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.
Taking Control of the Medicaid Eligibility Process: Strategies to Help Ensure Success.
WHO WE ARE

- founded in 2004
- work in over 44 states
- 23 staff attorneys and 30+ national contract attorneys
- now representing providers, facilities, third-party fiscal agents, healthcare associations and related entities nationwide

ABOUT THE FIRM

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

- Federal Judge agrees with sb2 inc. that Illinois must annually submit for CMS review the daily Medicaid rate for skilled nursing care, thereby opening the door for a much needed rate increase.

- Intervening on behalf of midsized provider, sb2 inc. reduces state’s attempted recoup of several hundred thousand dollars of alleged Medicaid overpayments by 90%.

- NJ appellate court agrees that notice denying resident’s Medicaid application was defective and orders a hearing on the merits.

- In significant win, sb2 uses constitutional arguments to stop state from blocking resident’s second application for Medicaid based on a legal principle that prohibits litigating the same matter twice.
Medicaid

**Illinois Medicaid Agency Must Relieve Processing, Pay Backlog**


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.


By Mary Anne Pazanowski

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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-06, 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 spokesperson 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 say 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

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The opinion is at http://src.bna.com/utiU.
WHY MEDICAID?
It is a certain and predictable source of revenue.
THE PROCESS
ADMISSIONS
MAKE ADMISSIONS YOUR PROCESS

Remember: it’s your financial welfare.
AVOID PROBLEMS

At admissions:

☑ Secure the requisite information.

☑ This will be a Medicaid resident.
THE ADMISSION PACKAGE

If you can get one thing signed, it's this.
WHAT’S NEXT?

The Medicaid Application: File it no matter what.*
WHEN?

10k*
WHY FILE AN APPLICATION?
RETROACTIVITY!

- Eligibility up to 90-120 days from date of application.
- This will be a Medicaid resident.
BUT WHAT IF RESIDENT SAYS...

We’ll handle the application process.
THE APPLICATION HAS BEEN FILED FOR TWO MONTHS

Now What?
ANSWER.

- Delay Action; and
- Inaction Appeals.
(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 days for applicants who apply for Medicaid on the basis of disability; and

2- Forty-five days for all other applicants.

42 C.F.R. § 435.912
DELAY ACTION

1. Federal action
2. ADA Violation
3. Due process violation
4. Request automatic approval
5. Attorney General involvement (settlement)
INACTION APPEAL

- Administrative level
- Economical and easy
NEXT STEP

The Denial
NOTICE

The agency must send each applicant written notice of the agency's decision on his/her application.

42 C.F.R. § 435.912
NOTICE REQUIREMENTS

- A statement of what action the state intends to take;
- The reasons for the intended action;
- The specific regulations that support the action; or
- The change in federal or state law that requires the action.

42 C.F.R. § 431.210 and 42 C.F.R. § 435.919
An explanation of:

- The individual's right to request an evidentiary hearing if one is available, or a state agency hearing; or

- In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

- An explanation of the circumstances under which Medicaid is continued if a hearing is requested.
Should we appeal?
(Always consider if Prejudicial Delay is at play. Crucial.)
ALWAYS APPEAL

If you don’t appeal, you WILL lose money.
YOU’RE AUTHORIZED TO APPEAL

Federal Regulation
NEXT STEP

Orphan’s Court
INCAPACITATED OR DECEASED RESIDENTS

☐ Guardianship/conservatorship—NO.
☐ Estates—NO.
☐ Medicaid Authorized Representatives (MARs)—YES!
WHAT’S NEXT?

Know the Regulations
UNAVAILABILITY AND ELIGIBILITY

The caseworker shall only take into consideration income and resources that are available to the applicant or recipient.
Nonliquid resources are property which is not cash and which cannot be converted to cash within 20 days.
In sum, if the applicant has attempted, but has been unable to convert the property into cash, then it is non-liquid and cannot bar Medicaid eligibility. An applicant’s resources are not available when he or she does not have the power (or there is a legal impediment) to liquidate the asset.
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.
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.
The agency must provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, in a manner that is accessible to individuals with disabilities and those who are limited English proficient.
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.

42 U.S.C. § 1396; 20 C.F.R. § 416; HCFA Transmittal No. 64, § 3258.
If CMS doesn’t approve it, then your state can’t do it.
HOW TO MAINTAIN WHAT YOU’VE LEARNED TODAY?

Education & Training
KEY TAKEAWAYS

- Education is the key to taking control of the Medicaid eligibility process;

- Federal regulations and CMS control every aspect of Medicaid eligibility and are pro-resident/provider; and

- With effort and dedication you can have a great Medicaid eligibility program.
Q&A
SB2 INC. FEE MODELS FOR 2019

✔ 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.
**An Even Dozen: 12 Cases for $7.5k 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!

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