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 exceptional and affordable legal services to the health care provider community, with an emphasis on representing the long-term care industry.

The Four Issues Impacting Medicaid Dollars and Eligibility:

State Recoupments, Missing Verifications, Penalty Periods and Long Pending Applications.

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Who We Are

- founded in 2004
- work in over 44 states
- 23 staff attorneys and 30+ national contract attorneys
- represent 2800+ skilled care facilities

About the Firm

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

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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 use the judicial process to force the resident to do both.	**2.** If a resident passes away during the Medicaid Eligibility application or appeal process, eligibility can still be obtained. We often qualify deceased residents up to two years after their date of death.
3. If a resident is incapacitated and without an authorized representative or guardian (or, if either has "resigned") and her 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 seek automatic approval by filing a Delay Action.	**6.** If you have a resident and her community spouse refuses to provide verification of his assets and refuses to 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 months after the deadline.
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 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.	**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.

What Have We Done Lately For Our Clients?

- CA—in another first, sb2 inc. convinces California Court to allow a facility to be appointed as a resident's MAR to qualify her for Medicaid.
- KS—sb2 inc. files federal delay action at the end of September '16 and obtains 14 of 23 approvals in weeks!
- OH—board of review agrees with sb2 inc. that ALJ impermissibly assisted caseworker during hearing and orders a new hearing with a new ALJ.
- OH—sb2 inc. obtains approval to OME/PEME $27k in patient liability that was stolen by resident's son.

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When can and when CAN'T your state recoup Medicaid dollars?
The answer will surprise you!

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The Problem

Your company owns 15 facilities in OH. Yesterday, several of the facilities that you oversee received recoupment notices/adjudications demanding the return of $1 million in Medicaid dollars that were allegedly paid out erroneously to former and current residents.

You have two choices: either pay it back, or fight it.

What do you choose?

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The Solution

Fight it!

Under the Doctrine of Federal Preemption and common law, you are NOT on the hook for paying any of it back.

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Prologue.
What's Diving All of This?

CMS Audits

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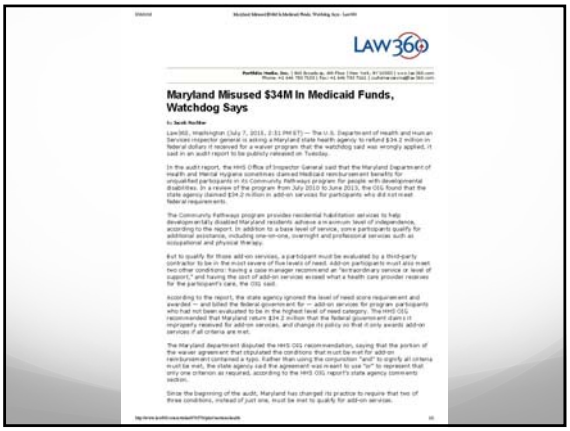

LAW360

Maryland Misused $34M In Medicaid Funds, Watchdog Says

During the three years of the audit, HHS, through the Centers for Medicare and Medicaid Services, reimbursed the state agency for $178.7 million of the $329 million total for all add-on services, the OIG said. The watchdog reviewed $34.2 million, and is asking for all of it back.

Representatives for the Maryland agency and for the HHS OIG did not immediately respond to messages seeking comment on Tuesday.

--Editing by Stephen Berg.

Step One of the Analysis

Federal Preemption

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Real Life Case Studies

The Maryland, Virginia & OH Examples

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Federal Law Reigns Supreme

- State recoupment regs must be approved by CMS.
- Provider appeals.
- Builder analogy.

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Look to MCO Regs

These are Informative.

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Federal Common Law

You're Not Responsible for Their Mistakes

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Real Life Case Study

Texas Court:

Plainly, if it is your mistake, you pay for it, **unless** the recipient misled you or accepted the payment knowing you did not owe it.

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Applying What We've Learned

OH recoupments/adjudications

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Bonus Practice Tip of the Week!

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Key Takeaways

- Don't ever ask the fox how to guard the hen house.
- If a state regulation conflicts with a federal regulation, then it is null and void as a matter of law.
- Look to other federal regulations for guidance.
- Case law undercuts what the states are trying to do.

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Is the inability to comply with verification requests leading to lost Medicaid revenue?

Turn the tables and learn how to place the burden on the caseworkers instead!

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The Problem

You oversee five facilities for a regional provider. At each facility you have several residents who have been denied Medicaid eligibility because of their inability to produce several pieces of verification requested by their case workers.

Your Regional Medicaid Director has asked if there is any way to "save" these applications on appeal and get these residents approved for benefits.

What do you do?

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The Solution

There is a way to save these applications.

Let's learn how!

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The Ohio Case and the Slow Process of Disillusionment

As evidenced by the attached Opinion, the caseworker has the burden to obtain requested verification.

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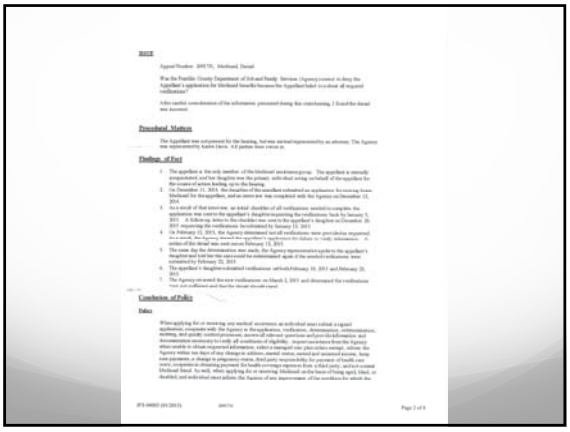
Ohio Department of Job and Family Services
Bureau of State Hearings

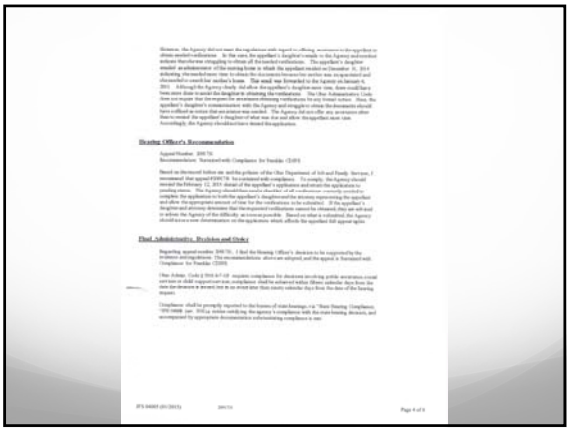
State Hearing Decision

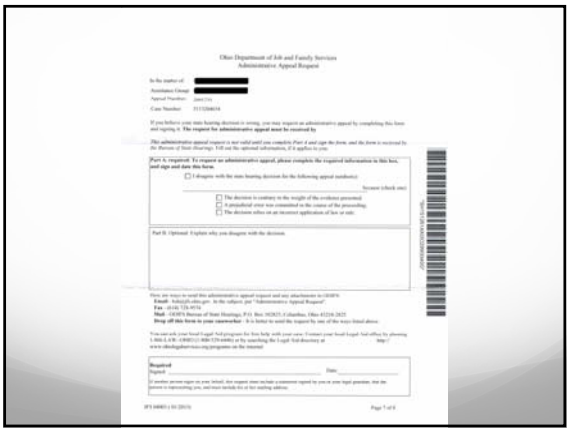


Decision of Fact

Conclusion of Policy

Order





Ohio Department of Job and Family Services
Administrative Appeal Request

Knowing the Following Federal Regulations is the Key to Redirecting the Burden

- The following regulations must be used to educate caseworkers about their responsibilities owed to your residents and protect revenue.

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Unavailability and Eligibility

- The caseworker shall only take into consideration verifications that are available to the applicant or recipient.
- State regulations (Ohio's Best Evidence Rule)

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2012 GAO Report on Medicaid Financial Verifications

- In 2012 Congress mandated that each state create/join a system that allows it to check and obtain all the verifications requested in their Medicaid application.
- Most states haven't done this, which we use to our advantage.

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Verifying Financial Information

The agency **must** in accordance with this section request the following information relating to financial eligibility from other agencies in the state and other states and federal programs to the extent the agency determines such information is useful to verifying the financial eligibility of an individual.

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Assistance

The agency **must** provide assistance to any individual seeking help with the application or renewal process in person, over the phone, online **and** in a manner that is accessible to individuals with disabilities and those who are limited English proficient.

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Real Life Case Study

The New Jersey Example

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The Critical Importance of the Assistance Letter

This is the key to preserving retroactivity in the event that the caseworker does not understand the federal regulations.

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Key Takeaways

- You can qualify a resident without producing all the verification required by the caseworker.
- Caseworkers are mandated by Congress to obtain verifications to qualify your residents for Medicaid.
- You must employ assistance letters as part of your Medicaid/Medicare eligibility process.

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Reducing penalty periods by using a recently discovered CMS Rule and Undue Hardship Waivers.

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The Problem

Over the last 16 months there has been a dramatic uptick in penalty or restricted periods because of residents allegedly transferring assets solely for Medicaid planning purposes and for less than fair consideration.

Your CFO estimates that they are costing your region about $200k every quarter. You have been asked to come up with some solutions to present at the next regional meeting.

What do you do?

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The Answer

Addressing penalties that have already been assessed, you need know what CMS says you can do.

Turning to future penalties, you need to attack them by using Undue Hardship Waivers.

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Presumptions Kill

Whoever said that you can't Other Medical Expense Penalty Periods?

Not CMS!

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Everything Starts & Ends Here

CMS has to approve EVERYTHING.

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The CMS Fine Print

"This guidance provided States with the option of not allowing any deductions for medical and remedial care expenses incurred as a result of imposition of a transfer of assets penalty period. States that would like to implement this approach were told to amend their Title XIX State plan to reflect their election of this option. Specifically, States should amend "Reasonable Limits on Amounts for Necessary Medical or Remedial Care not Covered Under Medicaid." When amending the Title XIX State plan, CMS suggested that States use the following language:

The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

It is our understanding that [your state] has implemented this in practice but it is not *reflected* in the State plan."

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Due Process is Always an Issue

CMS demands constitutional specificity too. For example:

"Any reasonable limits used by a State must be specified in the State's Plan, 'Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered by Medicaid.' It is important to note that if a State does not specify its reasonable limits in the Supplement, it will be assumed that the State does not apply any limits to the deduction of medical or remedial expenses under the post-eligibility process."

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Penalty Period Terms Defined

- **Transfer of Assets:** Includes payments out of checking accounts, transfers of real property, charitable or other gifting of funds and assignments of insurance policies etc.
- **Look-Back Period**: 5 years.
- **Fair Market Value:**

  Cash transfers--face value.

  Real Property--the amount by which a property would sell on the open market if put of for sale.

  Note: Medicaid often goes by the tax assessed value.

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The 2 Part Penalty Period Test

Do they meet the following criteria?

1. For less than fair market value; AND
2. Solely for Medicaid planning purposes.

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Penalties: Rebut the Following Presumptions

- The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.
- The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

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What if you cannot rebut the presumption?

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Seek an Undue Hardship Waiver!

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Undue Hardship Waiver

An undue hardship exists when the application of the transfer of assets provisions would deprive an individual of medical care so that her health or life would be endangered or it would deprive the individual of food, clothing, shelter or other necessities of life.

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What to Include in the UHW

- letter from doctor showing resident needs nursing care,
- discharge letter,
- documentation that authorities were alerted, and
- documentation of a good faith effort to recover transferred assets.

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Key Takeaways

- Presumptions are costing our industry hundreds of millions of dollars each year. Remember: without CMS approval states cannot act. It's that simple.
- Medicaid recipients can fight penalty periods one of two ways:
  1) rebutting the presumption, or
  2) seeking an undue hardship waiver
- Most states are not following CMS regulations directing how UHWs are to be determined. We need to go after them.

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Delay Actions and How to Use Them to Increase Revenue and Decrease Lost Retroactivity

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The Questions?

Is your facility's operating revenue suffering because your Medicaid applications are pending forever?

Are caseworkers routinely sitting on your Medicaid applications and refusing to timely talk about/process them?

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The Answers!

1. Federal Delay/Declaratory Judgment Actions.
2. Administrative Inaction Appeals.

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Real Life Case Study

Your company has 12 facilities in Alabama. Your Medicaid pending list for just two of these facilities is over $3 million dollars because you presently have 17 Medicaid applications that have pended on average for longer than 6.5 months.

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Federal Law Requires States to Process Medicaid Applications Timely

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

(1) **Ninety (90) days** for applicants who apply for Medicaid on the basis of disability; and

(2) **Forty-five (45)** days for all other applicants.

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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.

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"The Settlement"

- **Attorney General's Office Gets Involved**.
- **Agency agrees to:**
  - Keep 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!!!

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Administrative Inaction Appeal

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

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7th Circuit Decision – Smith v. Miller

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

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Key Takeaways

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Q&A

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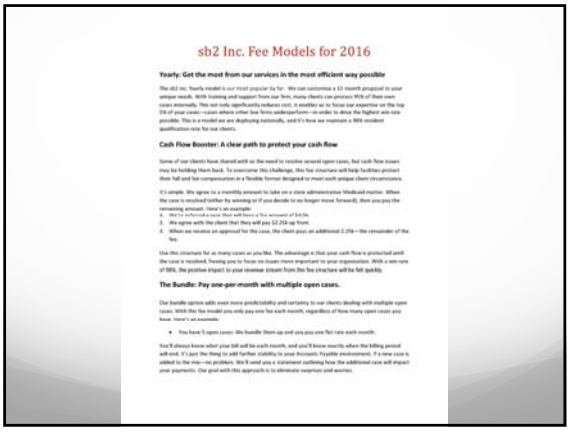

sb2 Inc. Fee Models for 2016

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

Cash Flow Booster: A clear path to protect your cash flow

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

Please Do Not Hesitate to Contact Us if You Have Any Questions!

"Medicaid/Medicare Eligibility & Reimbursement is getting harder because of DOJ and CMS crack downs. Just look at what North Dakota is getting hit with!"

Chad Bogar, Managing Partner

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