No. 19-470

IN THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

LESLIE LISNITZER, individually and on behalf of all others similarly situated,

Plaintiff-Appellee,

v.

HOWARD ZUCKER, M.D., as Commissioner of the New York State Department of Health, and MICHAEL HEIN, as Acting Commissioner of the Office of Temporary and Disability Assistance of the New York State Department of Family Assistance

Defendants-Appellants.

On Appeal from the United States District Court
for the Eastern District of New York

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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INTRODUCTION

The United States respectfully submits this amicus brief in response to the Court's request for the federal government's views. This brief will address whether the Medicaid statute and regulations, including 42 U.S.C. § 1396a and 42 C.F.R. §§ 431.244 and 431.246, require a State to conclusively determine a claimant's eligibility for Medicaid in a single fair hearing within specified time limits. For the reasons discussed below, the Medicaid regulations generally do require a State's fair hearing to render a final and definitive decision resolving a claimant's eligibility for Medicaid within 90 days of the claimant's fair hearing request. A fair hearing decision that remands an application for Medicaid eligibility to a local agency for further consideration does not satisfy the regulatory requirement of "final administrative action" within 90 days. Those conclusions follow from analysis of the applicable regulation's text, structure, and drafting history and from consideration of background administrative law principles and the policies embodied in the Medicaid statute and regulations.

STATEMENT

I. Statutory and Regulatory Background

A. Federal Medicaid Fair Hearing Requirements

Medicaid is a joint state-federal program in which the federal government provides funding to States for medical services for low-income individuals. *See* 42 U.S.C. § 1396 *et seq*. To receive federal funding, a State must develop a plan that meets federal requirements and that is approved by the Centers for Medicare & Medicaid Services, an agency within the U.S. Department of Health and Human Services (HHS). *See, e.g.,* 42 U.S.C. § 1396a(b); 42 C.F.R. §§ 430.10, 431.10.

A State plan must designate "a single State agency to administer or to supervise the administration of the plan." 42 U.S.C. § 1396a(a)(5). A State plan must "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." *Id*. § 1396a(a)(8). And a State plan must provide "an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." *Id*. § 1396a(a)(3).

HHS has promulgated regulations governing fair hearings. 42 C.F.R. pt. 431, subpt. E. One provision addresses fair hearing decisions. 42 C.F.R. § 431.244 (Hearing Decisions Regulation). Among other things, the Hearing Decisions Regulation requires a State agency to "take final administrative action . . . [o]rdinarily[] within 90 days from . . . the date the agency receives a request for a fair hearing." 42 C.F.R. § 431.244(f)(1)(ii). In some circumstances, the agency must take final administrative action more urgently. For example, the regulations require a State agency to provide for "an expedited fair hearing process" in cases in which a decision issued under the usual 90-day timeframe "could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function." *Id.* § 431.224(a)(1). In an expedited fair hearing, the agency must "take final administrative action" on an eligibility decision "as expeditiously as possible."[1] *Id.* § 431.244(f)(3)(i). The Hearing Decisions Regulation permits State Agencies to exceed the time limits for final administrative action in only two "unusual

[1] State Agencies may eventually be required to take final administrative action in expedited hearings involving denials of eligibility "no later than 7 working days after the agency receives a request for expedited fair hearing." 42 C.F.R. § 431.244(f)(3)(i). That requirement will become effective six months after HHS publishes a notice in the Federal Register. *See id.* § 435.1200(i).

circumstances"—where "[t]he agency cannot reach a decision because the appellant requests a delay or fails to take a required action" or where "[t]here is an administrative or other emergency beyond the agency's control." *Id.* § 431.244(f)(4)(i).

HHS has also issued a *State Medicaid Manual* (*Manual*), which provides the Department's interpretations of the federal requirements applicable to participating States. *See* JA 43 (*Manual*, Foreword). With respect to fair hearing time limits, the *Manual* explains that "[t]he requirement for prompt, definitive, and final administrative action means that all requests for a hearing are to receive prompt attention and will be carried through all steps necessary to completion." JA 54 (§ 2902.10). The *Manual* further states that the hearing authority must make "[a] conclusive decision in the name of the State agency." JA 55 (§ 2903.2(A)). "[I]f the materials submitted are insufficient to serve as a basis for a decision," the State agency may "refer the matter back to the hearing officer for a resumption of the hearing." *Id.* But, the *Manual* cautions, "[r]emanding the case to the local unit for further consideration is not a substitute for 'definitive and final administrative action.'" *Id.*

B. New York Medicaid Fair Hearing Policies and Practices

The State of New York administers its Medicaid program through local social service districts (local districts), subject to regulation by the New York Department of Health, which New York has designated as its single State agency responsible for supervising the State's implementation of Medicaid. N.Y. Soc. Serv. Law §§ 363-a, 365(1)(a); *see* 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10(b)(1). In accordance with its designation as New York's single State agency, the Department of Health has responsibility for promulgating "policy, rules and regulations" governing Medicaid fair hearings, and with "making final administrative determinations and issuing final decisions concerning such matters." N.Y. Soc. Serv. Law § 364(2)(h). The Department of Health has delegated to the Office of Temporary and Disability Assistance its authority to conduct fair hearings and make final decisions for "applicants for and recipients of medical assistance." 18 N.Y. Comp. Codes, R. & Regs. tit. 18, § 358-2.30(b); *see id.* §§ 358-5.6(a), (b), 358-6.1; *see also* JA 408 (New York State plan delegating authority to the Office of Temporary and Disability Assistance to conduct fair hearings concerning Medicaid).

The district court in this case made a number of findings concerning New York's fair hearings practice. In New York, the focus of a fair hearing

is not "whether the appellant is eligible for the Medicaid benefit at issue" but instead "is limited to the reasons stated in the local agency notice" for denying an application for Medicaid. SPA 6, ¶ 21. In some cases, a fair hearing decision may reject a local district's reason for its denial and remand the matter to the local district for further consideration. *Id.* ¶¶ 23, 24. In such cases, the fair hearing decision "does not determine the appellant's eligibility" for Medicaid. *Id.* ¶ 23. Instead, on remand, the local district must "continue to process the application" and must "issue a new decision as soon as possible." *Id.* ¶ 25. If the local district again denies the application for Medicaid, the claimant "must request a new fair hearing" to obtain review of the new ground for denial. SPA 8, ¶ 31.

II. Prior Proceedings

A. Lisnitzer's Fair Hearing

Plaintiff Leslie Lisnitzer applied to a local district, the Suffolk County Department of Social Services, for Medicaid coverage to pay the cost of his monthly Medicare Part B premium. SPA 8, ¶ 1. Lisnitzer's income exceeded the limit for Medicaid coverage, but he asked the local district to consider his application under a New York state policy directive "designed to maximize Medicare coverage for high users of medical services." *Id.* ¶ 2. The local

district denied Lisnitzer's application without considering Lisnitzer's eligibility under the policy directive. *Id.* ¶ 3.

Lisnitzer requested a fair hearing, arguing that he was eligible for Medicaid under the state policy directive and asking that the hearing officer direct the local district to approve payment. SPA 9, ¶¶ 4, 6. With Lisnitzer's consent, the hearing officer granted the local district an adjournment to permit it to consider Lisnitzer's eligibility under the state policy directive. *Id.* ¶ 7. When the hearing resumed, the local district argued that the state policy directive does not apply to Lisnitzer. *Id.* ¶ 8. Within 90 days of Lisnitzer's request for a fair hearing, the Office of Temporary and Disability Assistance "'reversed' the [local district's] denial of benefits and 'remanded' the matter to the [local district], directing the agency 'to make the [eligibility] determination . . . following the [state policy directive]' and 'to comply immediately with the directive[].'" SPA 10, ¶ 10 (third and fourth alteration in original).

B. District Court Proceedings and Subsequent State Action

Lisnitzer brought suit, seeking class certification, challenging New York's practice of remanding Medicaid fair hearing claims to local districts without making eligibility determinations within the time limits prescribed

by federal regulations. SPA 1. While Lisnitzer's federal action was pending, the local district again denied Lisnitzer's application for Medicaid. SPA 10, ¶ 13. Lisnitzer notified the New York State Compliance Unit that the local district's decision did not comply with the fair hearing decision because it did not consider his application under the state policy directive. *Id.* Three days later, the local district reversed itself and determined that Lisnitzer was eligible for Medicaid. SPA 11, ¶ 14. The local district issued its decision 342 days after Lisnitzer's request for a fair hearing. *See* SPA 9, ¶ 4 (fair hearing requested June 10, 2011); SPA 11, ¶ 14 (local district eligibility determination made May 17, 2012).

After a bench trial, the district court granted class certification and held that New York's remand practice violates a Medicaid applicant's right to an eligibility determination within the federal time limits.[2] SPA 19. The Hearing Decisions Regulation requires a State to take "final administrative action" within 90 days of a fair hearing request in most circumstances. 42 C.F.R. § 431.244(f)(1)(ii). The district court observed that "[n]either the

[2] The district court held that this case had not become moot despite New York's determination that Lisnitzer was eligible for benefits because Lisnitzer's claim was the sort that is capable of repetition yet evading review, and because the class certification relates back to the filing of Lisnitzer's complaint. SPA 13-14.

Medicaid Act nor the governing regulations define the phrase 'final administrative action.'" SPA 17. At the same time, federal law does not prohibit a State agency from remanding the case to a local district. *Id.* But the court understood the requirement of "final administrative action" to "mean[] that the state was required to provide a final determination of eligibility for benefits within [90 days], not simply any disposition, including a 'remand,' of the appeal." SPA 18. Thus, while the State agency may remand the matter to a local district, "any remand should specify the time in which the agency must act and report back so that the [State agency] can render a final determination within that 90-day period." *Id.* (quoting *Konstantinov v. Daines*, 956 N.Y.S.2d 38, 39-40 (N.Y. App. Div. 2012)).

The district court permanently enjoined New York from remanding fair hearings to local districts "without rendering final determinations of eligibility based upon the development of complete fair hearing records within 90 days of the hearing requests exclusive of adjournments requested by [Medicaid applicants]." JA 401.

ARGUMENT

A Fair Hearing Decision Must Definitively Resolve a Claimant's Eligibility for Medicaid Within the Applicable Time Limit

The district court correctly held that the Hearing Decisions Regulation requires a conclusive determination of an applicant's Medicaid eligibility within the specified deadline in any appeal challenging a local district's ineligibility determination.

I. Traditional Tools of Interpretation Demonstrate that the Hearing Decisions Regulation Requires Definitive Resolution of an Eligibility Claim

In *Shakhnes v. Berlin*, this Court held that a State need not implement relief ordered in a fair hearing decision within the time limits specified in the Hearing Decisions Regulation because the implementation of relief is distinct from the "final administrative action" required by the regulation. 689 F.3d 244, 257 (2012) (discussing 42 C.F.R. § 431.244(f)). In so holding, the Court considered "the structure, text, and drafting history of the applicable regulations, together with a review of administrative law principles and other statutory and regulatory provisions." *Id.* Employing those traditional interpretive tools to the question at issue here leads to the conclusion that to

be "final administrative action," a fair hearing decision must definitively determine a claimant's Medicaid eligibility.

A. Structure, Text, and Drafting History

1. The HHS regulations governing State fair hearings do not define "final administrative action." *See* 42 C.F.R. § 431.201 (definitions). But the structure and text of the Hearing Decisions Regulation make clear that only a decision that conclusively determines a claimant's eligibility is "final administrative action."

"Ordinarily," the State agency conducing the fair hearing "must take final administrative action" within 90 days of receiving the claimant's request for a fair hearing. 42 C.F.R. § 431.244(f)(1)(ii). However, the fair hearing regulations require State plans to provide for "an expedited fair hearing process" for individuals whose "life, health, or ability to attain, maintain, or regain maximum function" could be jeopardized by decision under the ordinary 90-day time limit. *Id.* § 431.224(a)(1). When a fair hearing is expedited, the Hearing Decisions Regulation requires the State agency to take "final administrative action" on an accelerated basis. For example, in the case of an adverse eligibility determination, the State agency must "take final administrative action . . . as expeditiously as possible." *Id.*

§ 431.244(f)(3)(i). In light of the exigent circumstances provoking the need for expedited hearings, "final administrative action" is most naturally read as requiring a definitive eligibility determination. Understood otherwise, the regulation would permit inconclusive fair hearing decisions that could result in multiple remands and appeals, which could jeopardize the life or health of a Medicaid applicant, thus frustrating the purpose of expedited hearings.

The Hearing Decisions Regulation's requirement of "final administrative action" applies equally to all fair hearing decisions; there is no reason to think that the term has one meaning for expedited hearings and another for those undertaken in the ordinary course. *Cf. Law v. Siegel*, 571 U.S. 415, 422 (2014) ("[W]ords repeated in different parts of the same statute generally have the same meaning."). Because "final administrative action" is best understood as requiring a State agency to make a definitive eligibility determination in expedited fair hearings, the term should be understood as requiring the same in all fair hearings.

2. The drafting history of the Hearing Decisions Regulation also supports that interpretation.

Before Congress enacted the Medicaid statute, it established other federal-state cooperative programs to assist needy individuals. Congress

provided grants to States for old-age assistance, for aid to dependent children, and for aid to the blind as part of the Social Security Act of 1935, for example. Pub. L. No. 74-271, ch. 531, §§ 2-3, 401, 1001, 49 Stat. 620, 620-621, 627, 645. For all of those programs, to receive federal funding, States had to submit to the Social Security Board for approval a plan that satisfied certain statutory qualifications. *Id.* §§ 2(a), 402(a), 1002(a). "In the early years," the Social Security Administration used informal means, such as "mimeographed memoranda and regional field letters," to inform States about what was needed for federal approval of a State plan. Advisory Comm'n on Intergovt'l Relations, *Statutory and Administrative Controls Associated With Federal Grants for Public Assistance* 10 (1964), https://perma.cc/PJ6Y-48LA. Beginning in 1946, the Social Security Administration formalized its communication with the States by publishing the federal requirements in the *Handbook of Public Assistance Administration* (*Handbook*). *See* JA 584-88 (excerpt from 1954 edition).

Among the requirements for State plans enumerated by the Social Security Act was the "opportunity for a fair hearing" for claimants whose applications for benefits were denied. Pub. L. No. 74-271, §§ 2(a)(4), 402(a)(4), 1002(a)(4). From an early date, the *Handbook* interpreted the

statutory fair-hearing provision to require "definitive and final administrative action on every request for a hearing." JA 587 (§ 6310(4)). It emphasized that "[t]he decision on the hearing constitutes the ultimate decision of the State agency," and it cautioned that "[r]emanding the case to the local unit for further consideration is no substitute for 'definitive and final administrative action' by the State agency." JA 588 (§ 6310(9)).

After Congress established the Medicaid program in 1965, the Department of Health, Education, and Welfare added a supplement to the *Handbook* to address the federal requirements for State Medicaid plans. *See* JA 589-94 (excerpt from 1966 Supp. D). Like the public assistance programs that preceded it, the Medicaid program requires State plans to provide claimants whose applications were denied the opportunity for a fair hearing. Health Insurance for the Aged Act, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 343 (1965) (codified as amended at 42 U.S.C. § 1396a). The supplement carried over the *Handbook*'s previous explanation of the need for "definitive[] and final administrative action" that is a "conclusive decision" and its caution about remanding cases to the local unit for further consideration. JA 592 (§ D-6540), 593 (§ D-6540). But the supplement also identified as a "criteri[on] for the [a]dministration of the [State p]lan" the

requirement that a fair hearing decision culminate in "a final administrative decision in the name of the State agency on all issues that have been the subject of a hearing." JA 590 (§ D-6530(3)); *see* JA 593 (§ D-6540). The supplement also required State agencies to adopt "[a] definitive over-all time limit—preferably within 45 days, but not to exceed 90 days—between the date of the request for the hearing and the date of the agency's decision." JA 590 (§ D-6530(9)).[3]

In 1971, the Department of Health, Education, and Welfare promulgated a regulation that adopted the requirement in the *Handbook* and its Medicaid supplement that fair hearing decisions result in "definitive[] and final administrative action" within "60 days from the date of the request for a fair hearing." 36 Fed. Reg. 3034, 3035 (Feb. 13, 1971); 45 C.F.R. § 205.10(a)(11) (1972); *see* 38 Fed. Reg. 22,005, 22,008 (Aug. 15, 1973) (extending time limit to 90 days). The years of sub-regulatory explanation of the meaning of "definitive and final administrative action" described above informs the interpretation of the regulation. The Department and

[3] Most of the supplement's requirements and explanations have been carried over to the *State Medicaid Manual*, which replaced the *Handbook* for purposes of the administration of State Medicaid programs. *See* JA 54 (§ 2902.10); JA 55 (§ 2903.2(A)); *supra* p. 4.

participating States would have been aware that the *Handbook* and supplement characterized a "final administrative decision" as a decision that is "conclusive" and that resolves "all issues that have been the subject of a hearing" within an "over-all time limit." JA 590 (§ D-6530(3)), JA 593 (§ D-6540). There is no reason to conclude that "definitive and final agency action" meant anything less in the regulation that formalized the *Handbook* requirement.[4]

* * * *

In short, the text, structure, and drafting history of the Hearing Decisions Regulation show that to be "final administrative action" a fair hearing decision must conclusively determine a claimant's Medicaid eligibility.

[4] In 1979, the Department of Health, Education, and Welfare "redesignate[d] and clarif[ied]" various Medicaid regulations. 44 Fed. Reg. 17,926, 17,926 (Mar. 23, 1979). As revised (and in its current form), the Hearing Decisions Regulation requires State agencies to take "final administrative action" within 90 days of receiving a hearing request. *Id.* at 17,933; *see* 42 C.F.R. § 431.244(f). The Department made clear that in omitting the adjective "definitive," it intended no change in meaning. 44 Fed. Reg. at 17,926 (stating that redesignation and clarification was "without substantive change").

B. Administrative Law Principles

In *Shakhnes*, the Court observed that "[w]ell-settled principles of administrative law" inform the meaning of "final administrative action" in the Hearings Decision Regulation. 689 F.3d at 260. Under the Administrative Procedure Act, an agency action is "final" and subject to judicial review "if two conditions are met: (1) 'the action must mark the consummation of the agency's decisionmaking process—it must not be of a merely tentative or interlocutory nature,' and (2) 'the action must be one by which rights or obligations have been determined,' or from which 'legal consequences will flow.'" *Id.* (quoting *Bennett v. Spear*, 520 U.S. 154, 177-78 (1997)) (quotation marks omitted); *see Soundboard Ass'n v. FTC*, 888 F.3d 1261, 1267 (D.C. Cir. 2018) ("[E]ach prong of *Bennett* must be satisfied independently for agency action to be final."). The Supreme Court has construed the finality requirement "pragmatic[ally]," driven in part by the principle that "piecemeal review" of agency action "at the least is inefficient and upon completion of the agency process might prove to have been unnecessary." *FTC v. Standard Oil Co.*, 449 U.S. 232, 242-43 (1980).

New York employs a similar approach to administrative finality, which is a requirement for judicial review of agency action, including judicial review

of Medicaid fair hearing decisions. N.Y. C.P.L.R. 7801; *see* N.Y. Soc. Serv. Law § 22(9)(b); *see also Shakhnes*, 689 F.3d at 260 (relying on state administrative law principles to interpret "final administrative action"). To be final and subject to judicial review, "the action must impose an obligation, deny a right or fix some legal relationship as consummation of the administrative process." *Ranco Sand & Stone Corp. v. Vecchio*, 49 N.E.3d 1165, 1169 (N.Y. 2016) (quotation marks omitted). That requirement involves "a pragmatic evaluation . . . of whether the decisionmaker has arrived at a definitive position on the issue that inflicts an actual, concrete injury." *Id.* (quotation marks omitted; omission in original). In addition, administrative action is not final unless "the apparent harm inflicted by the action may not be prevented or significantly ameliorated by further administrative action or by steps available to the complaining party." *Id.* (quotation marks omitted).

Under both federal and New York finality principles, a Medicaid fair hearing decision that does not resolve an applicant's eligibility for Medicaid and instead remands the claim to a local agency for further consideration is not "final." *Cf. Pueblo of Sandia v. Babbitt*, 231 F.3d 878, 880 (D.C. Cir. 2000) ("It is well settled that, as a general rule, a district court order remanding a case to an agency for significant further proceedings is not

final."). It is by definition "interlocutory" in nature. *See CSX Transp., Inc. v. Surface Transp. Bd.*, 774 F.3d 25, 28 (D.C. Cir. 2014) ("In an administrative adjudication, a final order typically disposes of all issues as to all parties.") (quotation marks omitted). And because the need for judicial review may be obviated by the local agency's decision on remand, any harm inflicted by a fair hearing remand order may "be prevented or significantly ameliorated by further administrative action." *Ranco Sand*, 49 N.E.3d at 1169 (quotation marks omitted); *see Pueblo of Sandia*, 231 F.3d at 880 (similar). A remand order also does not determine a claimant's right to receive Medicaid benefits or the State's obligation to provide them. It therefore does not "impose an obligation, deny a right or fix some legal relationship as a consummation of the administrative process." *Ranco Sand*, 49 N.E.3d at 1169; *see Bennett*, 520 U.S. at 178-79.

Administrative law principles thus further support the conclusion that a "final administrative action" is a definitive resolution of the ultimate issue that is the subject of the fair hearing.

C. Policy Considerations

Congress enacted the Medicaid statute to assist States in furnishing "medical assistance on behalf of families with dependent children and of

aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396-1. To further that objective, Congress requires States to "assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients." *Id.* § 1396a(a)(19); *see* 42 C.F.R. § 435.902. And reflecting the importance of access to healthcare, Congress directed participating States to ensure that "medical assistance . . . be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). In light of Congress's emphasis on the rapid provision of medical assistance to eligible individuals, HHS requires State agencies to determine an applicant's eligibility for Medicaid within 45 days of the date of application (90 days in the case of applicants who apply for Medicaid on the basis of disability), and to "[f]urnish Medicaid promptly" to those deemed eligible. 42 C.F.R. §§ 435.912(c)(3), 435.930.

The requirement that a fair hearing result in "final administrative action" generally within 90 days must be understood in light of those policies. Interpreting "final administrative action" to require a conclusive eligibility determination helps ensure that claimants receive a prompt answer in a

single fair hearing. That construction thus harmonizes with the policies of administrative simplicity and the rapid provision of benefits to eligible individuals, and so furthers the best interests of applicants and beneficiaries. By contrast, if an interlocutory decision remanding a claim to a local agency qualifies as a "final administrative action," a claimant may need to request multiple fair hearings to receive a definitive answer. Such a drawn-out process conflicts with the objective of speedy decision, prompt provision of assistance, and administrative simplicity.

II. New York's Contrary Arguments Lack Merit

New York contends that a fair hearing decision that reverses a local district's reason for denying benefits and that remands the claim for further consideration qualifies as a "final administrative action" within the meaning of the Hearing Decisions Regulation. That is mistaken.

A. According to New York, "federal regulations specifically carve out Medicaid eligibility determinations from the 'final agency action'" required by the Hearing Decisions Regulation. Reply Br. 15. In New York's view, eligibility determinations are a form of "corrective action," a type of relief required by a fair hearing that reverses a decision adverse to a claimant, which is governed by a separate regulation. Opening Br. 32 (discussing 42

C.F.R. § 431.246). And because this Court has determined that the implementation of relief is not part of "final administrative action," New York contends that the Hearing Decisions Regulation does not require States to make conclusive eligibility determinations by the applicable deadline. Opening Br. 32; *see id.* at 30 (discussing *Shakhnes*).

That argument misunderstands the Corrective Action Regulation, which requires States to "promptly make corrective payments" when a "hearing decision is favorable to the applicant." 42 C.F.R. § 431.246(a). An eligibility determination is not a payment. In addition, a State's obligation to take corrective action is triggered by a fair hearing decision that a claimant is eligible for Medicaid. An eligibility determination cannot be both a corrective action and its trigger.

B. Next, New York urges that a fair hearing decision that rejects a County Agency's reason for denying a claimant's eligibility and remands for further consideration is final under administrative law principles. Addressing *Bennett*'s first prong, New York contends that such a remand order is not interlocutory because it "definitively" resolves the parties' dispute about the "the grounds for denial at issue on appeal." Reply Br. 20. But resolving one issue is not enough to make an administrative order final.

See CSX Transp., 774 F.3d at 28 ("In an administrative adjudication, a final order typically disposes of all issues as to all parties.") (quotation marks omitted). New York's reliance on the Supreme Court's decision in *U.S. Army Corps of Engineers v. Hawkes Co.* is misplaced. Reply Br. 20 (discussing 136 S. Ct. 1807 (2016)). In that case, the agency "ha[d] ruled definitively" on the ultimate issue. *Hawkes*, 136 S. Ct. at 1814. It was possible that the agency could revise its determination in the future based on new information. *Id.* But "[t]hat possibility," the Court held, "is a common characteristic of agency action, and does not make an otherwise definitive decision nonfinal." *Id.* Thus, *Hawkes* did not hold that an agency action "'definitively' resolv[ing] a dispute in a way that is binding on the parties" is final "even when the agency continues to process an application." Reply Br. 20.

Addressing the second *Bennett* prong, New York argues that a remand decision "determines rights or obligations or has legal consequences" because a local district will be bound by the fair hearing decision's resolution of the dispute. Opening Br. 34 (quotation marks omitted). But that is not the sort of "obligation" or "legal consequence" that satisfies the requirement. In a fair hearing considering the denial of Medicaid eligibility, only a decision

conclusively determining the claimant's eligibility "fixes" a "legal relationship" between the State and the claimant. *Paskar v. DOT*, 714 F.3d 90, 96 (2d Cir. 2013); *cf. CSX Transp.*, 774 F.3d at 30 (binding agency order that required a party to participate in agency adjudication did not create the sort of "immediate obligations and legal consequences" needed for final agency action). Neither New York's "duties or its obligations [were] altered" by the fair hearing decision in this case. *Asbestec Const. Servs., Inc. v. EPA*, 849 F.2d 765, 769 (2d Cir. 1988).

For an agency action to be final, it must satisfy both of *Bennett*'s requirements. *Soundboard Ass'n*, 888 F.3d at 1267. The remand order satisfies neither.[5]

C. Finally, New York argues that the division of responsibility between local districts and the State agency supports its construction of the Hearing Decisions Regulation. Opening Br. 33; Reply Br. 16-18. Local

[5] New York states that "Lisnitzer could have challenged in state court the fair hearing decision's rejection of his request to immediately issue a definitive determination of Medicaid eligibility." Opening Br. 35. That, New York contends, indicates that the fair hearing remand decision was final. *Id.* But such a suit would be a state-court analogue to the present suit, which is not a challenge to final agency action but to a state practice that Lisnitzer alleges violates his federal and state rights. *See* JA 34-35. The fair hearing decision at issue in this case is not final under New York administrative law principles. *See supra* pp. 17-19.

districts are principally tasked with "the complex task of determining Medicaid eligibility." Opening Br. 33. By contrast, the State agency's role is "to correct specific errors made by the local district." *Id.* "[E]ligibility determinations are complex and fact-driven," New York explains, and "the record at a fair hearing may not contain enough evidence to resolve eligibility altogether." Reply Br. 17. Thus, even when a fair hearing decision reverses a local district's determination that a claimant is ineligible for Medicaid, the local district may need "to conduct additional investigation if more facts are needed." *Id.* For these reasons, requiring the State agency to make conclusive eligibility determinations would "replace the local district's role" in "determining Medicaid eligibility." Opening Br. 33.

That argument is undercut by New York's representation that its "policy mandates that, '[i]f more than one reason exists [for denial], the local district must state as many reasons for the [denial] as are applicable.'" Reply Br. 18-19 (quoting JA 658). If local districts must identify all applicable grounds for denial, then they generally will make the factfinding necessary to support their decisions. In that case, the need for "additional investigation" to supplement the evidentiary record will be the exception rather than the rule, and a State agency can generally determine a claimant's

eligibility in a single fair hearing. And in those cases in which further factfinding is needed, the State agency may remand the case to the fair hearing officer to take additional evidence, or to the local district that made the eligibility determination, if necessary—provided that the State agency issues a conclusive determination of the claimant's eligibility within the applicable time limits. *See* 42 C.F.R. § 431.244(f); JA 55 (*Manual*, § 2903.2(A)).[6]

Ultimately, the Medicaid statute requires that a State plan designate "a single State agency to administer or to supervise the administration of the plan." 42 U.S.C. § 1396a(a)(5). It is that single State agency that has responsibility for ensuring compliance with the requirements of the Medicaid statute and implementing regulations, including the requirement to provide

[6] The *Manual* cautions that remand to the "local unit" is not a substitute for "final administrative action" within the applicable time limit. JA 55. New York contends that "local unit" is "not a reference to the entity that makes the initial administrative determination," but a reference to the entity conducting a local evidentiary hearing as part of the fair hearing process. Reply Br. 12; *see id.* at 12-14; Opening Br. 35; *see also* 42 C.F.R. §§ 431.232, 431.233 (authorizing local evidentiary hearings). That is mistaken. The term "local unit" derives from the *Handbook*, which uses the term to denote the agency that makes the initial benefits determination and that implements the fair hearing decision. *See, e.g.*, JA 593 (§ D-6540) (discussing a "report by the local unit to the State agency of action taken to carry out the hearing decision").

"an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." *Id.* § 1396a(a)(3). Longstanding HHS regulations permit the single State agency to authorize other entities to perform certain functions under its plan. *See* 42 C.F.R. § 431.10(c). But when a State agency delegates some of its functions, it retains ultimate responsibility for the administration of the plan and for ensuring that federal requirements are satisfied. 42 U.S.C. § 1396a(a)(5), 42 C.F.R. § 431.10(c)(3), (e).

CONCLUSION

For the foregoing reasons, the district court correctly held that the Medicaid regulations generally do require a State's fair hearing to render a final and definitive decision resolving a claimant's eligibility for Medicaid within 90 days of the claimant's fair hearing request.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 29(a)(5) because it contains 5,549 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in CenturyExpd BT 14-point font, a proportionally spaced typeface.

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CERTIFICATE OF SERVICE

I hereby certify that on February 19, 2020, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Second Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

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