medicaid program covers the cost of delivering personal care services, but State employees do not generally provide those services directly. Instead,

[2] For legibility, we omit the reference to Title 18 of the New York Codes, Rules and Regulations in our many later citations to Section 505.14.

New York contracts with entities known as managed long-term care plans (MLTCPs), which provide these services to Medicaid beneficiaries. *See* N.Y. Pub. Health Law § 4403-f(1)(a). MLTCPs, in turn, often enlist their own network of home-care providers to fulfill their enrollees' care needs. Thus, MLTCPs, although known as "plans," are private entities responsible for coordinating and delivering personal care services for enrollees.

New York reimburses MLTCPs at a capitated rate: an MLTCP receives a fixed monthly payment for each enrollee regardless of the level of services that a particular enrollee receives. The State is also charged, under federal regulations, with providing close supervision of MLTCPs. *See, e.g.*, 42 C.F.R. §§ 438.66 (monitoring system requirements), 438.228 (grievance and appeal process requirements).

B. Eligibility and enrollment

The process that an individual must follow to enroll in personal care services is governed primarily by Section 505.14 of Title 18 of the N.Y.C.R.R.[3] Section 505.14 is a voluminous, detailed regulation, totaling nearly 25,000 words, and we provide only a summary of its most salient provisions in this Section and throughout the opinion. In short, under that regulation, the enrollment process involves two basic steps. First, the State determines whether a Medicaid recipient is eligible for personal care services at all. *See* § 505.14(b)(2)(iii)(*a*)–(*b*), (b)(4)(i). Second, if the recipient is eligible, the MLTCP

[3] The version of Section 505.14 in effect during Bellin's enrollment and subsequent appeals was enacted in 2016, but in 2021 (after Bellin filed suit), New York adopted an amended regulation. The 2021 regulation, which is currently in effect, governs Bellin's allegations of ongoing violations of federal law and her broader claims on behalf of a putative class of similarly situated individuals. *See Ex parte Young*, 209 U.S. 123, 159 (1908). We therefore cite and discuss the 2021 version of Section 505.14.

determines the level of personal care services that is appropriate for her needs. *See* § 505.14(b)(2)(iii)(*e*).

1. Initial authorization of home-based personal care services

For a Medicaid recipient to be eligible to receive personal care services, that care must be "medically necessary for maintaining [the] individual's health and safety in his or her own home." § 505.14(a)(1). Beyond this primary medical necessity requirement, beneficiaries must satisfy several other conditions. The beneficiary's health status must be "stable," and she must be "capable of making choices about [her] activities of daily living." § 505.14(a)(3)(i)–(ii) (emphasis removed). More cost-effective alternatives to at-home personal care services must also be insufficient to meet the beneficiary's needs. § 505.14(a)(3)(iii). Finally, as of the 2021 amendment to Section 505.14, beneficiaries must satisfy a "minimum needs requirement[]" to be eligible for personal care services: they must generally require physical assistance with more than two daily activities. § 505.14(a)(3)(iv).

To determine whether these threshold eligibility requirements are met, prospective enrollees must undergo a "comprehensive assessment" of their "medical, social, cognitive, and environmental needs." N.Y. Pub. Health Law § 4403-f(7)(g)(i). An independent assessor, and not the MLTCPs themselves, conducts the comprehensive assessment. This wide-ranging evaluation forms the basis for both the State's determination that a Medicaid recipient is (or is not) eligible for personal care services generally and also for the MLTCP's later "development and provision of an appropriate plan of care" for beneficiaries who are determined to be eligible. *Id.*

The assessment has two primary components. First, a registered nurse independently evaluates the individual's circumstances and needs. § 505.14(b)(2)(i)(*a*)–(*b*). To do so, nurse assessors use a tool known as the Community Health Assessment

(CHA). The CHA is a detailed questionnaire that, among other things, is designed to ensure the assessor reviews the individual's health condition in a consistent fashion with other assessors, *see* J. App'x 2507–24, and to score the individual's capacity to perform basic tasks—walking, bathing, managing medications, and so on—using a numerical rubric, *see id.* at 2516–17. Based on the results of the CHA, as well as on a review of the individual's medical records, discussions with family members, and the nurse's own observations, the nurse assessor determines whether the individual will require community-based long-term care services continuously for more than 120 days. *See* N.Y. Pub. Health Law § 4403-f(7)(b)(i).

Second, a physician, physician assistant, or nurse practitioner conducts an "[i]ndependent medical examination" of the applicant: the medical professional examines the individual, reviews the results of the independent assessment, and writes a "practitioner order" that summarizes the individual's medical condition and "indicate[s] whether the individual is self-directing and . . . medically stable." § 505.14(b)(2)(ii). If the assessor concludes that the applicant requires more than 120 days of community-based long term care services and is otherwise eligible for personal care services, the applicant is considered a "potential enrollee," and may solicit proposed plans of care from MLTCPs. N.Y. State Dep't of Health, Off. of Health Ins. Programs (DOH), MLTC Policy 14.04 (May 22, 2014), https://perma.cc/SZE3-7PA6.

2. Development of a plan of care

A potential enrollee may contact one or more MLTCPs and request that each develop a proposed plan of care. The starting point for developing such a plan is the CHA. As noted above, one section of the CHA is used to evaluate on a numerical scale the individual's capacity to perform "activities of daily living" such as getting dressed and bathing, as well as "instrumental activities of daily living," such as cleaning and

preparing meals.[4] DOH MLTC Policy 16.07 (Nov. 17, 2016), https://perma.cc/QHG4-FCAK; *see* J. App'x at 2516–17. Based on the results of the CHA, the practitioner order, the results of any approved task-based assessment tools, the potential enrollee's medical records, and other sources of information, the MLTCP prepares and proposes a plan of care.

The more extensive the contemplated care, the more constraints on care authorization the State imposes. For example, before an MLTCP may authorize more than 12 hours of services per day, it must first refer the case to an "independent medical review" panel composed of medical professionals and other clinicians. § 505.14(b)(2)(v). Such a panel reviews the assessments and documentation of the potential enrollee and may request additional information or conduct an additional evaluation. § 505.14(b)(2)(v)(*a*)–(*e*). It then prepares a nonbinding recommendation for the MLTCP on the "reasonableness and appropriateness" of the MLTCP's proposed plan of care. § 505.14(b)(2)(v)(*f*). The MLTCP must consider this recommendation before offering to provide an enrollee with more than 12 hours of daily care on average. § 505.14(a)(5)(ii)(*b*). Authorization of 24-hour personal care services such as those Bellin sought is subject to additional regulations, as described in more detail below. *See* § 505.14(a)(2), (a)(4).

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[4] MLTCPs are permitted, but not required, to supplement the CHA's findings with findings from task-based assessment tools of their choosing in developing a proposed plan of care. *See* DOH MLTC Policy 16.07. These tools are designed to help an MLTCP quantify the number of hours of care a potential enrollee will likely require, not simply assess task-level performance like the CHA. These tools must comply with New York State Department of Health guidance, and their use requires the Department's formal approval. Importantly, the tools cannot set "'one size fits all' limits" and must allow for "individualized assessment." *Id.* The Department explains that its policies bar MLTCPs from relying on task-based assessment tools to authorize 24-hour care because these tools are not designed to quantify "assistance that may be needed on a more continuous or 'as needed' basis." *Id.* For that reason, they are of limited relevance to this appeal.

After one or more MLTCPs have offered the prospective enrollee a plan of care, the enrollee then selects and enrolls in one of those plans. *See* N.Y. Pub. Health Law § 4403-f(7)(b)(vi). That plan of care becomes effective, and the enrollee begins receiving services, on the first day of the month following the date on which she enrolls or, if she enrolls after the 20th of the month, on the first day of the second month following her date of enrollment. *See* J. App'x at 45 n.1, 523–24.

C. Appeals

New York regulations afford Medicaid beneficiaries the right to appeal some personal care services determinations, but not others. Before enrollment, if the initial assessment results in a determination that an individual is altogether ineligible for personal care services, she has the right to a "fair hearing"—essentially, an administrative appeal—to contest that determination. N.Y.C.R.R. tit. 18, § 360-10.8(b)(2). If, however, an individual is determined to be eligible for personal care services but is not satisfied with the plan of care offered by an MLTCP, she has no right to contest that initial offer in any respect. In other words, only the binary eligibility determination—and not the terms of the offered plan of care itself—is at this point subject to challenge.

After enrollment, and once a beneficiary starts receiving care, her appeal options expand. As most relevant here, she may at any time request an increase in care, and if the request is denied, she may immediately appeal that denial. N.Y.C.R.R. tit. 18, §§ 360-10.3(a)(1) (defining appealable actions to include "denial or limited authorization of a requested service, including type or level of service"), 360-10.8(b)(5). The initial offer is not a similarly appealable action under Section 360-10.3(a)(1), however, because that offer reflects an assessment of the "appropriate services the MLTCP can offer a potential enrollee" rather than a decision on "a particular service request"—even if the prospective enrollee has declared that she would prefer more coverage than the MLTCP offered. J. App'x at 47.

Federal regulations set deadlines for the adjudication of requests for increased care and appeals of denials of such requests. They generally require MLTCPs to provide a decision within seven days of receiving a post-enrollment request for increased services. 42 C.F.R. § 438.210(d)(1)(i)(A). Until 2026, that period was 14 days, and it was this longer decision window that governed the proceedings giving rise to Bellin's suit. *See id.* § 438.210(d)(1)(i)(B). Federal regulations permit extensions of the decision timeframe if an MLTCP submits a request to the Department of Health and "justifies . . . a need for additional information and how the extension is in the enrollee's interest." *Id.* § 438.210(d)(1)(ii)(B). Further, federal regulations compress the decision timeframe if the standard timeline "could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function." *Id.* § 438.210(d)(2)(i). In such emergency cases, the MLTCP must provide a decision "as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service." *Id*.

Under any of these decisions timelines, the applicant may appeal any adverse benefit determination internally to the MLTCP once the MLTCP provides a decision. *Id.* § 438.402(c)(1)(i); *see also* 42 U.S.C. § 1396u-2(b)(4); 42 C.F.R. § 438.402(c)(2)(ii). MLTCPs must generally resolve these internal appeals within 30 days. 42 C.F.R. § 438.408(b)(2). Just as with the initial decision, they may extend this timeframe by "show[ing] . . . that there is need for additional information and how the delay is in the enrollee's interest." *Id.* § 438.408(c)(1)(ii). In expedited appeals, MLTCPs must provide a decision within 72 hours. *Id.* § 438.408(b)(3).

If the enrollee's internal appeal affirms the adverse benefit determination, she may request an external appeal: a State-administered "fair hearing." *Id.* § 438.408(f)(1); *see* N.Y.C.R.R. tit. 18, §§ 358-3.1, 360-10.8(a)–(b). At the fair hearing, the parties may present evidence, and the MLTCP must justify its adverse determination. N.Y.C.R.R. tit. 18, § 360-10.8(e)(2)(i)(*f*)(*6*), (f)(3). An administrative law judge then prepares a report

and recommendation for the Commissioner of the Department of Health (or a designee), who issues a final decision confirming or reversing the MLTCP's adverse benefit determination based on the fair hearing record. *See id.* §§ 358-5.6(b)(9), 358-6.1. This administrative decision is itself then subject to judicial review in New York state court. *See id.* § 358-6.1(c); N.Y. C.P.L.R. § 7801 *et seq*.

If an enrollee's appeal is successful (whether through the internal appeal process, the fair-hearing process, or judicial review), the effective date of the higher level of services will be made retroactive, potentially allowing for reimbursement of costs incurred by the enrollee while an appeal was pending. But the retroactivity will extend only to the date of the MLTCP's initial denial of the request—not to the date of the request itself or to the date of enrollment with the MLTCP. *See* J. App'x at 1533–36. As a result, an enrollee cannot recover costs she incurred during the period that her request for increased services was being adjudicated by the MLTCP. And while an enrollee challenging a *reduction* to her personal care services (or her disenrollment) may be able to continue receiving her existing level of services while the fair hearing process is underway, federal and state regulations appear to offer no analogous mechanism by which an enrollee seeking an *increase* in care may receive that higher level of care while her appeal is pending. *See* N.Y.C.R.R. tit. 18, § 360-10.8(g); *see also* 42 C.F.R. § 438.420; N.Y. Soc. Serv. Law § 365-a(8).

II. Factual background

The following factual statements are drawn from the parties' submissions pursuant to Rule 56.1 of the Local Rules for the Southern District of New York. Except as otherwise noted, the facts are not in dispute.

Rosalind Bellin, a Medicaid recipient currently in her late 80s who resides in the Bronx, suffers from several serious illnesses that limit her ability to care for herself

independently. In April 2019, Bellin applied to enroll in a personal care services plan with three MLTCPs, including RiverSpring. In May, RiverSpring conducted an assessment of Bellin and determined that she required eight hours of personal care services, seven days a week. Neither of the other two MLTCPs offered Bellin more than eight hours of daily care.

Through her attorney and her daughter, Bellin notified RiverSpring that eight hours of daily care would be insufficient and that she required additional care. She nonetheless elected to enroll, on May 15, 2019, in RiverSpring's proposed plan, which would become effective (*i.e.*, her at-home care would begin) on June 1. On May 22, Bellin, through her attorney, sought to internally appeal RiverSpring's eight-hour determination. RiverSpring informed her, however, that she had no right to appeal before the June 1 effective date. So, on June 3, two days after her enrollment became effective, Bellin again appealed the eight-hour determination to RiverSpring. On June 4, RiverSpring advised her that its initial enrollment offer was not appealable. It further advised her, though, that it would treat her appeal as a request for an increase in care.

Accordingly, RiverSpring conducted another assessment of Bellin on June 15. \That evaluation led to essentially the same conclusion as the first: the assessor concluded that Bellin's condition had not changed and estimated that she required 8.7 hours of at-home care daily, seven days a week. Days later, Bellin's daughter reported to RiverSpring that Bellin's condition had deteriorated further and that she required additional personal care services. Thus, on July 10, RiverSpring conducted a third assessment of Bellin. That assessment concluded that Bellin's condition had in fact deteriorated and that she now required 24-hour care. Based on that assessment, RiverSpring authorized an increase to 24-hour personal care services, effective July 13. Bellin has been receiving 24-hour care since that authorization—though the parties dispute whether her increased level of care began on July 13 or July 15.

On July 5, while RiverSpring was determining whether an increase in care level was warranted, Bellin sought a fair hearing from the State to challenge RiverSpring's failure to process her May appeal of the initial eight-hour determination. In a September 2019 decision, the State initially reversed RiverSpring's determination and authorized 24-hour care for Bellin retroactive to June 1. But after the Department of Health moved for reconsideration, the State amended its decision in March 2020, and pared back Bellin's victory on procedural grounds. In the amended decision, the Commissioner's designee agreed with RiverSpring that its initial offer (of eight hours of daily care) was not appealable. The designee also found, however, that Bellin's June 3 post-enrollment request for 24-hour care was "supported by credible medical evidence" and that federal regulations had required RiverSpring to issue a decision on that request within 14 days. J. App'x at 125; *see* 42 C.F.R. § 438.210(d)(1). Based on those conclusions, the Commissioner's designee awarded Bellin 24-hour personal care services retroactive to June 18, 2019 (four weeks earlier than the July 13 date authorized by RiverSpring).[5]

Thus, the State's procedures resulted in two gaps for Bellin: a gap in State-authorized care and a gap in financial reimbursement. First, in part because she could not appeal her plan of care until after that plan had gone into effect on June 1, she did not actually begin to receive 24-hour care through RiverSpring, she contends, until July 15—a period without receiving State-authorized, 24-hour care that was prolonged by her inability to lodge an earlier appeal. Second, because the State made her 24-hour care authorization retroactive to June 18 and not to June 1, Bellin has not been able to seek reimbursement for any costs that she incurred between June 1 and June 17 to

[5] The State's amended fair hearing decision treated RiverSpring's June 4 notice letter, which stated that RiverSpring would treat Bellin's June 3 appeal of RiverSpring's initial offer as a request for an increase in care, as the start of the 14-day clock, therefore producing a June 18 effective date. *See* J. App'x at 125.

secure the additional 16 hours of daily personal care services that brought her care to the around-the-clock level. These gaps in 24-hour care authorization—and the procedures that produce them—are the focus of this litigation.

III. Procedural history

On June 18, 2019, while Bellin pursued the administrative appeals procedures available to her, she filed suit in the Southern District of New York to challenge the adequacy of those procedures. Her complaint alleged that the Medicaid Act and its implementing regulations, as well as the Due Process Clause of the Fourteenth Amendment, require New York to provide Medicaid recipients with an opportunity to bring an immediate appeal of an MLTCP's initial offer of personal care services. She also sought to assert those claims on behalf of a class of similarly situated individuals. She requested class-wide injunctive and declaratory relief.[6]

In April 2020, the District Court (Hellerstein, *J.*) dismissed Bellin's complaint for failure to state a claim for relief. *Bellin v. Zucker*, 457 F. Supp. 3d 414, 424 (S.D.N.Y. 2020). As to Bellin's Medicaid Act claims, the court found that "nothing in these statutes or regulations requires Defendants to provide potential enrollees with the opportunity to appeal initial determinations regarding their level of in-home personal care services." *Id.* at 420. As to her constitutional claim, the court held that the protections of the Due

[6] Bellin does not seek a retroactive award of payment for any costs she incurred in securing additional personal care hours between June 1 and June 17. Nor could she do so under the constraints of the Eleventh Amendment. *See Edelman v. Jordan*, 415 U.S. 651, 677 (1974). Any compensation she may receive, were she to prevail on her due process claim and avail herself of the appeals procedures she seeks, would be pursuant to other "administrative procedures [that] may already be available under state law," not pursuant to a federal court order. *Quern v. Jordan*, 440 U.S. 332, 347–48 (1979); *see id.* at 348 (finding no Eleventh Amendment barrier to relief where decision to authorize "retroactive benefits rests entirely with the State, its agencies, courts, and legislature, not with the federal court"); *see also Morenz v. Wilson-Coker*, 415 F.3d 230, 237 (2d Cir. 2005).

Process Clause did not apply because, it concluded, Bellin "did not have a property interest in a particular level of care." *Id.* at 422. In the court's view, Bellin had not sufficiently alleged that New York's personal care services eligibility regulations "cabin [the State's] discretion in a way that mandates a particular outcome" and thereby give rise to a property interest. *Id.* at 423.

Bellin appealed that decision to this Court. We affirmed the dismissal of her statutory and regulatory claims, finding that the Medicaid Act and its implementing regulations require a right to appeal only an "'adverse benefit determination'" and that "MLTC[P]s' initial personal care hours determinations cannot constitute adverse benefit determinations." *Bellin v. Zucker* (*Bellin I*), 6 F.4th 463, 483–84 (2d Cir. 2021) (first excerpt quoting 42 C.F.R. § 438.404(b)). But we vacated the dismissal of Bellin's due process claim and remanded for further proceedings, concluding that Bellin had carried her burden at the pleading stage of "plausibl[y] alleg[ing] that MLTC[P]s' discretion is channeled so as to create a property interest in initial hours determinations." *Id.* at 481.

With her due process claim revived, Bellin then moved the District Court to certify a Rule 23(b)(2) class of "[a]ll past, present and future New York State Medicaid recipients who . . . have applied or will apply for Medicaid-funded personal care services from MTLC[P]s," as well as three related subclasses. J. App'x at 49; *see* Fed. R. Civ. P. 23(b)(2). The District Court denied the motion. *Bellin v. Zucker*, No. 19-CV-5694, 2022 WL 4592581, at *6 (S.D.N.Y. Sept. 30, 2022). It found Bellin's proposed class definition "overbroad," and, even though the court then supplied and considered its own "narrow[er]" class definition, it still found that "a class cannot be defined to satisfy the implied requirement of ascertainability." *Id.* at *2. It reasoned that the class definition is "based on subjective criteria" and that "identifying class members would require a mini-hearing on the merits of [each] potential class member's claim." *Id.* at *6.

After the close of discovery, the parties cross-moved for summary judgment. In February 2024, the District Court granted summary judgment to Defendants. *Bellin v. Zucker* (*Bellin II*), No. 19-CV-5694, 2024 WL 381022, at *4 (S.D.N.Y. Feb. 1, 2024). As it had during the motion to dismiss proceedings, the court concluded that the State's standards for determining the appropriate level of personal care services "do[] not meaningfully channel the discretion" of assessors. *Id.* As a result, the court held, Bellin had no property right in a particular level of care and could not claim any related due process protections. *Id.*

Bellin timely appealed. She challenges the grant of Defendants' summary judgment motion, the denial of her own, and the earlier denial of her motion for class certification.

DISCUSSION

We review *de novo* a district court's grant of summary judgment, construing "the evidence in the light most favorable to the nonmoving party and draw[ing] all reasonable inferences in that party's favor." *Ketcham v. City of Mount Vernon*, 992 F.3d 144, 148 (2d Cir. 2021). A court may grant summary judgment only when there is "no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a).

To determine whether a state's procedures violate the Due Process Clause of the Fourteenth Amendment, we must assess, first, whether the state has deprived the plaintiff of a liberty or property interest, and if so, second, whether the state's existing procedures are "constitutionally adequate" for protecting that interest. *Kapps v. Wing*, 404 F.3d 105, 112 (2d Cir. 2005); *see Barrows v. Burwell*, 777 F.3d 106, 113 (2d Cir. 2015). For the reasons discussed below, we decide in Bellin's favor on the first question and in Defendants' favor on the second.

I. Qualifying Medicaid recipients have a property interest in receiving 24-hour personal care services under New York law

As the Supreme Court established in *Goldberg v. Kelly*, public assistance benefits may qualify for constitutional due process protections as a type of property. 397 U.S. 254, 262 & n.8 (1970). For a benefits program to generate a constitutionally protected property right rather than merely a privilege, the prospective recipient must demonstrate a "legitimate claim of entitlement" to benefits—not just an "abstract need" for them or a "unilateral expectation" of receiving them. *Bd. of Regents of State Colls. v. Roth*, 408 U.S. 564, 577 (1972). In differentiating between the two, we ask "whether the state statute or regulation at issue meaningfully channels official discretion by mandating a defined administrative outcome." *Sealed v. Sealed*, 332 F.3d 51, 56 (2d Cir. 2003); *see Olim v. Wakinekona*, 461 U.S. 238, 249 (1983) (considering whether the state has "plac[ed] substantive limitations on official discretion.").

A regulatory scheme can structure a state decisionmaker's benefits determination in two basic ways. First, it might afford a decisionmaker unguided discretion—that is, it might give the decisionmaker "the power to grant or deny a benefit regardless of whether particular criteria are met." *Bellin I*, 6 F.4th at 476. For example, a scheme might "merely *authorize*[] particular actions and remedies" rather than "require a certain outcome." *Sealed*, 332 F.3d at 56. Where an official is authorized to take an action but "is simply not bound by standards" in arriving at a decision, it cannot be said, for due process purposes, that a beneficiary has an entitlement to benefits and an attendant property interest in them. *Bd. of Pardons v. Allen*, 482 U.S. 369, 375 (1987) (internal quotation marks omitted).

Second, a regulatory scheme might afford a decisionmaker a narrower form of discretion in awarding benefits: if a scheme imposes standards that constrain decision-making, but the official "must use judgment in applying the standards," a property

interest in the benefits may be cognizable. *Id.* (internal quotation marks omitted). This narrower range of discretion "is not incompatible with the existence of a [protected] interest" so long as a particular outcome is "required" after the decision-making authority "determines (in its broad discretion) that the necessary prerequisites exist." *Id.* at 376 (emphasis removed); *see also Barrows v. Becerra*, 24 F.4th 116, 139 (2d Cir. 2022) ("[E]ven though an official may have to 'use judgment in applying' a standard, that does not preclude the existence of a protected interest." (quoting *Allen*, 482 U.S. at 375)). In such cases, the critical inquiry is "whether the prescribed criteria are open-ended and subjective, or determinate and well-defined." *Bellin I*, 6 F.4th at 476. The latter "meaningfully channel[] official discretion," thereby generating a property interest. *Sealed*, 332 F.3d at 56.

We first consider whether the regulatory scheme that governs Bellin's asserted property interest affords the State unguided discretion to determine whether 24-hour personal care services are appropriate and conclude it does not. We then consider whether the narrower guided discretion that the scheme affords the State in making this determination is meaningfully channeled, and conclude that it is.

A. The State does not have unguided discretion in authorizing 24-hour personal care services

The regulatory scheme governing Medicaid-funded, at-home personal care services is designed (1) to assess a beneficiary's needs and (2), if she requires personal care services, to provide her with a plan of care that meets those needs. For that reason, Section 505.14 first requires a comprehensive, independent assessment of the assistance an individual requires. *See* § 505.14(b)(2)(i)(*a*)–(*b*). It then ties the MLTCP's "authorization . . . of personal care services, including the level, amount, frequency and duration of services," directly to the results of that assessment: the authorization "*must be based on and reflect* the outcome of [the independent assessment]." § 505.14(b)(4)(iii)

(emphasis added); *see also* N.Y. Pub. Health Law § 4403-f(7)(g)(i) (requiring that "[t]his assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the enrollee"). To implement that linkage requirement, other provisions of Section 505.14 direct that the plan of care "must identify" both the "personal care service functions or tasks with which the individual needs assistance," as well as the "amount, frequency and duration of services" that are necessary "to meet these needs." § 505.14(b)(2)(iii)(*e*)(*1*)–(*2*). Section 505.14 thus entitles eligible beneficiaries to a plan of care that meets their identified needs.

The State's published policy guidance reflects the mandatory nature of personal care services authorizations for Medicaid recipients once the prerequisites for those services have been met—including, and especially, for 24-hour care. For example, one Department of Health policy provides, "[a]ll [MLTCPs] must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance." DOH MLTC Policy 16.07. Another similarly mandates that the plan of care the MLTCP develops "must . . . meet[] the patient's scheduled and unscheduled day and nighttime personal care needs." DOH Policy Directive GIS 03 MA/003 (Jan. 24, 2003), https://perma.cc/7VPA-69NM. Indeed, the State agreed in the district court proceedings that "a plan of care must be able to meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance." J. App'x at 2155 (State Defendant's response to Bellin's Rule 56.1 statement).

The mandatory nature of personal care services authorizations is also reflected in the State's own contracts with MLTCPs. For example, the State's model contract directs that MLTCPs "will use the assessment instrument specified by the Department . . . to assess each Applicant for MLTC[P] enrollment" and directs that a plan of care "must be developed based on the findings of this assessment." J. App'x at 1139; *see also id.* at 1296

(model contract stating that enrollees have "the Right to receive medically necessary care"). Both the Department of Health and RiverSpring confirmed that understanding. J. App'x at 2040 (Department of Health declarant stating that, pursuant to the model contract, the "proposed plan must address, among other things, the enrollee's assessed needs"); *id.* at 3138 (senior RiverSpring executive agreeing that if an individual requires "a particular number of hours" of care, "that [level of] service . . . must be given").

The mandatory linkage between assessed needs and services offered is also required by federal regulations, which provide that the State's contract with MLTCPs "[m]ust ensure that the [MLTCP's] services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished." 42 C.F.R. § 438.210(a)(3)(i). As a result, an MLTCP's failure to provide medically necessary services may result in the State's denying it reimbursement or imposing sanctions. *See, e.g.*, J. App'x at 1179 (model contract providing that capitation payments may be denied if an MLTCP has "failed substantially to provide medically necessary . . . services"); *id.* at 1223 (model contract listing "[f]ailing substantially to provide medically necessary services that the Contractor is required to provide" as an "[u]nacceptable practice[]" that is subject to sanctions).

The State argues that the relevant laws and regulations "'merely *authorize*[]'" the provision of personal care services and leave the fundamental decision whether to provide authorized services to the State's discretion. Appellee's Br. at 36 (quoting *Sealed*, 332 F.3d at 56). In support of that view, the State notes that state law provides that an MLTCP "*may* enroll eligible persons . . . upon the completion of a comprehensive assessment." N.Y. Pub. Health Law § 4403-f(7)(g)(i) (emphasis added). It observes further that Section 505.14 provides only that "[b]efore more than 12 hours of personal care services per day . . . *may be authorized*, additional requirements . . . must be satisfied." § 505.14(a)(5)(ii)(*b*) (emphasis added); *see also* § 505.14(b)(4)(iv) (providing

that an MLTCP "*may authorize* only the hours or frequency of services actually required by the individual" (emphasis added)).

We draw a different conclusion from these provisions. The relevant statutory and regulatory provisions set out a clear, two-step process: first, determining an individual's needs and, second, developing a plan of care that meets those needs. The State's proposed reading would untether the careful assessment of an individual's needs from the care an MLTCP is required to authorize, and in so doing make the regulatory scheme self-defeating. In context, the "may" language in the provisions the State cites is more persuasively read as establishing a necessary prerequisite—*e.g.*, "may enroll eligible persons . . . [*only*] upon the completion of a comprehensive assessment," N.Y. Pub. Health Law § 4403-f(7)(g)(i)—rather than as conferring unguided discretion at the enrollment phase. So understood, these provisions sensibly reinforce, rather than undermine, the critical linkage between the level of assistance required and the level of assistance authorized that undergirds the structure of the regulatory scheme.

Thus, we have no difficulty in concluding that New York has not committed to the unguided discretion of the State (and the MLTCPs, which act on the State's behalf) the determination of what particular level of personal care services an enrollee requires.

B. Statutes, regulations, policies, and practices meaningfully channel discretion in authorizing 24-hour personal care services

We next consider whether the relevant regulatory criteria "meaningfully channel[] official discretion" as to whether or not to authorize 24-hour services. *Sealed*, 332 F.3d at 56. In answering that question, "we must consider the regulatory scheme as a whole," including the "relevant statutes and regulations," as well as "informal rules or institutional practices." *Bellin I*, 6 F.4th at 475. We conclude that the relevant regulatory criteria adequately cabin discretion in both theory and practice, supporting Bellin's property interest in 24-hour care.

We emphasize, though, that this case does not present, and Bellin does not pose, the question whether a qualifying Medicaid recipient has a property interest in receiving any particular number of daily personal care hours—for example, in 14 hours of daily care rather than eight. Bellin asks us only to recognize her property interest in receiving 24-hour personal care services as opposed to some level of part-time personal care services: a binary determination. *See* Appellant's Br. at 3. To be sure, New York's Medicaid regulations define two subtypes of 24-hour personal care services, "[l]ive-in 24-hour personal care services" and "[c]ontinuous personal care services."[7] § 505.14(a)(2), (a)(4) (emphases removed). But we also need not decide whether qualifying Medicaid recipients have a property interest in receiving one form of 24-hour care or the other. Our analysis is limited to determining whether, in light of applicable state and federal law, qualifying beneficiaries have a constitutional property interest in receiving 24-hour care (of some kind) rather than part-time care (of some kind)—not whether that entitlement also reaches particular levels of part-time care or a particular type of 24-hour care.

To answer that question, we first consider the regulatory criteria governing 24-hour-care authorization decisions. We then examine how those criteria are applied by

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[7] The former type entails a "live-in 24-hour personal care aide" and is appropriate when the individual's needs for assistance are "sufficiently infrequent" that the aide "would be likely to obtain, on a regular basis, five hours daily of uninterrupted sleep during the aide's eight hour period of sleep." § 505.14(a)(4). If an individual's needs are so frequent that even a live-in aide cannot meet them without unduly sacrificing sleep, she may be eligible for "[c]ontinuous personal care services," a level of care that entails multiple aides working in shifts. § 505.14(a)(2) (emphasis removed); *see also* § 505.14(b)(2)(iii)(c). Both "[l]ive-in 24-hour personal care services" and "[c]ontinuous personal care services" require that the recipient need assistance "with toileting, walking, transferring, turning and positioning, or feeding" throughout the day. § 505.14(a)(2), (a)(4) (emphasis removed). Because the distinction between these two forms of 24-hour care is not directly relevant to this appeal, we use "24-hour personal care services" to encompass both types.

the State in its fair hearing decisions. We conclude that the criteria themselves and the State's historical application of them establish the existence of a property interest in 24-hour care for qualifying Medicaid recipients in New York State.

1. The State's personal care services criteria meaningfully channel discretion

As previewed, we conclude that the personal care services criteria set forth in the State's regulations and policies meaningfully channel official discretion as to whether the MLTCP must authorize 24-hour personal care services. Recall that, to qualify for any level of personal care services (whether part-time care or 24-hour care), potential enrollees must satisfy five baseline requirements: medical necessity, stability, self-direction, cost-effectiveness, and minimum needs. To receive 24-hour care, they must also require assistance with "toileting, walking, transferring, turning and positioning, or feeding" throughout a "calendar day." § 505.14(a)(2), (a)(4). If an individual satisfies both sets of criteria—the baseline requirements and the 24-hour-care-specific requirements—they are entitled to 24-hour personal care services. Together, these criteria meaningfully channel MLTCPs' discretion in authorizing 24-hour care.

a. Criteria for authorizing personal care services of any kind

Consider first the five primary prerequisites to eligibility for any level of personal care services.

(i) Medical necessity. Personal care services must be "medically necessary for maintaining an individual's health and safety in his or her own home." § 505.14(a)(1). Consideration of the medical necessity requirement is guided by the CHA and the initial assessment process. As the State's own evidence demonstrates, that process is "designed for reliability and uniformity across potential enrollees." J. App'x at 47 (declaration of Department of Health official). In the proceedings here, a Department of Health official testified on behalf of the State that the nurses who conduct the

assessment "are trained to be objective in collecting facts and doing evaluations and assessments." J. App'x at 2634. The starting point for the assessment is the CHA, which requires a detailed evaluation of an individual's condition and needs. *See* J. App'x at 971, 1730, 2001–02, 2099, 2147, 2516–17. The "purpose of the CHA," as the Department of Health official testified, is to have a "standardized tool and to be as objective as possible." J. App'x at 2634. The CHA enables objective assessment in part by orienting the assessor's analysis around an individual's performance in conducting a specified list of "activities of daily living," like dressing and bathing, and "instrumental activities of daily living," like preparing meals and cleaning, all according to a defined numerical rubric. DOH MLTC Policy 16.07; *see* J. App'x at 2516–17. Proper application of the CHA is further restricted by the CHA reference manual, which provides detailed guidance on how nurse assessors must code CHA assessment items.

(ii) Stability and (iii) self-direction. Each of the next two prerequisites—that the individual be "stable" and "self-directing"—is clearly defined by regulation. An individual is considered "stable" if a "sudden deterioration or improvement" of her condition is unlikely and her plan of care will not require frequent adjustment. § 505.14(a)(3)(i) (emphasis removed). An individual is "self-directing" if she is "capable of making choices about [her] activities of daily living" or if another individual or agency is able to play that decision-making role on her behalf. § 505.14(a)(3)(ii). These requirements constrain MLTCPs' discretion by calling for specific, narrow medical judgments assessing defined characteristics of the applicant.

(iv) Cost-effectiveness. The individual must have no cost-effective alternatives to in-home personal care services available to meet her needs—for example, receiving voluntary assistance from family members or obtaining services through other medical assistance programs. § 505.14(a)(3)(iii), (b)(2)(iii)(*a*)(*12*)–(*13*). This requirement is undergirded by an enumerated list of objective considerations. *See, e.g.*,

§ 505.14(b)(2)(iii)(*a*)(*8*) (whether the individual's needs can be met "more cost-effectively by other long-term care services," such as "the assisted living program or the enriched housing program"), (b)(2)(iii)(*a*)(*9*) (whether the individual's needs can be met "more cost-effectively . . . in cooperation with an adult day health or social adult day care program"), (b)(2)(iii)(*a*)(*10*) (whether the individual's needs can be met "through the use of telehealth services"). As we observed in *Bellin I*, the regulation "does not just leave the assessment of cost-effectiveness to the MLTC[P]s without providing any substantive guidance"; rather, it "delineates the considerations and alternatives that should be taken into consideration." 6 F.4th at 478. These objective considerations are hallmarks of channeled discretion.

(v) Minimum needs. Finally, the minimum-needs criterion simply requires ascertaining whether the individual has been diagnosed with dementia or Alzheimer's disease, tallying up the raw number of activities of daily living with which an individual needs assistance, and assessing whether the assistance required is merely supervision or something more. *See* § 505.14(a)(3)(iv). An assessor's task is then merely to determine whether the individual meets the minimum-needs threshold: for individuals with dementia or Alzheimer's disease, whether they require "at least supervision with more than one activity of daily living," and for all others, whether they require "at least limited assistance with physical maneuvering with more than two activities of daily living." *Id.* Thus, this requirement, too, rests on objective criteria and specific, narrow medical judgments.

b. Criteria for authorizing 24-hour personal care services

Once the five threshold criteria for receiving any level of personal care services are satisfied, the determination whether to authorize 24-hour personal care services is even more constrained. New York regulations expressly define the needs that trigger an entitlement to 24-hour personal care services: to be eligible for 24-hour care, a

qualifying Medicaid recipient must have frequent needs for "assistance during a calendar day with toileting, walking, transferring, turning and positioning, or feeding." § 505.14(a)(2), (a)(4). In other words, assessors must evaluate whether an individual requires assistance with a specified list of activities—"toileting, walking, transferring, turning and positioning, or feeding"—and then estimate the likely frequency of those needs during the day and night. § 505.14(a)(2), (a)(4).

Those evaluations are further constrained by additional State guidance. To guide assessors' evaluation of whether an individual has the specified needs for assistance, the regulations require them to determine "whether the practitioner order indicated a medical condition that causes" those specified needs. § 505.14(b)(2)(iii)(*d*)(*1*). To guide assessors' evaluation of the timing of those needs, the regulations require them to determine the "frequency at which the individual needs" such assistance, § 505.14(b)(2)(iii)(*d*)(*3*), whether the required assistance is needed "during the individual's waking and sleeping hours and, if not, why not," § 505.14(b)(2)(iii)(*d*)(*4*), and whether the required assistance "can be scheduled or may occur at unpredictable times," DOH MLTC Policy 16.07; *see also* J. App'x at 2155. The CHA is used to inform these judgments. *See* J. App'x at 2689–90 (Department of Health official testifying that the CHA is used to document the frequency of needs for assistance). Other Department of Health policy directives provide additional guidance on the "definitions and eligibility requirements" pertaining to the two types of 24-hour personal care services. DOH MLTC Policy 15.09 (Dec. 30, 2015), https://perma.cc/TKS7-RH65.

Thus, the State's regulations expressly describe a threshold between part-time and 24-hour care and disaggregate the 24-hour-care authorization decision into specific assessments of the frequency, timing, and predictability of an individual's specified needs for assistance. Each of these determinations is, in turn, reviewed by an "independent medical review" panel, as is the proposed plan of care. § 505.14(b)(2)(v).

These aspects of the regulatory program meaningfully channel MLTCPs' discretion in determining whether to authorize 24-hour care.

2. The State's fair hearing decisions further demonstrate meaningful channeling

In addition to statutes, regulations, and policies, a "constant, consistent pattern of [administrative] decisions" can also be "sufficient to create a property interest." *Furlong v. Shalala*, 156 F.3d 384, 395 (2d Cir. 1998). In pressing the additional argument that the State's treatment of 24-hour-care appeals presents such a pattern here, Bellin has produced a compilation of 108 fair hearing decisions issued in personal care services appeals from January 2016 through March 2022. *See* J. App'x at 3938–4029. We may also take judicial notice of State fair hearing decisions that are not in the record.[8] *See* Off. of Temp. & Disability Assistance, *Fair Hearing Decision Archive*, https://otda.ny.gov/hearings/search. The State, for its part, has not called any additional fair hearing decisions to our attention. It is our assessment that the fair hearing decisions readily reinforce our conclusion that qualifying Medicaid recipients in New York have a property interest in receiving 24-hour personal care services: they demonstrate that the State itself, through its adjudication of personal care services appeals, has long recognized the closely circumscribed nature of the discretion MLTCPs are afforded in determining whether to authorize 24-hour care.

To start, the fair hearing decisions in the record—reviewing MLTCPs' denials of requests for an increase to 24-hour care—consistently frame the issue, analysis, and conclusion in objective terms: whether the MLTCP's determination that an increase to

[8] We do so only to establish the fact of the decisions and their stated reasoning—not for the truth of the matters asserted within those decisions. *Bellin I*, 6 F.4th at 471 n.10 (finding that fair hearing decisions are "are public records properly subject to judicial notice under Federal Rule of Evidence 201(b)," though not "for the 'truth of the matters asserted'" (quoting *Staehr v. Hartford Fin. Servs. Grp., Inc.*, 547 F.3d 406, 425 (2d Cir. 2008))).

24-hour care is not medically necessary is "correct" or "not correct."[9] Additional reported fair hearing decisions refer to the requirements of Section 505.14 and related policies as eligibility "criteria" that the MLTCP must correctly determine and that the appellant must prove.[10] These decisions do not frame the inquiry as a review of an MLTCP's exercise of open-ended discretion.

These decisions' focus on objective review in framing their analyses carries through to the analyses themselves. The decisions in the record nearly always turn on whether a party has established the objective criteria that govern eligibility for 24-hour care, and the decisions consistently treat those criteria as susceptible to evidence-based review. For example, in one fair hearing, an applicant challenged the MLTCP's determination that he was entitled to only 12 hours of daily care, when he claimed to qualify for 24-hour care. *See* Fair Hearing No. 7509330L (Apr. 5, 2017), at 12–13. After considering several CHAs, the testimony of the applicant's friends and family members,

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[9] *See, e.g.*, Fair Hearing No. 7292450H (Apr. 29, 2016), at 18 (denial of request to increase from 12 hours of daily care to 24-hour personal care was "not correct"); Fair Hearing No. 7603418Q (Sept. 6, 2017), at 11 (denial of request to increase from six hours of daily care to 24-hour personal care was "not correct"); Fair Hearing No. 7965956Q (May 22, 2019), at 13 (denial of request to increase from eight hours of daily care to 24-hour personal care was "not correct"); Fair Hearing No. 8276185M (Mar. 12, 2021), at 16 (denial of request to increase from 12 hours of daily care to 24-hour personal care was "not correct"); Fair Hearing No. 8316051Y (July 1, 2021), at 17 (denial of request to increase from seven hours of daily care to 24-hour personal care was "not correct").

[10] *See, e.g.*, Fair Hearing No. 8495091H (Aug. 29, 2022), at 13 (finding that the appellant's evidence was "not sufficient to justify or meet the criteria for an increase in Personal care assistance services hours"); Fair Hearing No. 8562620H (Feb. 3, 2023), at 21 (finding that the appellant "has met the criteria for [one type of 24-hour personal care]"); Fair Hearing No. 8633543N (July 20, 2023), at 21 (finding that the appellant "has met the criteria for the provision of 24 hours, 7 days weekly continuous care"); Fair Hearing No. 8815271K (July 9, 2024), at 25 (finding that the appellant "failed to establish that they met the eligibility criteria for 24-hour split-shift care."); Fair Hearing No. 9035045P (Aug. 27, 2025), at 20 (discussing the "specific and strict criteria for 24/7 [personal care services] authorization" under Section 505.14).

and other agency documents, the Commissioner's designee concluded that (1) the appellant needed unscheduled "assistance with toileting, walking, transferring, turning, and positioning, during the day, as well as at night," and (2) her overnight needs could not be met by friends and family members or with adaptive equipment. *Id.* at 15. It accordingly directed the MLTCP to authorize 24-hour care. *Id.* Other reported fair hearing decisions reversing an MLTCP's denial of a 24-hour care request turn on similarly objective considerations.[11]

The State protests that the fair hearing decisions Bellin presents simply demonstrate that "the State takes seriously its obligation . . . to ensure that [MLTCPs'] determinations are supported by evidence and do not violate rules governing their exercise of discretion." Appellee's Br. at 44. But that is exactly the point. MLTCPs' determinations whether to provide 24-hour care are rooted in predicate factual findings that are subject to evidentiary review and in exercises of limited discretion that the State reviews to ensure conformity with the rules channeling this discretion. That MLTCPs' decisions are susceptible to such administrative review by the State—whose rulings are, in turn, subject to judicial review by state courts, *see* N.Y.C.R.R. tit. 18, § 358-6.1(c)—provides a fair corroboration that the State has meaningfully channeled MLTCPs'

[11] *See, e.g.*, Fair Hearing No. 7517997K (Apr. 20, 2017), at 17 (finding that the appellant is "extremely weak," "cannot ambulate without a great deal of assistance," and "is in danger of falling at night when she attempts to use the commode"); Fair Hearing No. 7603418Q (Sept. 6, 2017), at 11 (finding that "[t]he record establishes that the Appellant requires assistance at all hours of the day and a few times during the over-night hours"); Fair Hearing No. 7609514H (Sept. 15, 2017), at 6 (finding that the "evidence establishes the Appellant's total incontinence and greater than assistance-level need . . . with at least ambulation and incontinent care"); Fair Hearing No. 7641666R (Nov. 3, 2017), at 20 (finding that the appellant "has unscheduled toileting and incontinence needs and requires related human assistance"); Fair Hearing No. 7758346J (May 16, 2018), at 10 (finding that the appellant "requires extensive scheduled and unscheduled assistance during a calendar day, with tasks such as toileting, walking and transferring").

discretion with respect to 24-hour-care authorization, as we have explained. *See Bellin I*, 6 F.4th at 480 (finding that "[t]he fact that administrative review is possible for such similar claims supports Bellin's claim [to a property interest]"); *see also Allen*, 482 U.S. at 381 (finding that the availability of "judicial review" is an "indication of a legislative intent to cabin . . . discretion"). For the same reason, the district court's observations that fair hearing decisions are "fact-intensive" and that the State often affirms the MLTCP's decision support, not undermine, identifying the proposed property interest. *Bellin II*, 2024 WL 381022, at *4.

In attempting to minimize the significance of the 108 fair hearing decisions Bellin has compiled, the State correctly points out that these decisions represent only a small fraction of the universe of potentially relevant fair hearing decisions, which number in the thousands. But the State does not point to any fair hearing decisions that treat MLTCPs' discretion in authorizing 24-hour care as the kind of open-ended discretion that the State urges us to find here. Thus, the record evidence, as well as this Court's review of an additional sampling of fair hearing decisions, tends to confirm the ultimately objective nature of 24-hour care authorization decisions.

3. The State's arguments to the contrary fail to persuade

The State argues that, because the assessors charged with making care-authorization decisions are afforded a degree of discretion in applying and weighing the criteria outlined above, the regulatory scheme cannot generate a property entitlement. To be sure, and as Bellin concedes, the assessment process requires clinicians to exercise their own professional judgment in determining exactly which services are medically necessary. *See* J. App'x at 465, 2171. As with any complex medical judgment, the determination whether 24-hour care is medically necessary for an individual requires a degree of assessor discretion—even in the context of such detailed criteria informing that determination. *See* J. App'x at 2634 (Department of Health official

testifying that "I'm not sure . . . anything is 100 percent [objective]" because "[w]e're dealing with human beings," but that "the CHA is intended to be as objective as possible."); *id.* at 3138 (senior RiverSpring executive explaining that not every aspect of the CHA is "a hundred percent an objective observation" because assessors rely in part on information given by the beneficiary and caregivers). For example, in completing the CHA, a nurse assessor may need to determine whether an individual requires "[l]imited assistance" with bed mobility (defined as "guided maneuvering of limbs, physical guidance without taking weight") or, instead, "[e]xtensive assistance" (defined as "weight-bearing support . . . by 1 helper where person still performs 50% or more of subtasks"). J. App'x at 2517. Two nurses evaluating the same individual might sometimes reach modestly different conclusions.

Assessors may also weigh the evidence collected—from the CHA, medical records, and so on—differently and in ways that reflect their own individual experiences and observations. *See* J. App'x at 3139–40. In conducting their evaluations, they must also account for "the individual's preferences," as well as "social and cultural considerations." § 505.14(b)(2)(iii)(*a*)(*3*). Further, in high-needs cases, the independent medical review panel may expand the record by "request[ing] additional information or documentation, including medical records, case notes, and any other material the lead physician deems important to assist the panel's review and recommendation." § 505.14(b)(2)(v)(*e*). These aspects of the assessment process, no doubt, introduce a degree of subjectivity and discretion into the result.

But courts have long distinguished criteria that are so "open-ended and subjective" as to untether them entirely from substantive guidance from those that are "determinate and well-defined," even though they may still require judgment to apply. *Bellin I*, 6 F.4th at 476 (citing cases). Two of our precedential cases in particular help to illustrate this critical distinction.

First, in *Barrows v. Becerra*, this Court recently considered the claims of hospitalized patients asserting a property interest in maintaining their inpatient status. 24 F.4th at 123–24 [2022]. That status would make them eligible for Medicare Part A coverage, whereas outpatient status would result in less generous Medicare Part B coverage. *Id.* To draw a line between the two, the federal government promulgated the "Two Midnight Rule," *id.* at 125, providing that "inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights," 42 C.F.R. § 412.3(d)(1). Under the rule, the treating physician must make an initial determination "based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event." *Id.* § 412.3(d)(1)(i). A committee of physicians then reviews that initial determination and decides whether inpatient care is medically necessary. *Barrows*, 24 F.4th at 125–26, 140 & n.132.

This Court held that the Two Midnight Rule "adequately channels official discretion" so as to create a property interest in Part A coverage. *Id.* at 139. The reviewers' "use of judgment" to "determine whether they expect[ed] a patient to require hospital care that crosse[d] two midnights" did not mean that "their discretion [was] not adequately channeled for purposes of discerning a property interest." *Id.* at 140. We explained that, "[w]hen a [reviewer] uses judgment in applying the standards set by the state, so long as an administrative action is 'required after the [reviewer] determines (in its broad discretion) that the necessary prerequisites exist,' a property interest exists in the benefits regime." *Id.* (quoting *Allen*, 482 U.S. at 376) (emphasis removed).

Second, in *Board of Pardons v. Allen*, the Supreme Court examined whether an inmate had a constitutionally protected liberty interest in parole release. 482 U.S. at 381

[1987]. A Montana statute required the parole board to grant parole "when in its opinion there [was] a reasonable probability that the prisoner c[ould] be released without detriment to the prisoner or to the community" and the prisoner was "able and willing to fulfill the obligations of a law-abiding citizen." *Id.* at 376–77. Drawing on its earlier decision in *Greenholtz v. Inmates of Nebraska Penal and Correctional Complex*, 442 U.S. 1 (1979), the Court held that the state statute created a protected liberty interest even though the release decision was "'necessarily subjective . . . and predictive,'" and the "discretion of the Board [was] 'very broad.'" *Allen*, 482 U.S. at 381 (quoting *Greenholtz*, 442 U.S. at 13). In *Allen*, as in *Greenholtz*, what was most critical was that "release [was] *required* after the Board determine[d] (in its broad discretion) that the necessary prerequisites exist[ed]." *Allen*, 482 U.S. at 376; *see id.* at 380–81.

The personal care services criteria described above are no more open-ended or subjective than the ones found compatible with a property interest in *Barrows*, *Allen*, and *Greenholtz*. For example, we see a degree of subjectivity in all of the following determinations: whether a patient will "require hospital care that crosses two midnights," a patient's "current medical needs," and "the risk of an adverse event," 42 C.F.R. § 412.3(d)(1) (*Barrows*); whether "there is reasonable probability that the prisoner can be released without detriment to the prisoner or to the community," whether parole is in "the best interests of society," and whether a prisoner "is able and willing to fulfill the obligations of a law-abiding citizen," Mont. Code Ann. § 46-23-201(1)–(2) (1985) (*Allen*); whether "[t]here is a substantial risk that [a prisoner] will not conform to the conditions of parole," whether a prisoner's "release would depreciate the seriousness of his crime or promote disrespect for law," whether a prisoner's "release would have a substantially adverse effect on institutional discipline," "[t]he adequacy of the offender's parole plan," and upon considering 13 other factors, "[a]ny other factors the

board determines to be relevant," Neb. Rev. Stat. § 83-1,114(1)(a)–(c), (2)(b), (2)(n) (1976) (*Greenholtz*). None is fully objective.

In reasoning otherwise, the District Court and the State make the same fundamental error: in essence, they read our "mandating a defined administrative outcome" language in *Kapps*, *Sealed*, and *Bellin I* to mean that, in applying the required standards, no two decisionmakers could come to different conclusions. *Sealed*, 332 F.3d at 56. But that is not the import of that phrase. As both this Court and the Supreme Court have explained, the proper inquiry is whether, after the decision-making authority "determines (in its broad discretion) that the necessary prerequisites exist," a particular outcome is "*required*." *Allen*, 482 U.S. at 376; *see also Barrows*, 24 F.4th at 140. The State has no discretion—none—to deny a Medicaid beneficiary 24-hour personal care services *if* the "necessary prerequisites" to those services have been found to be satisfied. *Allen*, 482 U.S. at 376; *see above* Discussion Section I.A. That is the sense in which the scheme "mandat[es] a defined administrative outcome." *Sealed*, 332 F.3d at 56. Nonetheless, even "broad discretion" in determining *whether* those "necessary prerequisites" are satisfied can be compatible with the existence of a property interest. *Allen*, 482 U.S. at 376. Here, to be sure, New York law affords decisionmakers a degree of discretion in making 24-hour-care authorization decisions. But this discretion is carefully and sufficiently bounded to create a property interest under *Allen* and its progeny. That is the sense in which the scheme "meaningfully channels official discretion." *Sealed*, 332 F.3d at 56.

The District Court's primary basis for finding that Bellin had no property interest in 24-hour care was its view that, unlike in *Barrows* (where, it said, the Two Midnight Rule "mandated" an outcome based on "[o]ne simple input—whether or not a patient had to spend two nights at the hospital"), the CHA "gathers many inputs, all filtered through the nurse assessor's perspective," a process that the court thought "require[d]

subjective evaluation with no predictable result." *Bellin II*, 2024 WL 381022, at *3. That analysis misunderstands the reasoning of *Barrows* by coupling the two distinct questions identified above. If it is determined that a patient will have to spend two nights at the hospital, it is mandatory to designate her status as "inpatient" for Medicare Part A purposes, as the District Court correctly observed. *Barrows*, 24 F.4th at 140. But the determination *whether* the Two Midnight Rule was satisfied was itself a distillation of "complex medical factors," such as "the severity of signs and symptoms" and the patient's "current medical needs." 42 C.F.R. § 412.3(d)(1)(i). And these complex factors were filtered through the "medical judgment" of evaluators. *Barrows*, 24 F.4th at 140; *cf. Greenholtz*, 442 U.S. at 8 (observing that parole decisions "involve[] a synthesis of record facts and personal observation filtered through the experience of the decisionmaker"). In other words, the determination in *Barrows* involved the same kind of guided discretion that is present here.

The State similarly argues that its personal care services regulatory scheme does not meaningfully channel discretion as to 24-hour-care authorizations because "the number of hours of personal care services . . . cannot be mandated or predicted in advance by rote calculations or formulas." Appellee's Br. at 34. But, as we have stressed, that is not the test. Like the District Court, the State misunderstands where discretion is permitted (in applying criteria for decision-making) and where it is not (in departing from those criteria). The question is not whether these tools eliminate all discretion; it is whether they "meaningfully channel[]" that discretion. *Sealed*, 332 F.3d at 56. In *Greenholtz*, for example, the parole board was permitted to consider "[*a*]*ny other factors* the board determines to be relevant." Neb. Rev. Stat. § 83-1,114(2)(n) (1976) (emphasis added); *see also Allen*, 482 U.S. at 374 (noting this "catchall factor" in *Greenholtz*). But the existence of that residual discretion upon evaluating other enumerated, detailed, mandatory criteria did not defeat the existence of a property interest in that case,

Greenholtz, 442 U.S. at 13, and neither does it do so in this one. As we explained in resolving Bellin's first appeal, "[a]lthough the criteria involve professional and subjective determinations, many of the criteria are also objective and fixed." *Bellin I*, 6 F.4th at 478. The fixed criteria outlined in Section 505.14 and the State's related policies "place substantive limitations on the MLTC[P]s' decision-making." *Id.* at 479.

As the State observes, the ultimate decision at issue in *Barrows* was a binary one—whether or not to classify a patient's status as inpatient. *See* Appellee's Br. at 39–41. The same is true of the decisions at issue in *Allen* and *Greenholtz*—whether or not to grant parole. Additional considerations might bear on an individual's property interests in non-binary determinations, such as the precise number of personal care hours that is appropriate for a given individual who does not require around-the-clock care. But, as explained above, the question we decide here—whether a qualifying Medicaid recipient has a property interest in 24-hour personal care services rather than part-time personal care services under New York law—involves a determination that may fairly be characterized as binary, we think, and one that is carefully delimited by New York regulations. *See, e.g.*, § 505.14(a)(2), (a)(4). Thus, the cases discussed above are squarely on point, and the State's argument fails.

* * *

Because New York's laws, regulations, policies, and practices establish that qualifying Medicaid recipients in the State have a property interest in 24-hour personal care services, and because the State does not identify persuasive record evidence to the contrary, we conclude that the District Court erred in holding that due process protections do not attach and in granting summary judgment to Defendants on that basis.

II. On this record, New York's procedures are constitutionally adequate for protecting qualifying beneficiaries' interest in 24-hour care

Having concluded that qualifying Medicaid recipients have a property interest in 24-hour personal care services, we next must examine New York's procedures and ask whether they adequately protect that interest. That inquiry requires balancing three considerations: (1) the importance of the "private interest" at stake; (2) the "risk of an erroneous deprivation of such interest" under the existing procedures, along with the "probable value, if any, of additional or substitute procedural safeguards"; and (3) the weight to afford the "Government's interest," including the "fiscal and administrative burdens" that additional procedures would impose. *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976). In our view, and based on the factual record here, the private interests at stake are meaningful to the affected individual but nevertheless limited; the procedures Bellin proposes would likely have little or no effect on the risk of erroneous deprivation and would only slightly expedite the correction of erroneous deprivations that do occur; and the burden on the government arising from the new procedures is modest but not insubstantial. Balancing these considerations, we conclude that New York's procedures adequately protect qualifying Medicaid recipients' interest in timely receiving 24-hour personal care services.

Because the District Court concluded that Bellin had no property interest at all in receiving 24-hour at-home care, it did not reach the question whether New York's procedures are constitutionally adequate. We similarly declined to reach this issue in Bellin's first appeal. *Bellin I*, 6 F.4th at 483. We reach it here, however, because the parties have since had an opportunity to develop the evidentiary record and have briefed the issue both before the District Court and in this appeal.

A. The private interests at stake are meaningful but limited

The primary private interest in this case is an enrollee's interest in promptly obtaining 24-hour (rather than part-time) at-home care when a need for that care develops. Current procedures preclude an immediate appeal of the authorization of care. The risk is that an enrollee in need of around-the-clock personal care may go several additional weeks before she begins to receive it.

This interest, while meaningful, is narrow because New York's current procedures already mitigate the effect of a possible deprivation in three ways. First, a Medicaid recipient may immediately appeal outright denials of personal care services. N.Y.C.R.R. tit. 18, § 360-10.8(b)(2); 42 C.F.R. § 438.402(c)(2)(ii). For that reason, the private interest we consider here affects only those individuals who, like Bellin, have been authorized to receive part-time but not full-time care, not those who have been denied personal care services altogether.

Second, Medicaid recipients with urgent needs may pursue expedited pathways to obtaining the care they require. If a beneficiary has immediate needs for personal care services before enrolling in a plan of care, state regulations direct the State to "arrange for the provision of" the necessary services "as expeditiously as possible." § 505.14(b)(7)(i)–(ii). And if, after enrollment, the "standard timeframe" for adjudicating requests for increased services "could seriously jeopardize the enrollee's life or health," the enrollee is entitled by federal law to receive a decision on her request for increased services within 72 hours. 42 C.F.R. § 438.210(d)(2)(i). If the request is denied, the MLTCP must also resolve any internal appeal within 72 hours. *Id.* § 438.408(b)(3).

The availability of these pathways further reduces the risk of adverse effects for those with an acute need for immediate care. Here, Bellin never sought relief through

these urgent-needs routes and does not seek to represent the more accentuated interests of the narrower class of individuals who have such urgent needs.

Third, the delay introduced by New York's procedural bar on appeals of initial offers is relatively short.[12] *See Fusari v. Steinberg*, 419 U.S. 379, 389 (1975) ("[T]he possible length of wrongful deprivation of . . . benefits is an important factor in assessing the impact of official action on the private interests."). In practice, MLTCPs may in some cases fail to meet the applicable legal deadlines, as occurred in Bellin's own case. But Bellin points to no record evidence of significant systematic delays by MLTCPs or the State that regularly stretch the period an enrollee goes without 24-hour care to lengths of arguably constitutional significance.

Thus, while we have recognized a "substantial" private interest in obtaining healthcare coverage when, absent the receipt of public assistance, "patients may have to endure lower-quality medical care or even forgo it altogether," the interests in this case are much narrower. *Barrows*, 24 F.4th at 141. We consider only the private interest in modestly expedited access to 24-hour services for individuals who are seeking at-home personal care (not medical treatment in a clinical setting), who already receive part-time personal care, and who have not claimed an urgent need for the care they seek.

The financial interests at stake for the enrollee are also limited. In weighing the significance of the private interest, we have distinguished between the "complete

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[12] Under existing procedures, an enrollee seeking to appeal her plan of care must first wait until the plan goes into effect before requesting more care. That delay between enrollment and the start of care is approximately 10 to 40 days under the State's existing contracts, depending on the proximity of the date of enrollment to the end of the month. If she requests more care on the first day that she begins receiving services under the initial plan, she must then wait up to seven days for the MLTCP to provide a decision on her request. *See* 42 C.F.R. § 438.210(d)(1)(i)(A). Thus, in theory, the combined delay allowed by the existing procedures and regulations is approximately two to seven weeks. The record is silent on the average length of that delay in practice.

termination" of benefits, on the one hand, and rules that "merely impose[] a set-off against future reimbursements," on the other. *Oberlander v. Perales*, 740 F.2d 116, 121 (2d Cir. 1984). Enrollees' financial interests here more closely resemble the latter. An enrollee who ultimately prevails in her appeal of a denied request for increased services may receive a retroactive adjustment of her plan's effective date and may receive reimbursement for qualifying out-of-pocket costs incurred after that effective date.

True, under the State's practice, that retroactive authorization goes back only to the date of the MLTCP's decision on her request, not to the date of the request itself. *See* J. App'x at 1533–36. And as a result, applicants like Bellin, who pay out-of-pocket for additional services while their appeals are pending, may be eligible for reimbursement of some, but not all, of their costs to procure additional personal care services while their appeal is pending. But any remaining short-term cost obligations arising from State-imposed limits on retroactive reimbursement—for Bellin, two weeks' worth of non-reimbursable costs—are surely different in kind than the "brutal need," as described in *Goldberg*, that is inflicted when "a welfare recipient" who is otherwise "destitute, without funds or assets," faces the complete termination of benefits. 397 U.S. at 261. And even during that non-reimbursable period, enrollees like Bellin still receive Medicaid-funded, part-time personal care services—they are deprived only of around-the-clock care.

We conclude, then, that the private interests that Bellin has shown to be at stake in this case are meaningful, but limited in both time and cost. The State represents, without objection from Bellin, that the "immediate needs" assessment, expedited authorization, and expedited appeal pathways are readily available. *See* Appellee Br. at 48; J. App'x at 977, 1496–97, 2048–50. Were these safety valves for individuals with acute, immediate needs difficult to obtain, available only in theory, or subject to severe and systematic delays, the private interests at stake would be significantly weightier.

B. The proposed procedures would not reduce the risk and only modestly reduce the length of erroneous deprivation

The procedures Bellin seeks to have imposed could theoretically decrease the risk of erroneous deprivation in two ways: first, by reducing the likelihood that an enrollee is incorrectly authorized to receive only part-time (instead of 24-hour) care, and, second, by shrinking the delay between enrollment and the authorization (on appeal) of 24-hour care.

We see no basis to believe that the proposed procedures are likely to reduce the risk of incorrect determinations. The record evidence is sparse on the risk of error and on how providing the right to appeal initial offers might affect it. Further, Defendants challenge the import of the evidence that has been offered.[13] And Bellin does not explain, even as a theoretical matter, why the additional procedures she seeks would reduce that error rate. Indeed, if enrollees were able to appeal an initial offer as Bellin requests, the procedures by which MLTCPs and the State would review plans of care and the evidence they would consider in doing so would be unchanged: both the initial plan-of-care offer and subsequent decisions whether to increase services must account for the results of the initial assessment, including the CHA, as well as any additional

[13] In her Rule 56.1 counter-statement, Bellin pointed to record evidence that (she asserted) establishes a 72% reversal rate across 6,366 fair hearing decisions reviewing MLTCPs' denials of requests for increased care. J. App'x at 4088–89. On appeal, she cites that evidence in support of her due process argument. Appellant's Reply Br. at 17; *see Barrows*, 24 F.4th at 141 & n.147 (describing a 37.5% reversal rate as a "high rate of error"). *But see Mathews*, 424 U.S. at 347 (noting the difference between reversal rate among appealed cases and overall reversal rate and describing reversal rate statistics as "relevant" but "certainly not controlling in this case"). But in the District Court proceedings, Defendants moved to strike the relevant portions of Bellin's counter-statement as procedurally improper. The District Court found that Defendants' motion "ha[d] merit" but denied it as moot in its summary judgment order in Defendants' favor. *Bellin II*, 2024 WL 381022, at *1 n.1. In light of our conclusion that the error rate itself is not central to Bellin's due process claim, we express no view on the merits of Defendants' motion to strike and do not rely on the proffered reversal-rate statistics.

evaluations the MLTCP might conduct. *See, e.g.*, Fair Hearing No. 7225409L (Jan. 15, 2016), at 14; Fair Hearing No. 7298986J (May 10, 2016), at 15; Fair Hearing No. 7362941K (Aug. 17, 2016), at 13–14. Thus, Bellin has not shown that the procedures she proposes are likely to reduce the risk of erroneous plan-of-care determinations at all.

Rather, as we have described, Bellin's claim focuses on the *timing* of appeals, not the prevailing outcomes. In essence, she wishes only to avail herself of the existing review procedures earlier: that is, immediately upon enrollment in a plan, not weeks or more later, after receiving an adverse initial decision.

It is true that administrative delay in providing benefits "can become so unreasonable as to deny due process," but we are not persuaded that the record evidence supports such a finding here. *Kraebel v. N.Y. City Dep't of Hous. Pres. & Dev.*, 959 F.2d 395, 405 (2d Cir. 1992). The relevant regulatory and contractual provisions imply a delay due to the challenged procedures on the order of weeks, not many months, and the record contains no systematic evidence of longer delays in practice. *Cf. Isaacs v. Bowen*, 865 F.2d 468, 477 (2d Cir. 1989) (six-month delay introduced by challenged procedure not violative of due process); *Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532, 547 (1985) (nine-month adjudication not "unconstitutionally lengthy *per se*" absent a showing that delay was "unreasonably prolonged"); *Mathews*, 424 U.S. at 342 (procedures contributing to delay that "exceeds one year" not violative of due process).

Further, much of the potential delay in securing increased care is attributable to other aspects of the appeals procedures—not those that Bellin challenges. For example, even if the State adopted the procedures Bellin proposes, she and other enrollees would still be subject to the State's exhaustion requirement: that an enrollee pursue an internal appeal of a denial of increased services with the MLTCP before seeking a fair hearing from the State. MLTCPs are generally allowed 30 days to decide those appeals. 42 C.F.R.

§ 438.408(b)(2); *see also id.* § 438.408(b)(3) (requiring expedited resolution of appeals in limited circumstances). The State then enjoys an additional 90 days from the date of a fair hearing request to issue a fair hearing decision. N.Y.C.R.R. tit. 18, § 358-6.4(a). Enrollees would be subject to these decisional timeframes even if they had the right to immediately appeal initial offers.

Neither side identifies record evidence bearing on how long the internal and external appeals processes take or on what portion of that period, in practice, is fairly attributable to the absence of an immediate appeal right for initial determinations. And the exhaustion requirement present here is typical of administrative-review proceedings arising from benefits determinations. *See, e.g.*, Conn. Gen. Stat. Ann. §§ 38a-591(a)((19), 38a-591d(g), 38a-591e(f); Vt. Stat. Ann. tit. 3, § 3091(i). So, the "probable value" of the proposed procedural changes on care timelines is uncertain at best. *Mathews*, 424 U.S. at 335.[14]

We conclude, then, that offering enrollees the right to an immediate appeal of initial determinations may modestly reduce the duration of any erroneous deprivations but is unlikely to decrease the risk of erroneous deprivation *per se*—that is, the error rate in MLTCPs' assessments of the appropriate level of services.

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[14] In addition to their timing, the existing procedures do differ from the proposed procedures in the potential out-of-pocket cost for enrollees: the State's practice if an enrollee prevails in her appeal is to make the effective date of the enrollee's coverage retroactive to the date by which the MLTCP was required to provide an initial decision on the request for increased services (for Bellin, June 18), and not to the effective date of the plan of care (for Bellin, June 1), as would be case under the procedures Bellin proposes. *See* J. App'x at 125 (amended fair hearing decision modifying the effective date of Bellin's 24-hour care from June 1 to June 18 for this reason), 1533–36 (Department of Health official describing this general practice). That difference may have implications for an enrollee's ability to recoup out-of-pocket expenses incurred while her request was being adjudicated. *See above* Background Section I.C. But those implications, if any, are merely incidental to the core relief Bellin seeks for herself and the putative class: the right to an earlier appeal.

C. The increased burden on the government is marginal

Finally, we consider the magnitude of the burden that the requested procedures would impose on the State. *Mathews*, 424 U.S. at 335. Procedural change always entails some measure of administrative burden for the government and compliance costs for its agents. A change in the initial-appeal rule would require the Department of Health to develop new guidance and procedures, and to communicate those changes to MLTCPs and more generally. *See* J. App'x at 2052–53 (State declarant describing the required cascading regulatory and administrative changes). The MLTCPs, in turn, would need to update and disseminate their own new policies.

And once the new procedures are implemented, MLTCPs would need to adjudicate the internal appeals of enrollees who elect to exercise the right to appeal their initial offers, and the State would need to provide fair hearing proceedings to enrollees whose internal appeals are denied and who seek external review. Finally, the net result of the expedited procedures would likely be to provide enrollees who successfully appeal their initial offers with several more weeks of 24-hour personal care services than they would have received under current procedures. MLTCPs can be expected to bear some additional administrative burden in providing those extra weeks of services.

We conclude, still, that requiring the State to permit enrollees to use existing procedural mechanisms (the internal appeal and fair hearing processes) to challenge an existing determination (the initial offer) would effect only a relatively modest additional burden because all the mechanisms for review are already in place. Again, Bellin simply seeks to avail herself of those existing procedures sooner.

The State protests that if even "a fraction" of enrollees requested fair hearings to appeal pre-enrollment offers, it "would have to expend significant resources." Appellee's Br. at 51. But in support it cites only evidence of the current volume of

appeals, not any significant record evidence on the critical question of how the current volume would *change* under the proposed procedures. Nor has it given much reason to believe, even as a theoretical matter, that an immediate right to appeal would result in a significant increase in the number of fair hearings. If, as the State contends, the existing right to request an increase in services and to appeal any denial of that request provides many of the same protections as would the right to appeal an initial offer that Bellin seeks, it stands to reason that many applicants are already using the existing process to challenge initial offers—just as Bellin did. So, much of any increase caused by new fair hearings appealing initial offers could well correspond with a commensurate decrease in fair hearings appealing denials of requests for increased services.

The proposed procedures also seem unlikely to impose a significantly increased burden for MLTCPs. In fact, permitting appeals of initial offers themselves—without requiring an additional request (for increased services), an additional evaluation of the enrollee (to evaluate the request), and an additional determination by the MLTCP (to decide the request)—may even *reduce* the burden on MLTCPs relative to the existing procedures. The State worries about the risk that applicants will pursue parallel appeals of multiple pre-enrollment offers from different MLTCPs. But Bellin seeks only a beneficiary's right to appeal an MLTCP's initial offer of services after she has elected to enroll in that MLTCP. *See* Appellant's Reply Br. at 20. Thus, adopting Bellin's position appears to present little risk of generating duplicative appeals.

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Ultimately, we are not persuaded that Bellin is constitutionally entitled to the additional process she seeks. The private interest in 24-hour care as opposed to part-time care ultimately is narrow (though personally meaningful), and the likelihood that an immediate right to appeal would reduce the risk of error is practically zero. *Mathews*, 424 U.S. at 335. Indeed, even Bellin does not contend that the procedures she seeks

would improve the accuracy of plan-of-care determinations themselves. The only remaining benefit is a modestly expedited decision timeline, but we have long recognized that administrative delays in the provision of benefits are permissible so long as they are reasonable. *See, e.g.*, *Cleveland Bd. of Educ.*, 470 U.S. at 547. Balancing the narrow private interest and the negligible effect of the proposed procedures against the government burden, we fail to find on the record before us a due process violation under *Mathews*.

Bellin has no doubt identified a significant shortcoming in the State's program for providing qualifying Medicaid recipients with personal care services. She has sought to improve this system for herself and, as importantly, for others like her. And she has established that under New York law, qualifying Medicaid recipients have a property interest in receiving 24-hour—rather than part-time—personal care services, triggering constitutional due process protections. But Bellin has not shown that, however imperfect, New York's current appeals procedures governing challenges to less than full 24-hour care fall short of the minimum guaranteed by the Due Process Clause.

CONCLUSION

For the reasons set forth above, we conclude that qualifying Medicaid recipients in New York have a property interest in receiving 24-hour personal care services. We also conclude that on this record, the State has shown that this interest is adequately protected by New York's existing procedures. We therefore **AFFIRM**, on this alternative ground, the judgment of the District Court in favor of Defendants.