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 get long-pending Medicaid applications and payments approved today.

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

ABOUT THE FIRM

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

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.

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.

WHAT HAVE WE DONE LATELY FOR OUR CLIENTS

- sb2 inc. wins two Undue Hardship Waiver petitions for longtime Kentucky client.
- For new Ohio client, sb2 inc. immediately qualifies 3 residents whose Medicaid applications had pended longer than allowed by CMS.
- sb2 inc. unwinds $103k recoupment by Illinois for alleged Medicaid overpayments to provider.
- sb2 inc. uses CMS Regulations to quickly qualify 12 Ohio residents for Medicaid for large regional provider based in Ohio.

Bloomberg Law

BNA's Health Care Daily Report™

VOL. 22, NO. 171 SEPTEMBER 6, 2017

Medicaid

Illinois Medicaid Agency Must Relieve Processing, Pay Backlog

Illinois's Department of Healthcare and Family Services must comply with federal timeliness standards when processing Medicaid applications and providing Medicaid benefits (*Doctors Nursing & Rehab. Ctr., LLC v. Norwood*, 2017 BL 309270, N.D. Ill., No. 1:16-cv-10255, 9/1/17).

Delays in processing Medicaid applications and paying benefits on behalf of eligible recipients are occurring throughout the country and have been especially acute in Illinois. The delays there, caused by the state's multiyear failure to pass a budget, present substantial problems for long-term care providers that rely on Medicaid for payment, as well as for beneficiaries who risk losing care as a result.

The U.S. District Court for the Northern District of Illinois Sept. 1 ordered the state's Medicaid agency to process applications and pay benefits with reasonable promptness, as required by the federal Medicaid law. That requirement is violated when an application has been pending for more than 90 days or a claim goes unpaid for more than 12 months, the court said.

The plaintiffs, a group of Medicaid-eligible individuals and long-term care facilities that care for them, provided enough evidence to show they are likely to succeed on their claims that the agency violated the federal standards, the court said in granting the pretrial relief. The plaintiffs also produced evidence they would suffer irreparable harm if the court denied their motion for preliminary relief, as several patients had outstanding balances, and the facilities said they couldn't continue caring for the patients without payment.

The court added the public has an interest in ensuring that Medicaid-eligible patients promptly receive needed medical care. "This, after all, is why Medicaid exists," Judge Elaine E. Bucklo wrote.

11th Amendment Argument Rejected This is "an important decision because we were able to get to the merits before jurisdiction was lost under the 11th Amendment" to the U.S. Constitution, Chadwick Bogar, an attorney for the plaintiffs, told Bloomberg BNA.

"Generally, after litigation like this is filed, states move quickly to approve long-pending applications for Medicaid to support a motion to dismiss based on the amendment," he said. Bogar is the managing partner at sb2 Inc., a Harrisburg, Pa., law firm. He represents several long-term care facilities.

The court previously said the long-term care providers' claims weren't barred by the 11th Amendment and the doctrine of sovereign immunity because the plaintiffs were seeking only prospective relief to ensure the state's future compliance with the law.

The 11th Amendment bars citizens from suing their states, but that bar isn't complete, the court said in a June order denying IDHFS Director Felicia Norwood's motion to dismiss the complaint. The provision bars suits for money damages, but doesn't preclude plaintiffs from seeking prospective injunctive relief to stop violations of federal law, even if compliance would require the state to spend money, the court said.

The plaintiffs in this case sought equitable relief, in the form of an order requiring the state to comply with the federal law's reasonable promptness requirement in the future.

The Illinois Attorney General's Office didn't respond to Bloomberg BNA's request for comment by deadline.

Chadwick Bogar and Katie Z. Van Lake, of sb2 Inc., Harrisburg, Pa., represented the plaintiffs. Brian Franklin Kolp and Michael D. Arnold, of the Illinois Attorney General's Office, Chicago, represented Norwood.

BY MARY ANNE PAZANOWSKI

To contact the reporter on this story: Mary Anne Pazanowski in Washington at mpazanowski@bna.com

To contact the editor responsible for this story: Peyton M. Sturges at PSturges@bna.com

The opinion is at http://src.bna.com/sfy.

 ISSN

Bloomberg Law

BNA's Health Care Daily Report™

VOL. 22, NO. 227 NOVEMBER 28, 2017

Medicaid

Nursing Home Can Fight Medicaid Agency's Refusal to Aid Residents

A nursing home can dispute a state Medicaid agency's refusal to pick up the tab for patients unable to pay their monthly allotment because their Social Security checks were stolen.

Westminster Nursing Center, doing business in Taylorsville, N.C., as Valley Nursing Center, Nov. 22 received the go-ahead from the U.S. District Court for the Eastern District of North Carolina to sue the state to recover payments on behalf of residents who assigned it their right to receive Medicaid benefits. The court also said defendant N.C. Department of Health and Human Services improperly denied requests that it pay the patients' bills because the regulation the N.C. HHS cited to justify its decision hadn't received approval from the federal Centers for Medicare & Medicaid Services (*Westminster Nursing Ctr. v. Cohen*, 2017 BL 420185, E.D.N.C., No. 5:17-cv-96, 11/22/17).

The decision may expand the income stream for nursing facilities, as it is the first to recognize their independent right to sue a state agency based on an assignment of Medicaid payments, according to the plaintiff's attorney, Chadwick Bogar, of sb2 Inc. in Harrisburg, Pa. The court's determination that states can't enforce plan amendments that haven't received federal CMS approval also is unique, he told Bloomberg Law.

A spokeswoman for the North Carolina Department of Justice, which represented the N.C. HHS, told Bloomberg Law the "office is reviewing the decision and working to determine next steps."

Patient Liability Under the Medicaid Act and its implementing regulations, Medicaid recipients undergoing long-term care at nursing homes must use part of their income to pay for the cost of their care. This payment is known as the "patient monthly liability."

There was a delay in payment from several Westminster residents who allegedly were victims of a fraud in which a third party intercepted their Social Security payments. The residents applied to the N.C. HHS for a deviation in their monthly payment liability. The agency denied the deviations.

Westminster had standing to challenge the denial under the Medical Assistance and Nursing Facility Services Mandate, the court said. Under this Medicaid Act provision, a state must make medical assistance available to all qualifying individuals.

The regulations implementing the provision allow states to reduce payments for long-term nursing care if the resident has an independent income. The state, however, may not consider as income amounts set aside for other purposes, such as other necessary medical expenses.

The CMS regulations don't specify whether an unpaid patient monthly liability qualifies as a necessary medical expense, but North Carolina's regulations says the state won't consider a monthly liability shortfall as a type of necessary medical expense that can be deducted from the patient's monthly liability.

North Carolina's regulation, however, hadn't been approved by the CMS. When the state decided the nursing home's claims on the basis of that rule, its decision was invalid, the court said. Bogar called that decision "huge," and said he has other claims pending in Arizona and Illinois based on state decisions made under regulations that similarly haven't been approved by the CMS.

Judge Louise W. Flanagan wrote the opinion.

sb2 Inc. represented the nursing home. The North Carolina Department of Justice represented the state HHS.

By Mary Anne Pazanowski

To contact the reporter on this story: Mary Anne Pazanowski in Washington at mpazanowski@bloomberglaw.com

To contact the editor responsible for this story: Peyton M. Sturges at psturges@bloomberglaw.com

The opinion is at http://src.bna.com/utU.

 ISSN

LEGAL "FIRST" RECAPTURES OVER $900K FROM IMPROPER RECOUPMENTS

sb2 inc. broke new legal ground by challenging the Ohio Department of Job and Family Services and the Ohio Department of Medicaid when the agencies recouped Medicaid funds already paid to a client for services provided to residents.

In 2013, the state of Ohio passed a statute authorizing these departments to recoup alleged overpayments made to facilities for residents that the state subsequently decided should not have been approved. But here's the problem: The state should have issued decertification notices to residents in accordance with CMS policy and federal law. Instead, the state arbitrarily determined that Medicaid benefits should not have been paid to residents and simply took the money back. It was an obvious attempt to shift federally-mandated obligations from the state to nursing facilities.

After nearly 8 months of litigation, we were able to demonstrate that the State of Ohio deprived these residents of their due process hearing and appeal rights protected by the Americans with Disabilities and Rehabilitation Acts, and the 14th Amendment of the United States Constitution. The result is that our client recovered 90% of the displaced funds, totaling over $900k.

While this is a totally new legal theory in the world of Medicare/Medicaid eligibility and reimbursement, it's the type of work we do every day to ensure our clients' interests are protected. Why not give me a call and see and how we might be able to break new ground on the reimbursement challenges your own facilities are facing?

Sincerely,

Chad Bogar
Managing Partner & CEO
sb2 inc.

WHAT
sb2 inc. Recovers Over $900k for Client with New Legal Theory

WHERE
Ohio

CONTACT
sb2 inc.
212.203.1334
info@sb2inc.com
www.sb2inc.com

THE PROBLEM

Your facility's operating revenue is suffering because Medicaid applications are pending for too long.

Caseworkers are routinely sitting on them and refusing to provide any assistance when they are asked for help.

To make matters even more difficult, when your applications are finally approved, Medicaid payments are delayed for months.

THE SOLUTION

- Federal Delay/Declaratory Judgment Actions.
- Administrative Inaction Appeals.
- CMS Compliance Audit

Real Life Case Study

Your company has 12 facilities around Chicago, IL. Your Medicaid pending list for just 4 of these facilities is over $3 million dollars because you presently have 90 Medicaid applications that have pended on average for longer than 7.5 months.

Federal Law Requires States to Process Medicaid Applications Timely

The agency MUST establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed—

- Ninety (90) days for applicants who apply for Medicaid on the basis of disability; and
- Forty-five (45) days for all other applicants.

Federal Delay Action

Request Federal Court to Declare that the Agency's Undue Delay:

- Violates Federal Medicaid Regulations.
- Constitutes Discrimination under the ADA.
- Results in a Due Process Violation.
- Case law mandates automatic Medicaid approval and retroactive eligibility.

“The Settlement”

Attorney General’s Office Gets Involved.

AGENCY AGREES TO:

- Work with facility toKeep the delayed applications open.
- Tell us what verifications are needed or what resources need to be spent down.
- Afford us reasonable time to obtain verifications or spend down resources.
- Timely process and approve the applications.

WE AGREE TO:

- Work with facility to provide verifications on delayed applications.
- Forgo automatic approval argument.
- Voluntarily withdraw litigation.

END RESULT

APPROVALS!!!

“No Settlement”

- Injunctive Relief.
- Prospective Compliance.
- Automatic Approval.

Administrative Inaction-Appeal

- File an appeal of the unlawful delay at the Administrative level.
- Low cost alternative.

7th and 10th Circuit Decisions

Eligibility is automatically granted for excessive delays in processing a Medicaid application.

CMS

Knowing the federal agency's role and power is critical to a successful resolution.

Specific Case Examples

- Ohio
- Kansas
- Illinois

“Long Pending Payments”

- 1 year from the effective date of the application.
- Violation of the ADA & Rehab Acts
- Violation of the Medicaid Act’s ”Reasonable Promptness” mandate.
- Injunctive relief.

KEY TAKEAWAYS

- Long pending Medicaid applications and payments are relatively easy fixes.
- Federal law (CMS) controls all aspects of Medicaid eligibility & reimbursement—there are no caveats (exceptions) whatsoever.
- We're not asking for anything that CMS hasn't already said that we're entitled to.

Q&A

THE 6 MUST-HAVE DOCUMENTS FOR AN EFFECTIVE MEDICAID/MEDICARE ELIGIBILITY PROGRAM

THE PROBLEM

Because of significant Medicaid write-offs over the last two years, your CFO has asked you how to create an effective & efficient Medicaid/Medicare eligibility & reimbursement program at your company.

What do you do?

THE SOLUTION

Because you recently attended a presentation at Mass Senior Care Association, covering several topics including the 6 must have documents needed for an effective Medicaid Program, you suggested that the first step would be to implement them as soon as possible.

THE ADMISSION PACKAGE

If you had to get just one document signed, what would it be?

REAL LIFE CASE STUDY

Cause and Effect

DESIGNATED AUTHORIZED REPRESENTATIVE FORM

This the most important document in your admission package from a Medicaid/Medicare eligibility & reimbursement stand point.

Why is that?

DESIGNATION OF AUTHORIZED REPRESENTATIVE

DATE: _____

RESIDENT NAME: _____

SOCIAL SECURITY#: _____

FACILITY NAME: _____

FACILITY ADDRESS: _____

To simplify the Medicaid application process, it can be helpful to designate a representative from the facility to act in the interests of the resident. This form authorizes specific person(s) from the facility to handle the resident's dealings with Medicaid.

I authorize_____at the following facility_____to be my authorized representative. I also authorize any employees or agents of the facility, including attorneys hired by the facility, to now represent me when:

- Initiating an application for Medicaid benefits
- Participating in all reviews of my eligibility for Medicaid benefits
- Taking action as necessary to establish my eligibility for Medicaid

I understand that the person acting as my authorized representative may change from time to time due to personnel or assignment changes. With this authorization, I agree that the facility, its employees and agents may secure a copy of all information necessary to assist in processing any applications for Medicaid on my behalf or to determine my eligibility for Medicaid benefits. This information may include any health information protected under HIPAA, or any of my personal financial and other information as needed.

I authorize the facility, its employees, and agents, to share my personal information to secure Medicaid benefits. I am waiving any and all claims of confidentiality over this information with respect to the facility, its employees and agents.

I understand and agree that any legal proceedings in regards to my Medicaid eligibility may be pursued either in my name or in the name of the facility. I waive any potential or actual conflicts of interest, which may exist from this appointment of authorized representation.

I also agree that any assistance provided does not prevent the facility and/or its attorneys from taking any actions necessary to recover unlawfully converted assets that may prevent me from qualifying for Medicaid benefits. It also does not prevent the facility or its attorneys from taking action to remedy something that may prevent me from qualifying for Medicaid benefits. Any information obtained by facility, while providing any assistance in regards to this authorization, may be used by the facility in any future action.

I understand that I may cancel this designation of an authorized representative at any time by notifying the authorized representative and the applicable county welfare agency in writing. Any facsimile, copy or photocopy of this authorization shall be as valid as the original.

SIGNATURE OF RESIDENT _____

PRINT NAME: _____

TITLE(if applicable): _____

ASSIGNMENT & TRANSFER OF KNOWN AND UNKNOWN EXCESS RESOURCES

This is the second most important document of the six; and if used correctly will speed up and increase revenue.

ASSIGNMENT AND TRANSFER OF EXCESS RESOURCES

As Determined by the Caseworker or County Agency

FACILITY NAME: _____

RESIDENT NAME: _____ DATE ADMITTED: _____

If a Resident has applied for Medicaid to pay for care at the facility, or if they plan to apply at some point in the future, they may have assets considered to be "excess resources" by the State of

Excess resources are described by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 – 1396v. These resources are defined as any cash, other personal property, or real property that an applicant or recipient of medical assistance either owns, or has the right to convert to cash.
These are resources that a Resident has the legal right to use for his or her care and support.

As part of the Medicaid determination process, the State of _____ may decide that a Resident has excess resources as defined in regulations at 42 C.F.R. §§ 435.400, 435.500, 435.600. 435.700 and 435.800. These resources would impact, delay or disqualify the Resident from receiving Medicaid benefits for a certain amount of time.

To avoid this issue, the Resident agrees to transfer to the Facility their right, title and interest to their assets, rights or other property determined by the State of _____ to be excess resources. This transfer will happen at the time of the Medicaid application for past, present or future services provided by the facility.

This agreement shall be in effect on the Resident's date of admission to the facility. Excess resources, as determined by the caseworker or county agency assigned to the Facility, will only be used as payment for invoices from the facility for care and treatment of the Resident.

The Resident or Resident's Authorized Representative agrees to this assignment and transfer of excess resources as determined by the caseworker or county agency as of this date: _____

SIGNATURE OF RESIDENT _____

PRINT NAME: _____

TITLE (if applicable): _____

REAL LIFE CASE STUDY

Iowa Hawkeyes!

ASSISTANCE LETTERS

Although it is arguably just as important as the other documents, there is no better way to protect an application for benefits when assets or verifications aren't available than the Assistance letter based on the federal regulations.

RE: MEDICAID ELIGIBILITY VERIFICATION

VIA ELECTRONIC MAIL

Dear_____,

We are pleased to represent_____in helping_____achieve Medicaid eligibility and reimbursement to enhance services and quality of care for the resident.
The department has requested certain verifications regarding_____'s Medicaid eligibility.
The facility is having difficulty obtaining these verifications, and I appreciate any assistance you can provide.

Through federal Medicaid regulations, the department has the ability to obtain information regarding _____'s financial account(s) via the electronic Asset Verification System (AVS). See 42 U.S.C.S. § 1396w(b) and 42 C.F.R. § 435.945. If the department cannot obtain the information on _____'s accounts via AVS, federal law instructs the agency to request this information directly from other state agencies or federal programs. 42 C.F.R. § 435.948.

Federal law prevents the burden being placed on an applicant to provide verifications of financial information when it is readily available to the agency through AVS or other sources. 42 C.F.R. § 435.948(b). Federal law also requires that the "agency must provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient." 42 C.F.R. § 435.908.

Federal law specifies that a Medicaid applicant's resources will not be cause for denial when resources are unavailable to the applicant. The applicant can be denied Medicaid only when the applicant, or an authorized representative, refuses to obtain information and/or refuses to allow the department to obtain the information.
In this light, the Facility respectfully requests that be the department be allowed to assist with obtaining the necessary verifications required to approve_____'s pending Medicaid application.
Should you have any questions, please don't hesitate to contact me at_____.

Sincerely,

REAL LIFE CASE STUDY

14 Denied Cases Opened

$700k in Medicaid Pending Erased

INACTION APPEAL

Long pending Medicaid applications are terrorizing clients throughout the country.

RE: INACTION APPEAL AND REQUEST FOR AUTOMATIC APPROVAL

VIA FACSIMILE

IN RE: MEDICAID APPLICATION OF: _____

To Whom it May Concern, On DATE: _____

FACILITY NAME: _____

submitted an application for Medicaid on behalf of

RESIDENT'S NAME: _____

The application is attached to this correspondence as Exhibit A.

As of today, no decision has been made on the application. (The Facility) herein appeals the

DEPARTMENT NAME: _____ inaction as

REQUEST: We demand a fair hearing on such. Federal law requires that (The Department) make an eligibility determination on a Medicaid application within forty five (45) days. See 42 C.F.R. §435.912(c)(3). The Federal Medicaid regulations permit an applicant to file an appeal ("Inaction Appeal") when the state Medicaid agency has failed to timely process an individual's Medicaid application or request and obtain interim benefits for automatic approval.

In light of (The Department's) failure to comply with federal and state Medicaid laws, (The Resident) is unable to pay for her room, board, care and services at (The Facility) during her period of Medicaid ineligibility in the amount of

OUTSTANDING BALANCE: _____. The Facility Invoice is attached to this correspondence as Exhibit B. Such inaction places (The Resident) at risk of being discharged from (The Facility) and jeopardizes her health, safety, and well-being. Federal law requires (The Department) to issue a determination on an individual's Medicaid application, and requires that every applicant be timely afforded such notice and a right to appeal such decision. (The Department's) failure to comply with federal Medicaid law deprived (The Resident) of her right to due process under 42 U.S.C. §1983 and constitutes unlawful discrimination pursuant to the Americans with Disabilities Act, 42 U.S.C. § 12132, and 28 C.F.R. § 35.130.

I respectfully request that interim benefits or automatic approval of the resident's application for Medicaid. Should you need anything further to process this request, please contact me immediately upon receipt of this correspondence.

To expedite the process, please fax any notice of action or request for information directly to my attention at FAX NUMBER: (_____)_____-_____.

Thank you for your prompt attention to this matter.

Sincerely, _____

Sincerely, [1] The Seventh Circuit Court of Appeals addressed a Department's delay in in Smith v. Miller, 695 F.2d 172 (7th Cir. 1981). In Smith, Medicaid recipients sued the Illinois Department of Public Aid ("Department") in a class action alleging that it failed to timely process requests for specialized medical care promptly under federal law and Illinois regulations. The District Court held that requests for specialized medical care had to be automatically approved. The Department appealed and the United States Court of Appeals upheld the District Court's holding.

REAL LIFE CASE STUDY

Big win in Illinois

27 Cases Approved in Kansas

17 Cases Approved in Ohio

SPOUSAL SUPPORT

Although this issue doesn't come up as often as the other issues, when it does, there's a significant possibility of lost retroactive Medicaid benefits.

ASSIGNMENT OF RIGHT TO COMMUNITY SPOUSAL SUPPORT

The purpose of this form is to help you to receive Medicaid benefits if your spouse is not able to provide sufficient information to enable you to qualify.

I, _____

(Name of Institutionalized Spouse requesting Medicaid benefits) agree to the following:

☑ I have been a resident at: _____ _____

(Facility Name) (Date)

☑ I do not have the necessary financial resources, and I am in need of Medicaid benefits to pay for my room, board care and assistance at:

_____ _____

(Facility Name)

☑ I am the spouse of: _____

(Name of Spouse of Person requesting Medicaid benefits)

and that person is refusing to cooperate in the Medicaid eligibility process, either in providing information regarding his or her financial resources to the

(State) _____

(Medicaid Agency) _____

or in spending down such resources in order to qualify me for Medicaid.

I, _____

(Name of Institutionalized Spouse requesting Medicaid benefits)

pursuant to 42 U.S.C. § 1396r-5(c)(3)(A), hereby irrevocably assign and transfer the totality of rights, title and interest to spousal support from the income or assets of

_____

(Name of Institutionalized Spouse requesting Medicaid benefits)

to the (State) _____

(Medicaid Agency) _____

pursuant to 42 U.S.C. § 1396r-5(c)(3)(A), hereby irrevocably assign and transfer the totality of rights, title and interest to spousal support from the income or assets of

SIGNATURE _____

(Signature of Institutionalized Spouse requesting Medicaid Benefits)

REAL LIFE CASE STUDY

It all started in Connecticut

UNDOCUMENTED IMMIGRANT REFERRAL FROM ACUTE CARE

This issue is becoming more pervasive from coast-to-coast.

UNDOCUMENTED IMMIGRANT PATIENT REFERRAL FROM ACUTE CARE PROVIDER

- DATE: _____
- RESIDENT NAME: _____
- SOCIAL SECURITY#: _____
- FACILITY NAME: _____
- FACILITY ADDRESS: _____

To assis t your Hospital with freeing up beds occupied by patients who lack the resources to pay for their stay, whose stay is not covered by Medicare, Medicaid, private insurance, or any other third party payor, and who is an Undocumented Immigrant, _____ has agreed to accept the above patient under the following conditions:

1. Until such time as the patient is repatriated back to his or her county of origin, hospital will pay the facility's private pay daily rate within in 30 days of receipt of all invoices; and

2. Hospital also agrees to reimburse _____ any and all direct costs incurred repatriating patient back to his or her county of origin, including but not limited to, transportation, agency placement fees, and the cost of care provided during such transportation, and the cost of care in the resident's country of origin.

As fully discussed in the Undocumented Immigrant Patient Agreement, which Hospital agrees to sign within 5 days of the date of this referral, Hospital and _____ acknowledge that nothing in this Agreement shall be construed to require _____ or any affiliate to generate business for Hospital, Hospital's representatives or any affiliated entity, or to require Hospital, Hospital's representatives or any affiliated entity of Hospital to generate business for _____. Notwithstanding the unanticipated effect of any of the provisions herein, the parties represent and warrant that they have not engaged in, and shall not during the Agreement engage in, any activity prohibited under the federal anti--kickback laws (42 U.S.C. §§ 1320a--7, 1320a--7a, 1320a--7b), the regulations promulgated pursuant to such federal statutes, or similar State or local statutes or regulations.

The parties further represent and warrant that during the Agreement, they will comply with any other federal or state law provision governing fraud and abuse or self--referrals under the Medicare or Medicaid programs, as such provisions may be amended from time to time.

Hospital and _____ further acknowledge and agree that the opportunity to make or receive Undocumented Immigrant Patient payments is not conditioned on the volume or value of referrals or business otherwise generated by, between or among the Hospital, _____, and any individual or entity affiliated with Hospital or _____.

PRINT NAME: _____

TITLE: _____

NAME OF HOSPITAL: _____

SIGNATURE OF RESIDENT _____

BONUS

Do you need a DAR to pursue an Undue Hardship Waiver to cure a transfer of assets for less than fair market value?

KEY TAKEWAYS

- You don't have to rework or amend your admission agreement to protect your Medicaid/Medicare dollars.
- Knowing and using the federal regulations will increase Medicaid/Medicare dollars and decrease losses.
- Common law assignment provisions are necessary to stop lost retroactivity because of excess resources.

Q&A

SB2 INC. FEE MODELS FOR 2018

- **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.

SB2 INC. FEE MODELS FOR 2018

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.

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

Chad Bogar, Managing Partner

cbogar@sb2inc.com or 212-203-1334

Sb2inc.com