DISCLOSURE OF COMMERCIAL INTERESTS

I have commercial interests in the following organization:

sb2 inc.

Chad Bogar, Owner/CEO/Managing Partner

sb2 inc. is a law firm dedicated to providing excellent and affordable legal services to the health care provider community, with an emphasis on representing the long-term care industry.

How to Use Federal Regulations to Protect Your Revenue from MCOs.

Revenue. Recognition. Recovery.®

WHO WE ARE

- founded in 2004
- work in over 44 states
- 23 staff attorneys and 30+ national contract attorneys
- Now representing healthcare associations and providers with over 2800 facilities

Revenue. Recognition. Recovery.®

ABOUT THE FIRM

We only want to handle the top 5% of your most difficult Medicaid cases.

Revenue. Recognition. Recovery.®

MEDICAID ELIGIBILITY CASE EXAMPLES: TOP 5% MOST DIFFICULT

1. If you have a resident who refuses to produce the verification or spend down excess resources to qualify for Medicaid, we can intervene and get them qualified.

2. If a resident passes away during the Medicaid Eligibility application or appeal process, eligibility can still be obtained. We often qualify decedents years after death.

3. If a resident is incapacitated and without an authorized representative or guardian (or, if either has "resigned") and their application for Medicaid has been denied, we can save the application even if the appeal is filed months after the deadline.

4. If an application has pended for longer than the mandatory processing time (usually 30 to 45 days), and the county issues a denial for excess resources or failure to submit requested verification, thereby costing you several months of retroactivity, we can fix this by appealing and arguing prejudicial delay.

5. If your facility has applications for Medicaid that have pended for longer than the mandatory processing time (usually 30 to 45 days), we can obtain automatic approval by filing a Delay Action.

6. If you have a resident and the community spouse refuses to provide verification of assets and will not spend down excess resources, we can still get the resident qualified for Medicaid under the Doctrine of Spousal Refusal.

7. If a resident's application for Medicaid is approved but with a penalty period, we can still get the resident qualified by showing that the transfers were not for Medicaid planning purposes or by a petition for an Undue Hardship Waiver.

8. If a resident's application for Medicaid is verbally denied, the denial is never issued, or the denial does not comply with federal regulations, we can save the application even if the appeal is filed years after the appeal deadline.

Revenue. Recognition. Recovery.®

MEDICAID ELIGIBILITY CASE EXAMPLES: TOP 5% MOST DIFFICULT

9. If a resident is approved for Medicaid and your state will not allow the resident to apply patient pay obligation to an uncovered balance at your facility, we can fix this so that you can.

10. If a resident has a bad authorized representative or guardian who is not taking the necessary steps to qualify your resident for Medicaid, we can remove them and get your resident qualified.

11. If your county is applying state regulations or internal memos that conflict with federal law, and in turn costing you significant Medicaid revenue, we can file a complaint in federal court to make them stop.

12. If your state is trying to recoup or clawback Medicaid dollars alleging that they were paid erroneously to your residents, we can intervene and fix the problem.

13. If you're not getting residents' patient pay liability each month because of tax liens, or it is being stolen by family members etc., we can intervene here as well and stop the bleeding and reduce the patient pay liability going forward.

14. If you know that a resident's assets have been stolen by a family member or third party, we can intervene and pursue a private criminal complaint.

15. If your state has reduced the daily Medicaid rate without CMS approval, we can make them stop and recover the difference.

16. If your state has failed to increase the daily Medicaid rate by refusing to conduct a yearly rate analysis, we can intervene and force them to do it.

17. If your MCOs are not paying timely, recouping benefits already approved, failing to timely authorize coverage, we can make them stop via a DOBI complaint.

18. If your MAPs are performing audits not approved by CMS and recouping previously approved Medicare benefits, we can stop the audits and recover the recouped dollars.

19. If your daily Medicaid rate hasn't been increased because of renovations or the purchase of new buildings, we can fix both.

Revenue. Recognition. Recovery.®

WHAT HAVE WE DONE LATELY FOR OUR CLIENTS

- sb2 inc. challenges state's nearly $1 million dollar recoupment and recovers over 90% for client.
- sb2 inc. recovers over $120k in long pending Veterans Administration benefits for national provider.
- After extensive litigation, New Mexico AG agrees to entry of court order opening Medicaid application denied in July '13.
- sb2 inc. unwinds 600k penalty period by using business valuation expert and qualifies resident for Medicaid.

Revenue. Recognition. Recovery.®

Bloomberg Law

BNA's Health Care Daily Report™

Illinois Medicaid Agency Must Relieve Processing, Pay Backlog

THE PROBLEM

For several years, Managed Care Organizations (MCOs) have been processing/approving Medicaid applications for the states where your company's facilities are located.

Your Vice President of Revenue Reimbursement has asked you to research what your facilities can do to address each issue listed below:

1. open up claims denied by your MCOs as untimely;

2. approved claims that have remained unpaid since August of '17; and

3. MCO recoupments based on audits.

Revenue. Recognition. Recovery.®

THE SOLUTION

- Learn the Federal & State Regulations and Common Law that apply to opening denied MCO claims, getting timely payment, and stopping recoupments.
- Understand how to use them to recover revenue.

Revenue. Recognition. Recovery.®

THE CONTRACT

What constitutes a valid reduced claim submission period?

- Mutual agreement
- Specific stipulation

Revenue. Recognition. Recovery.®

APPLICABLE FEDERAL COMMON LAW

In most circuits, when an insurer denies coverage of a claim because notice of that claim was late under the contract, the insurer has the burden and must show:

- The notice was late.
- That it was prejudiced by the late notice.

Revenue. Recognition. Recovery.®

HOW IS PREJUDICE IDENTIFIED?

There is a standard for determining prejudice:

Whether the insurer has suffered an adverse change or imposition due to the delay.

Revenue. Recognition. Recovery.®

STATE COURT CIVIL ACTIONS

Something new that's proven very effective whether the issue is missing documentation or untimeliness.

Revenue. Recognition. Recovery.®

APPLYING WHAT WE'VE LEARNED TO SEVERAL BIG ISSUES

Revenue. Recognition. Recovery.®

1. Poor Claims Submission Process

Revenue. Recognition. Recovery.®

2. Post Stabilization Care

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HOW TO PURSUE YOUR CLAIMS

- DOBI/CMS
- Federal Court

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WHAT'S THE REMEDY?

Monetary sanctions and possible loss of contract for bad MCO behavior!

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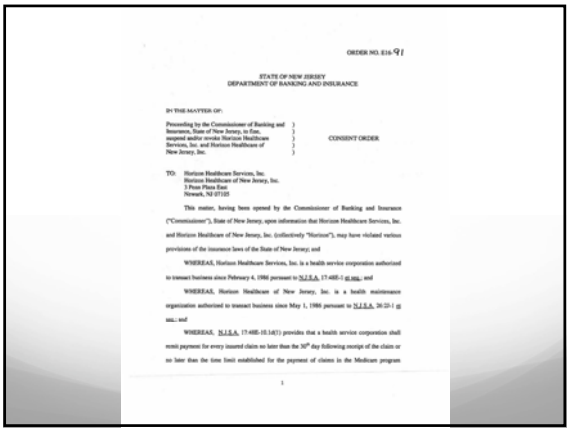

ORDER NO. E16-91

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF:

Proceeding by the Commissioner of Banking and Insurance, State of New Jersey, to fine, suspend and/or revoke Horizon Healthcare Services, Inc. and Horizon Healthcare of New Jersey, Inc.

CONSENT ORDER

TO: Horizon Healthcare Services, Inc.
Horizon Healthcare of New Jersey, Inc.
3 Penn Plaza East
Newark, NJ 07105

This matter, having been opened by the Commissioner of Banking and Insurance ("Commissioner"), State of New Jersey, upon information that Horizon Healthcare Services, Inc. and Horizon Healthcare of New Jersey, Inc. (collectively "Horizon"), may have violated various provisions of the insurance laws of the State of New Jersey; and

WHEREAS, Horizon Healthcare Services, Inc. is a health service corporation authorized to transact business since February 4, 1986 pursuant to N.J.S.A. 17:48E-1 et seq.; and

WHEREAS, Horizon Healthcare of New Jersey, Inc. is a health maintenance organization authorized to transact business since May 1, 1986 pursuant to N.J.S.A. 26:2J-1 et seq.; and

WHEREAS, N.J.S.A. 17:48E-10.1d(1) provides that a health service corporation shall remit payment for every insured claim no later than the 30th day following receipt of the claim or no later than the time limit established for the payment of claims in the Medicare program

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pursuant to 42 U.S.C. 1395cc(c)(3)(i), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th day following receipt if the claim is submitted by other than electronic means, provided the health care provider is eligible on the date of service, the person who received the health care service was covered on the date of service, the claim is for a service or supply covered under the health benefits plan, the claim is submitted with all the information requested on the claim form or in other instructions that were distributed in advance to the health care provider or covered person pursuant to N.J.S.A. 17B:30-51, and the health service corporation has no reason to believe that the claim has been submitted fraudulently; and

WHEREAS, N.J.S.A. 26:2J-8.1d (1) provides that a health maintenance organization shall remit payment for every insured claim no later than the 30th day following receipt of the claim or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. 1395cc(c)(3)(i), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th day following receipt if the claim is submitted by other than electronic means, provided the health care provider is eligible on the date of service, the person who received the health care service was covered on the date of service, the claim is for a service or supply covered under the health benefits plan, the claim is submitted with all the information requested on the claim form or in other instructions that were distributed in advance to the health care provider or covered person pursuant to N.J.S.A. 17B:30-51, and the health service corporation has no reason to believe that the claim has been submitted fraudulently ; and

WHEREAS, N.J.S.A. 17:48E-10.1d (7) provides that an overdue payment of a claim by a health service corporation shall bear simple interest at the rate of 12% per annum; and

WHEREAS, N.J.S.A. 26:2J-8.1d (7) provides that an overdue payment of a claim by a health maintenance organization shall bear simple interest at the rate of 12% per annum; and

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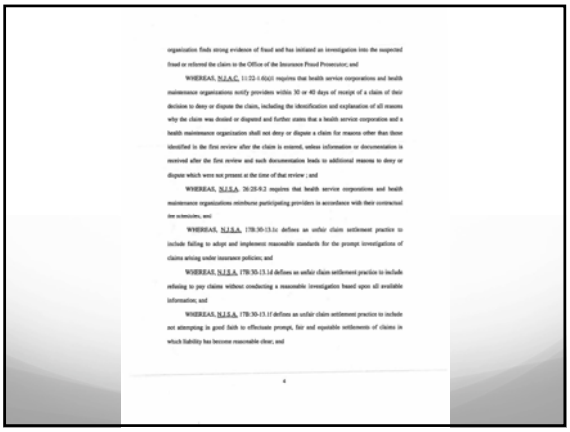
WHEREAS, N.J.S.A. 17:48E-10.1(d2) provides that if all or a portion of a claim is denied by a health service corporation as incomplete because the required substantiating documentation has not been submitted, the diagnosis coding, procedure coding or any other required information to be submitted with the claim is incorrect, the amount claimed is disputed or there is strong evidence of fraud by the provider and the health service corporation has initiated an investigation into the suspected fraud, the health service corporation shall advise within 30 days that the claim is incomplete with a statement as to what substantiating documentation is required for the adjudication of the claim, that the claim contains incorrect information with a statement as to what information must be corrected for the adjudication of the claim, of the amount disputed and the basis of the dispute, or that the health service corporation finds strong evidence of fraud and has initiated an investigation into the suspected fraud or referred the claim to the Office of the Insurance Fraud Prosecutor; and

WHEREAS, N.J.S.A. 26:2J-8.1(d2) provides that if all or a portion of a claim is denied by a health maintenance organization as incomplete because the required substantiating documentation has not been submitted, the diagnosis coding, procedure coding or any other required information to be submitted with the claim is incorrect, the amount claimed is disputed or there is strong evidence of fraud by the provider and the health maintenance organization has initiated an investigation into the suspected fraud, the health maintenance organization shall advise within 30 days that the claim is incomplete with a statement as to what substantiating documentation is required for the adjudication of the claim, that the claim contains incorrect information with a statement as to what information must be corrected for the adjudication of the claim, of the amount disputed and the basis of the dispute, or that the health maintenance



organization finds strong evidence of fraud and has initiated an investigation into the suspected fraud or referred the claim to the Office of the Insurance Fraud Prosecutor; and

WHEREAS, N.J.A.C. 11:22-1.6(a)1 requires that health service corporations and health maintenance organizations notify providers within 30 or 40 days of receipt of a claim of their decision to deny or dispute the claim, including the identification and explanation of all reasons why the claim was denied or disputed and further states that a health service corporation and a health maintenance organization shall not deny or dispute a claim for reasons other than those identified in the first review after the claim is entered, unless information or documentation is received after the first review and such documentation leads to additional reasons to deny or dispute which were not present at the time of that review ; and

WHEREAS, N.J.S.A. 26:2H-9.2 requires that health service corporations and health maintenance organizations reimburse participating providers in accordance with their contractual fee schedules; and

WHEREAS, N.J.S.A. 17B:30-13.1c defines an unfair claim settlement practice to include failing to adopt and implement reasonable standards for the prompt investigations of claims arising under insurance policies; and

WHEREAS, N.J.S.A. 17B:30-13.1d defines an unfair claim settlement practice to include refusing to pay claims without conducting a reasonable investigation based upon all available information; and

WHEREAS, N.J.S.A. 17B:30-13.1f defines an unfair claim settlement practice to include not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonable clear; and

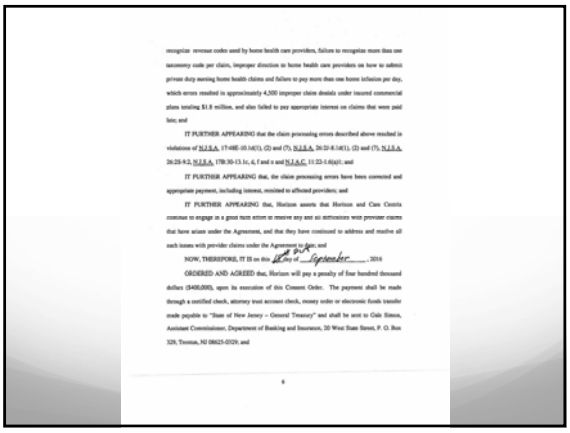
WHEREAS, N.J.S.A. 17B:30-13.1a defines an unfair claim settlement practice to include failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and

IT APPEARING that, Horizon entered into an agreement with CareCentrix, Inc., a certified organized delivery system, and CareCentrix of New Jersey, Inc., a licensed organized delivery system, for the provision of durable medical equipment, orthotics and prosthetics, home infusion services, home health services, medical foods and diabetic and medical supplies to Horizon commercial members effective July 1, 2015 (the "Agreement"); and

IT FURTHER APPEARING that, under the Agreement CareCentrix contracts with the providers of the above services, providers submit claims for these services to CareCentrix, CareCentrix applies mutually agreed upon systems edits to said claims and sends valid claims to Horizon, Horizon processes the claims and remits payment to CareCentrix, and CareCentrix then pays the providers consistent with Horizon's processing; and

IT FURTHER APPEARING that, the Department has received complaints from providers about CareCentrix's improper denial of claims, failure to promptly pay claims, inaccurate explanation of benefit and remittance advice forms and failure to pay interest on late claims with respect to services provided to Horizon commercial members on and after July 1, 2015; and

IT FURTHER APPEARING that, between July 1, 2015 and March 28, 2016, CareCentrix and Horizon had IT systems related issues that resulted in multiple errors in the processing of provider claims for services provided to Horizon commercial members under the Agreement, including failure to recognize modifiers used with certain HCPCS codes, failure to



recognize revenue codes used by home health care providers, failure to recognize more than one taxonomy code per claim, improper direction to home health care providers on how to submit private duty nursing home health claims and failure to pay more than one home infusion per day, which errors resulted in approximately 4,500 improper claim denials under insured commercial plans totaling $1.8 million, and also failed to pay appropriate interest on claims that were paid late; and

IT FURTHER APPEARING that the claim processing errors described above resulted in violations of N.J.S.A. 17:48E-10.1d(1), (2) and (7), N.J.S.A. 26:2J-8.1d(1), (2) and (7), N.J.S.A. 26:2S-9.2, N.J.S.A. 17B:30-13.1c, d, f and n and N.J.A.C. 11:22-1.6(a)1; and

IT FURTHER APPEARING that, the claim processing errors have been corrected and appropriate payment, including interest, remitted to affected providers; and

IT FURTHER APPEARING that, Horizon asserts that Horizon and Care Centrix continue to engage in a good faith effort to remove any and all obstructions with provider claims that have arisen under the Agreement, and that they have continued to address and resolve all such issues with provider claims under the Agreement to date; and

NOW, THEREFORE, IT IS on this 8th day of September, 2016

ORDERED AND AGREED that, Horizon will pay a penalty of four hundred thousand dollars ($400,000), upon its execution of this Consent Order. The payment shall be made through a certified check, attorney trust account check, money order or electronic funds transfer made payable to "State of New Jersey – General Treasury" and shall be sent to Gale Simon, Assistant Commissioner, Department of Banking and Insurance, 20 West State Street, P. O. Box 329, Trenton, NJ 08625-0329; and

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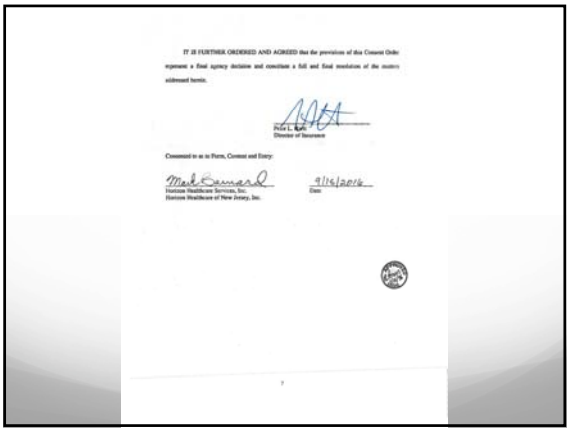

IT IS FURTHER ORDERED AND AGREED that the provisions of this Consent Order represent a final agency decision and constitute a full and final resolution of the matters addressed herein.

Peter L. Hall
Director of Insurance

Consented to as to Form, Content and Entry:

Mark Barnard
Horizon Healthcare Services, Inc.
Horizon Healthcare of New Jersey, Inc.

9/16/2016
Date

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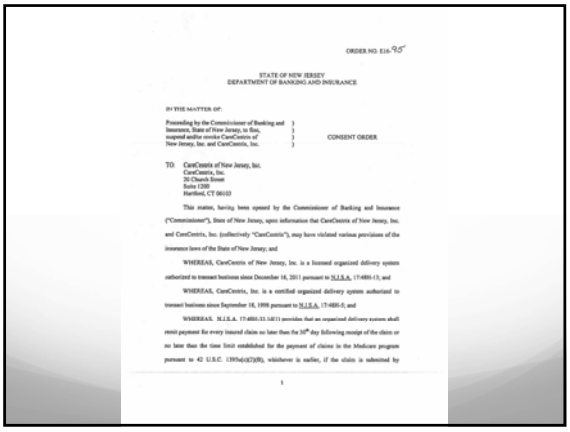

ORDER NO. E16-95

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF:

Proceeding by the Commissioner of Banking and Insurance, State of New Jersey, to fine, suspend and/or revoke CareCentrix of New Jersey, Inc. and CareCentrix, Inc.

CONSENT ORDER

TO: CareCentrix of New Jersey, Inc.
CareCentrix, Inc.
20 Church Street
Suite 1200
Hartford, CT 06103

This matter, having been opened by the Commissioner of Banking and Insurance ("Commissioner"), State of New Jersey, upon information that CareCentrix of New Jersey, Inc. and CareCentrix, Inc. (collectively "CareCentrix"), may have violated various provisions of the insurance laws of the State of New Jersey; and

WHEREAS, CareCentrix of New Jersey, Inc. is a licensed organized delivery system authorized to transact business since December 16, 2011 pursuant to N.J.S.A. 17:48H-13; and

WHEREAS, CareCentrix, Inc. is a certified organized delivery system authorized to transact business since September 18, 1998 pursuant to N.J.S.A. 17:48H-5; and

WHEREAS, N.J.S.A. 17:48H-10.1d(1) provides that an organized delivery system shall remit payment for every insured claim no later than the 30th day following receipt of the claim or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. 1395u(c)(2)(B), whichever is earlier, if the claim is submitted by

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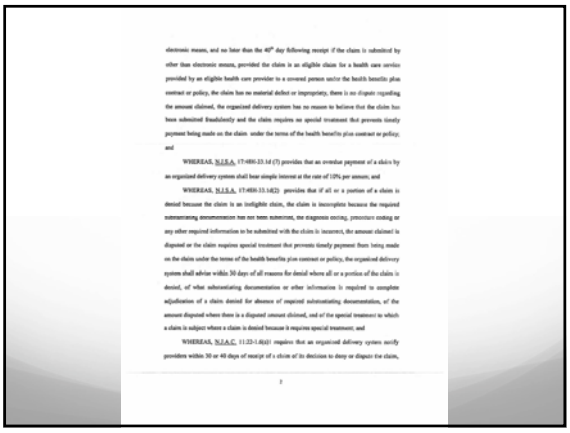
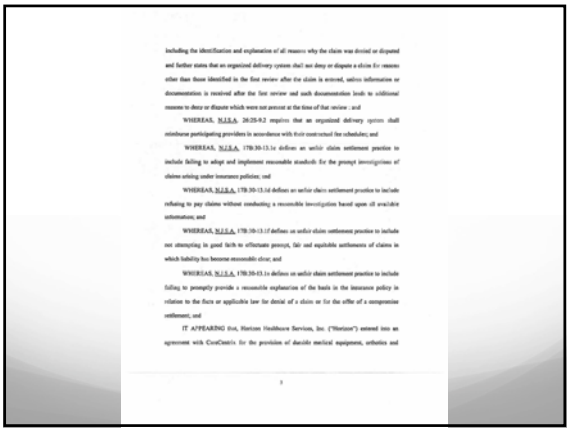


electronic means, and no later than the 40th day following receipt if the claim is submitted by other than electronic means, provided the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the health benefits plan contract or policy, the claim has no material defect or impropriety, there is no dispute regarding the amount claimed, the organized delivery system has no reason to believe that the claim has been submitted fraudulently and the claim requires no special treatment that prevents timely payment being made on the claim under the terms of the health benefits plan contract or policy; and

WHEREAS, N.J.S.A. 17:48H-33.1d (7) provides that an overdue payment of a claim by an organized delivery system shall bear simple interest at the rate of 10% per annum; and

WHEREAS, N.J.S.A. 17:48H-33.1d(2) provides that if all or a portion of a claim is denied because the claim is an ineligible claim, the claim is incomplete because the required substantiating documentation has not been submitted, the diagnosis coding, procedure coding or any other required information to be submitted with the claim is incorrect, the amount claimed is disputed or the claim requires special treatment that prevents timely payment from being made on the claim under the terms of the health benefits plan contract or policy, the organized delivery system shall advise within 30 days of all reasons for denial where all or a portion of the claim is denied, of what substantiating documentation or other information is required to complete adjudication of a claim denied for absence of required substantiating documentation, of the amount disputed where there is a disputed amount claimed, and of the special treatment to which a claim is subject where a claim is denied because it requires special treatment; and

WHEREAS, N.J.A.C. 11:22-1.4(a)1 requires that an organized delivery system notify providers within 30 or 40 days of receipt of a claim of its decision to deny or dispute the claim,



including the identification and explanation of all reasons why the claim was denied or disputed and further states that an organized delivery system shall not deny or dispute a claim for reasons other than those identified in the first review after the claim is entered, unless information or documentation is received after the first review and such documentation leads to additional reasons to deny or dispute which were not present at the time of that review ; and

WHEREAS, N.J.S.A. 26:2S-9.2 requires that an organized delivery system shall reimburse participating providers in accordance with their contracted fee schedules; and

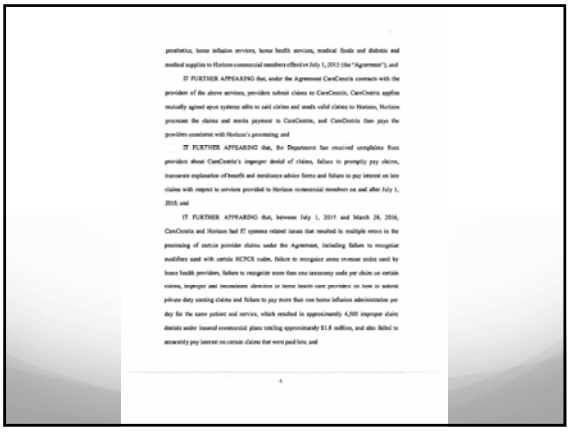
WHEREAS, N.J.S.A. 17B:30-13.1e defines an unfair claim settlement practice to include failing to adopt and implement reasonable standards for the prompt investigations of claims arising under insurance policies; and

WHEREAS, N.J.S.A. 17B:30-13.1d defines an unfair claim settlement practice to include refusing to pay claims without conducting a reasonable investigation based upon all available information; and

WHEREAS, N.J.S.A. 17B:30-13.1f defines an unfair claim settlement practice to include not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonable clear; and

WHEREAS, N.J.S.A. 17B:30-13.1o defines an unfair claim settlement practice to include failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and

IT APPEARING that, Horizon Healthcare Services, Inc. ("Horizon") entered into an agreement with CareCentrix for the provision of durable medical equipment, orthotics and

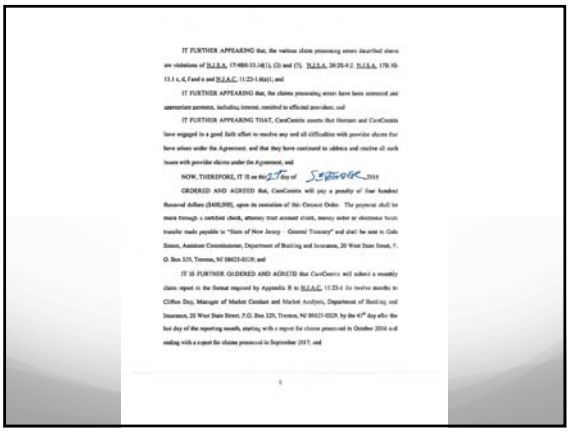


prosthetics, home infusion services, home health services, medical foods and diabetic and medical supplies to Horizon commercial members effective July 1, 2013 (the "Agreement"); and

IT FURTHER APPEARING that, under the Agreement CareCentrix contracts with the providers of the above services, providers submit claims to CareCentrix, CareCentrix applies mutually agreed upon systems edits to said claims and sends valid claims to Horizon, Horizon processes the claims and remits payment to CareCentrix, and CareCentrix then pays the providers consistent with Horizon's processing; and

IT FURTHER APPEARING that, the Department has received complaints from providers about CareCentrix's improper denial of claims, failure to promptly pay claims, inaccurate explanation of benefit and remittance advice forms and failure to pay interest on late claims with respect to services provided to Horizon commercial members on and after July 1, 2013; and

IT FURTHER APPEARING that, between July 1, 2015 and March 28, 2016, CareCentrix and Horizon had IT systems related issues that resulted in multiple errors in the processing of certain provider claims under the Agreement, including failure to recognize modifiers used with certain HCPCS codes, failure to recognize some revenue codes used by home health providers, failure to recognize more than one taxonomy code per claim on certain claims, improper and inconsistent direction to home health care providers on how to submit private duty nursing claims and failure to pay more than one home infusion administration per day for the same patient and service, which resulted in approximately 4,200 improper claim denials under insured commercial plans totaling approximately $1.8 million, and also failed to accurately pay interest on certain claims that were paid late; and



IT FURTHER APPEARING that, the various claim processing errors described above are violations of N.J.S.A. 17:48B-13.1(1), (2) and (7); N.J.S.A. 26:2S-9.2; N.J.S.A. 17B:30-13.1 a, d, f and e and N.J.A.C. 11:22-1.4(a)1; and

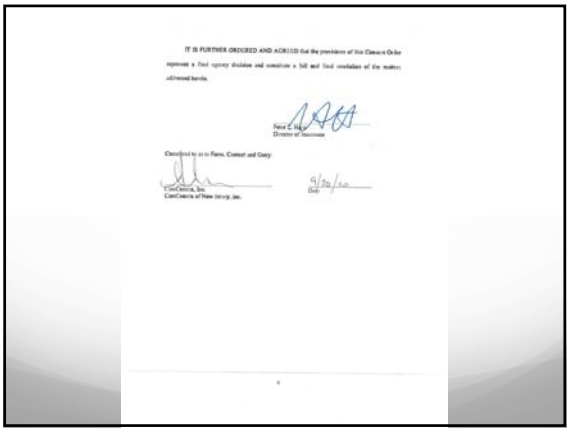
IT FURTHER APPEARING that, the claims processing errors have been corrected and appropriate payment, including interest, remitted to affected providers; and

IT FURTHER APPEARING THAT, CareCentrix asserts that Horizon and CareCentrix have engaged in a good faith effort to resolve any and all difficulties with provider claims that have arisen under the Agreement, and that they have continued to address and resolve all such issues with provider claims under the Agreement; and

NOW, THEREFORE, IT IS on this 2nd day of September, 2016

ORDERED AND AGREED that, CareCentrix will pay a penalty of four hundred thousand dollars ($400,000), upon its execution of this Consent Order. The payment shall be made through a certified check, attorney trust account check, money order or electronic funds transfer made payable to "State of New Jersey – General Treasury" and shall be sent to: Gale Simon, Assistant Commissioner, Department of Banking and Insurance, 20 West State Street, P. O. Box 325, Trenton, NJ 08625-0325; and

IT IS FURTHER ORDERED AND AGREED that CareCentrix will submit a monthly claim report in the format required by Appendix B to N.J.A.C. 11:22-1.4 for twelve months to Clifton Day, Manager of Market Conduct and Market Analysis, Department of Banking and Insurance, 20 West State Street, P.O. Box 325, Trenton, NJ 08625-0329, by the 45th day after the last day of the reporting month, starting with a report for claims processed in October 2016 and ending with a report for claims processed in September 2017; and



IT IS FURTHER ORDERED AND AGREED that the provisions of this Consent Order approved a final agency decision and constitute a full and final resolution of the matters addressed herein.

Peter C. Harvey
Director of Insurance

Consented to as to Form, Content and Entry:

CareCentrix, Inc.
CareCentrix of New Jersey, Inc.

9/20/16
Date

LAW360

NY Managed Care Biz Ponies Up $47M In False Claims Row

and the New York state attorney general's office for their assistance."

Relator David Hesler had filed the qui tam suit in November 2013. He will receive a to-be-determined portion of the federal government's share.

"We are pleased to reach this settlement and look forward to our continued collaboration with the state as we carry out our mission of helping New Yorkers in need," CenterLight said in a statement.

The U.S. is represented by Jeffrey K. Powell of the U.S. Department of Justice. New York is represented by Carolyn T. Ellis and Alex R. Scott of the state attorney general's office. Hesler is represented by Kathy S. Marks of Yankwitt LLP and Andrea M. Paparella of the Law Office of Andrea Paparella PLLC.

CenterLight is represented by Stephen A. Wernke of Ropes & Gray LLP.

The case is U.S. et al. ex rel. Hesler v. CenterLight Healthcare et al., case number 1:13-cv-08502, in the U.S. District Court for the Southern District of New York.

--Editing by Edrienne So.

WHAT ABOUT LATE PAYMENTS?

You have $750k in claims that were approved for payment going back to August '17.

How can we get this revenue through the door?

Revenue. Recognition. Recovery.®

THE 90/30 RULE

Know this rule if you want to get paid on time.

Revenue. Recognition. Recovery.®

WHEN PAYMENTS ARE LATE, WHAT LEVERAGE DO YOU HAVE OVER MCOS?

- CMS/DOBI Complaints
- Significant Monetary Sanctions

Revenue. Recognition. Recovery.®

ATTACKING MCOS

CMS/DOBI will intervene.

Revenue. Recognition. Recovery.®

Final Issue—Recoupments.

- These can be devastating. It's impossible to run a business when your revenue is contingent.
- Thankfully, a federal court has recently addressed the issue of mistaken payments.

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The MajestaCare Matter

- A Payment allegedly made by mistake isn't the end of the inquiry; it's just the beginning.
- Unless the provider would be "unjustly enriched", mistaken payments cannot be recouped.

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What Payments for the Wrong Amount?

This is interesting. Let's walk through it.

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Q&A

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SB2 INC. FEE MODELS FOR 2017

- **Yearly:** Get the most from our services in the most efficient way possible

  The sb2 Inc. Yearly model is our most popular by far. We can customize a 12--month proposal to your unique needs. With training and support from our firm, many clients can process 95% of their own cases internally. This not only significantly reduces cost, it enables us to focus our expertise on the top 5% of your cases—cases where other law firms underperform—in order to drive the highest win rate possible. This is a model we are deploying nationally, and it's how we maintain a 98% resident qualification rate for our clients.

- **The Bundle:** Pay one per month with multiple open cases

  Our bundle option adds even more predictability and certainty to our clients dealing with multiple open cases. With this fee model you only pay one fee each month, regardless of how many open cases you have.

  Here's an example:

  • You have 5 open cases: We bundle them up and you pay one flat rate each month.

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SB2 INC. FEE MODELS FOR 2017

- **An Even Dozen:** 12 Cases for $6.5k Month

  This payment model enables you to have 12 open cases at any given time, yet still pay a consistent flat monthly fee of $6.5k. When a case is concluded, or you decide to drop the issue, add a new case to fill the void and still pay the same amount. Maintain an even dozen and you'll always know when you can add a case and what you'll be paying every month.

  You'll always know what your bill will be each month, and you'll know exactly when the billing period will end. It's just the thing to add further stability to your Accounts Payable environment. If a new case is added to the mix—no problem. We'll send you a statement outlining how the additional case will impact your payments. Our goal with this approach is to eliminate surprises and worries.

- **Just the Basics:** New Thinking to Build Stronger Client Relationships

  The reality of dealing with many law firms is that they base their fee structure on the worst case scenario. These firms charge up--front for services that may only be used in dealing with extremely complicated legal matters. But with our Just the Basics fee structure, if you only require basic services, then that's why you pay for. Then, pay for additional services only if your needs change.

  Here's an Example:

  For services such as Medicaid Determinations and Appeals, you just pay a fee every time the service is used. For appeals, there is a straightforward project fee per--appeal. If two appeals are filed during your representation, you will pay that fee two times. That way, every time a new action is needed in your case, you will know the charge before that action is taken. Simple. Clear. Fair. No hidden charges.

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PLEASE DO NOT HESITATE TO CONTACT
US IF YOU HAVE ANY QUESTIONS!

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