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Protecting Your Client with a Medicaid Fair Hearing

By Jane M. Fearn-Zimmer, Esq.

Sometimes, a Medical Assistance (Medicaid) determination needs to be appealed in a Medicaid Fair Hearing. A Medicaid Fair Hearing is an administrative challenge to the determination of Medicaid eligibility (or a lack of Medicaid eligibility), which is reviewed by a hearing officer or an administrative law judge, according to the state's procedure. Under federal law, states must establish a Fair Hearing system.

Typical grounds for a Fair Hearing request can range from some computational errors made by the case worker, the improper imposition of a Medicaid penalty period, an error on the face of the determination (*i.e.*, the computation of income for the community spouse, the need to increase the community spouse's allowance even though the income was correctly completed), and, in very limited instances, discussed further below, unreasonable delay. Whatever the reason a Medicaid Fair Hearing is required, there are strategies to protect your clients' rights.

The Notice

The first step in the Fair Hearing process is to scrutinize the notice. Under federal law, a completed Medicaid application must be processed within 45 days. [*See 42 C.F.R. 435.912*] This means that if a complete Medicaid application with all the documents necessary to determine eligibility has been filed and not processed within the time required by federal law, then the lack of a timely decision provides a basis for a Fair Hearing. Doubtless, some practitioners routinely file for Fair Hearing on the 46th day. However, if feasible in your state, it is generally best to either speak or write to the caseworker and extend flexibility as needed to the county welfare office.

Preparation can be the key to success. As seasoned elder law attorney Mary Alice Jackson, Esq. of Austin, Texas, points out, it is important for both the prehearing conference and the Fair Hearing to know the file cold, be familiar with all of the transactions and issues involved in the underlying Medicaid application, and be able to cite to the state Medicaid Manual and/or the applicable federal Medicaid statute, regulation, or case to substantiate your argument. She recommends that when feasible, speak with county counsel in advance of the hearing. This is frequently viable in some states, including New Jersey, Pennsylvania, and Texas, but can be difficult in others, particularly in Florida, where the county's attorneys are often juggling different types of matters and have many demands on their time. Ms. Jackson suggests that bringing the State Medicaid Manual to the hearing and showing the judge and the county's attorney exactly which provision is implicated and why the county welfare office's position is incorrect can also be effective if you are unable to confer in advance of the hearing.

Frequently, in addition to substantive issues, there may be procedural due process violations. Under federal law, the Medicaid determination must be sufficiently clear and detailed to apprise the petitioner of why she did not receive Medicaid eligibility on the date requested and the basis for correcting this determination. [*Ortiz v. Eichler,* 794 F.2d 889 (3d. Cir. 1986)]. Based on my experiences in my home state of New Jersey, the Medicaid determination may omit the ultimate reason for the denial of Medicaid coverage. In these cases, the case worker may have stopped processing the case before working entirely through the file, leaving additional issues to be resolved after the initial hurdle is overcome in a Fair Hearing. Those subsidiary issues may not be stated clearly on the face of the notice and, therefore, your client is not apprised of the ultimate issue or how to protect her interests. In some cases, there may be a "hide the ball" approach to the Fair Hearing process, which is actually designed to be collaborative rather than adversarial.

If the notice is facially unclear, that is itself a basis for a Fair Hearing, which needs to be plainly stated in any Fair Hearing request letter. [*Ortiz, supra*]. On the other hand, if the notice clearly states one reason for the denial but the county welfare office persists in its position that Medicaid eligibility for the date in question remains denied, but also presents a new reason without issuing a new notice clearly stating that reason, then you have a new basis for your Fair Hearing, which is a defective notice. For instance, when Medicaid eligibility is improperly denied based on excess resources due to the purchase of a Deficit Reduction Act compliant annuity but the county welfare office changes tactics to argue excess income for failure to deposit the entire payment from an excess source of income into a Miller Trust or a Qualified Income Trust, then a new Medicaid notice would have to be issued, with full rights of appeal from that notice, and the petitioner should not be required to proceed to a Fair Hearing on the original notice.

File the Fair Hearing Request

The next step in the Fair Hearing process is to file a letter requesting a Medicaid Fair Hearing according to the applicable procedure in your state. Typically, the applicant has at least 10 days and up to 30 days to file a request for Fair Hearing, the time allotted varies from state to state. For example, the deadline to file a Fair Hearing in New Jersey runs in 20 days, whereas in Pennsylvania, the applicant has a period of up to 30 days to file.

The wording of the Fair Hearing request letter can be critical. Some state administrative systems define the Fair Hearing process as limited in jurisdiction. In such jurisdictions (which include my home state of New Jersey), you may find that in limited jurisdiction states, the government's representative may argue that any failure to include an issue in the request for a Fair Hearing may foreclose any argument or testimony regarding that issue on Fair Hearing. Note that such an argument is inconsistent with federal law, which provides that a in a Medicaid Fair Hearing, a petitioner is entitled to present evidence on all points relevant to establish her Medicaid eligibility. Attorney's fees should, if sought, be requested at the Fair Hearing.

This brings us to the discovery phase, which is relatively informal. Under federal law, the Medicaid applicant (or her attorney) has the right to examine the entire Medicaid file in advance of the Fair Hearing. The rules allowing for discovery are found both in the federal Medicaid regulations and frequently in state regulations, state Medicaid manuals or procedure operating memorandums, as well. In New Jersey, for instance, the right to review the file is found in the New Jersey Administrative Code and how the rule is applied may vary from county to county. Some counties will honor the file review request based on a letter, while others require a *subpoena duces tecum*. Some counties will simply mail a copy of the file on a disc, and others will require the attorney or paralegal to come to the county welfare office and review the paper file. The file review can provide a wealth of information regarding the Medicaid application in question and the practices and procedures of the county welfare office in general, that are not otherwise available. It is not unusual to find notes and e-mails and documents which could support an inference, borne out by testimony on cross-examination, that the agency's action was arbitrary and capricious.

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GAO Report Highlights Need for Increased 1115 Waiver Programs Oversight

On February 20, 2018, the General Accounting Office (GAO) publicly released GAO-18-220, a report to Congress requestors, examining various states' evaluations of their own 1115 Medicaid demonstration waiver programs. As discussed fully in the report, the Department of Health and Human Services, Centers for Medicare and Medicaid (CMS) is authorized to carry out its own evaluations of section 1115 demonstrations and in such instances, the states must comply fully with these evaluations. However, between 2014 and 2016, CMS initiated only three evaluations which were ongoing as of November, 2017.

The GAO report identifies major deficits in reported evaluation results in part due to the timing of the final, comprehensive reports as required at the expiration of the demonstration waiver programs, rather than at the conclusion of each 3- and 5-year cycle during the waiver's existence. For instance, Arizona, whose demonstration waiver program includes Managed Long Term Supports and Services (MLTSS) for complex populations of intellectually and developmentally disabled adults and for children with disabilities, was required to measure improvements on quality of life and access to care during the demonstration period for long-term care beneficiaries enrolled in MLTSS. Arizona's evaluation results were apparently submitted to CMS in October, 2016, only one month after CMS approved a 5-year renewal of the demonstration waiver. This report was missing important data on measures on hospital readmission rates, and beneficiaries' satisfaction levels with their health plans, providers and case managers. CMS subsequently required Arizona to submit an interim evaluation.

The GAO recommended that CMS develop written procedures requiring all states to submit final evaluation reports after the end of each demonstration cycle, regardless of the renewal status for the waiver. The GAO further recommended that CMS should issue written criteria addressing when the agency will allow limited evaluations of a demonstration waiver program. It was also recommended that CMS should also establish and implement a policy for publicly releasing findings from federal evaluations or demonstrations, with standards for timely release. The GAO's report is available online at *https://www.gao.gov/products/GAO-18-220*.

Review the File Carefully

You never know what you are going to find or how it may be helpful. This point is illustrated by a case involving the imposition of a Medicaid transfer penalty for the sale of the home to the children. The children bought their parents' house as a strategy to finance their father's assisted living care. The mother moved out of the former marital home to live with one of the children after the father entered into long term care. After some months, the parents' liquid funds were exhausted on the assisted living care of the father and the quality of care was sufficiently high that the family wanted to the father to remain in that facility. The usual solution would have been to sell the former marital home and use the home sale proceeds to pay for the care. However, in this case, the former marital home was in terrible condition, with electrical violations, rotting floors made of wood that had not been pressure treated, leaking windows, and other issues, such that had the home been inspected in order to obtain a certificate of occupancy, the property would have been condemned. The children valued the home based on information available on the internet, paid slightly above market rates considering the condition of the home, purchased the parents' home and proceeded to invest thousands of dollars and substantial "sweat-equity" to rehabilitate the property and facilitate its sale However, the real estate closing was unexpectedly delayed for six months for unrelated reasons, after which time, the case worker valued the home at the substantially higher fair market value as improved, not in the terrible condition the home was during the closing, and imposed a Medicaid transfer penalty for the child's purchase of the parents' home computed in the amount of the difference between the fair market value of the home as improved and the fair market value of the home prior to its rehabilitation.

The Medicaid file contained a retroactive appraisal and a video showing the deplorable condition of the real property at the time the children decided to purchase the home, and both were provided to the case worker at the time of the Medicaid application. The file review confirmed that the case worker had received and saved emails forwarding her

Obituary for Leonard Lewis Silverstein, Esq.

Prominent tax attorney, Leonard Lewis Silverstein, Esq., formerly of Bethesda, Maryland, passed away on February 14, 2018 at the age of 96. Mr. Silverstein was born in Scranton, Pennsylvania in 1921, and was a 1943 graduate of Yale University. After college, he served in the United States Navy in the Pacific during World War II and later attended Harvard Law School.

Leonard L. Silverstein worked for the Treasury Department, Internal Revenue Service and the Small Business Administration. In connection with his work on the 1954 income tax code, Mr. Silverstein perceived that there was a real need for clear, published explanations of the tax code for accountants, attorneys and other financial professionals. In 1959, he founded the BNA Tax Management Portfolio's series and served as vice president and Director of Tax Management. In 1960, he founded the law firm of Silverstein & Mullins, which was merged with the law firm of Buchanan, Ingersoll & Rooney, P.C., where he was a shareholder in the Pittsburgh, Pennsylvania office. He worked with many prominent public figures and philanthropists during his career in private practice, including the Rockefellers, Guggenheims, and Mellons, and played a prominent role in shaping the federal tax code provisions on charitable giving.

An avid patron of the arts, Mr. Silverstein learned French as an adult and was a member of the French Legion of Honor, France's highest honor conferred upon private citizens. He was also the past President of the Alliance Francaise of Washington, D.C., and a director of the National Symphony Orchestra Association, and served on other cultural and corporate boards. He is survived by his wife of many years, Elaine Wise Silverstein, a sister, two children and four grandchildren.

the video and photos during the Medicaid application process, which she initially denied. Knowing that the emails were saved in her file enabled counsel for the petitioner to walk up to her witness box, take her file, and cross-examine the case worker regarding the email forwarding the video, and elicited her admission during the Fair Hearing that she lied about not having received the evidence, and admitting that she never watched the tape of the home's deplorable condition and had discounted all of the evidence which was presented to her in the underlying Medicaid application. Her own file was used against her. Thus, the foundation for a finding that her disregard of the evidence was arbitrary and capricious was laid.

Some case workers take the position that the attorney is only permitted to review the file, so copies of documents in the file will not be provided. The counter to this position is that the federal rules facilitate not only the review of the file, but the ability of the petitioner to use the materials found in the file.

In some states, if additional discovery is required beyond the file review and document copies, further discovery must be authorized by an administrative law judge or hearing officer. Requests for admissions of documents may be particularly useful once ordered, on an application to the court. Request a judicial pretrial conference if one is not already scheduled, and ask the administrative law judge to list the additional discovery permitted and to incorporate the discovery deadlines into a pretrial order.

If the file review is conducted in the county welfare office, the meeting should be used as an informal settlement conference, particularly where the Fair Hearing was requested to correct a computational error on the part of the case worker, there is an issue with which transactions are included in computing a Medicaid penalty period, or there is an issue regarding the application of a complex formula.

Next comes the preparation of the brief and exhibits and preparing for the hearing. In the hearing, the initial burden to prove Medicaid eligibility rests on the petitioner, which can be shifted to the respondent. The best strategy in the hearing will depend in large part on the issues presented in the case. If a case worker has clearly made an error and the agency will not voluntarily correct the error, you will want to be sure to have served the case worker with a subpoena or an order to testify to ensure that the individual is present in the courtroom for cross-examination.

Some Fair Hearings will be required because the county welfare office and the petitioner have diametrically different view of the facts and applicable law. In other instances, the Fair Hearing may be necessary simply because the case worker has no authority at the county welfare board level to award the necessary increase. An example of this is a Fair Hearing to increase a community spouse's allowance where her income,

Nationwide Elder Fraud Sweep

The Corporation for National and Community Service estimates that 1 in 10 seniors is abused, and only 1 in 23 cases is reported to Adult Protective Services. Taking aim against the perpetrators of a variety of schemes victimizing the elderly, including lottery phone scams, grandparent scams, romance scams, IRS imposter scams, and guardianship scams, the United States Justice Department, working together with other federal, state, and local law enforcement agencies, has spearheaded a campaign resulting in the filing of multiple civil, criminal, and forfeiture actions, including criminal actions against more than 200 defendants worldwide.

Losses from elder financial fraud and abuse are estimated at more than half a billion dollars. The Justice Department, the FBI, the Federal Trade Commission, Senior Corps, and the Corporation for National and Community Service have partnered to combat elder abuse and protect our nation's seniors. Elder fraud complaints may be filed with the Federal Trade Commission at *https://www.ftccomplaintassistant.gov* or by telephone at 877-FTC-HELP.

Senior Corps provides service opportunities for Americans over age 55 and operates service programs in all 50 states and the District of Columbia. Senior Corps is hosting a series of webinars to raise awareness of how to protect seniors form scams and financial exploitation and how to work with elder justice professionals in your community.

combined with that of her spouse after application of the income first rule, remains insufficient to raise the healthy spouse's income to the amount of the minimum monthly maintenance needs allowance. Frequently, the administrative law judges hearing Medicaid Fair Hearings are required to make decisions in many other areas of administrative law as well and may not have a strong background in federal or state Medicaid regulations and case law. A brief outline of the policy concerns leading to the enactment of the statute or the promulgation of the regulation can be helpful. Again, taking care to substantiate each point of your argument with facts and the relevant citation to authority that supports your position will be key. It is important to be very organized, the use of binders and joint pretrial stipulations of fact are often appreciated by the judges.

It is important to have a handle on the procedural and evidentiary rules and principals that will be used in your client's case. For instance, in New Jersey, the rules of evidence are not strictly applicable, so hearsay is not in and of itself inadmissible. Know the rules that apply in your jurisdiction.

At the Hearing

During the actual Fair Hearing, Mary Alice Jackson recommends that the client or the client's spouse always be offered the opportunity to attend the hearing and participate. This puts a human face on the relief requested, and allows an opportunity to voice their feelings and opinions, facilitates a feeling of control on the family's party and can be cathartic. The client should be adequately prepared, ideally well in advance of the hearing. For many clients, it is the first time they have ever been in courtroom and it can be intimidating.

Counsel should be very organized in terms of presenting the evidence as well as presenting the law. The burden rests on the petitioner to set aside the original determination. When there is a lack of precedential authority in your jurisdiction, it is also helpful to refer to what other states' courts presented with similar facts have determined. Of course, being respectful, sensitive to the concerns of all individuals in the courtroom, and efficient with the judge's time is critical.

It is also helpful to have a working knowledge of not only your state's Medicaid manual but also the federal Medicaid statutes, rules, and procedures and case law in your jurisdiction. When there is a void of precedential authority in your jurisdiction, it is often helpful to refer to the Program Operations Manual System, more commonly known as the POMS. This is the primary source of information used by the Social Security Administration to process claims for Social Security Benefits. As such, the POMS are the Social Security Administration's interpretation of the law and do not have the force of regulations. However, despite not being given the force of a regulation, courts often defer to the interpretation of law as defined in the POMS. The POMS are relevant in determining the meaning of terms for Medicaid purposes because the Medicaid rules for evaluating resources may be no more restrictive than those for the Supplemental Security Income program. [*42 U.S.C. § 1396a(a)(10)(C)(i)(III)*]. Similarities in the Social Security and Medicaid program structures' suggest that the POMS may provide appropriate guidance.

While there is no substitute for years of experience, using the strategies and suggestions above will facilitate your client's success in the Fair Hearing process.

KEEPING CURRENT

Remainder in pooled trust passes to disabled beneficiary's heirs

National Foundation for Special Needs Integrity v. Reese, No. 17-1817 (7th Cir., February 7, 2018). The Eighth Circuit Court of Appeals rules that the assets remaining in a beneficiary's pooled trust account passed to her heirs-at-law when there was no Medicaid lien, the trust document contained confusing provisions, and the beneficiary named herself as the only remainder beneficiary. The disabled beneficiary, Theresa Givens, suffered from renal failure, was on dialysis, and suffered multiple strokes. She was injured from gadolinium dye, a substance used in MRIs and received the sum of approximately $255,000 from a class action settlement.

The plaintiff expressed her intention to help her children financially with the recovery proceeds but was ultimately persuaded by her attorneys to deposit the funds in a pooled trust. An account was established on her behalf with the plaintiff/National Foundation for Special Needs Integrity, a not-for-profit corporation serving as trustee of a pooled special needs trust. On the beneficiary designation paperwork, Givens named herself as the only contingent remainder beneficiary and did not name any surviving remainder beneficiary. Approximately one month after transferring the sum of approximately $234,000 to the trust, Givens died. Givens did not owe her state of residence any reimbursement upon death.

The plaintiff/Foundation contended that as trustee, the pooled trust was entitled to the remaining assets in the trust. The district court ruled in favor of the plaintiff/Foundation. The Seventh Circuit reversed and remanded, after considering the confusing and contradictory provisions in the trust document and finding that there was no evidence that Givens intended the Foundation to keep her money after death and ample evidence that Givens enjoyed close relationships with her children and wanted to help them after her death. The Eighth Circuit Court of Appeals concluded that the only plausible interpretation of Givens' naming herself as the sole remainder beneficiary was that she intended the proceeds to pass to her children through her estate. The court relied on the *Restatement (Third) of Property: Wills and Other Donative Transfers, § 10.2, cmt. e*, which provides that if a layperson drafts a donative transfer, it should be construed to have the intention the lay person would have intended.

For the full text of this decision, go to http://business.cch.com/elr/NationalFoundationForSpecialNeedsIntegrity_0218.pdf

Suit to Limit Medicaid Lien Amount Based on Subrogree's Understatement in Settlement Negotiations May Proceed

Vestal v. First Recovery Group, LLC. 6:17-cv-1567-Orl-40KRS, (M.D.Fla., Orlando Div., February 12, 2018). The plaintiff was a minor who received medical treatment through Medicaid for injuries sustained in a 2013 motor vehicle accident and allegedly fell victim to medical malpractice in connection with the treatment of her injuries. The plaintiff sought to recover for those injuries. In February, 2017, First Recovery Group, LLC (FRG), on behalf of the subrogee, WellCare, provided notice that the amount of the Medicaid lien incurred by the plaintiff was $14,089.29. The plaintiff settled the medical malpractice claim in May, 2017.

The district court concludes that Fla. Stat. § 409.910(17)(b) did not apply to bar the plaintiff's claims against the subrogee because the plaintiff was challenging an increased Medicaid lien amount based on its detrimental reliance, in settlement negotiations, on FRG's statement, on behalf of the subrogee, that the Medicaid lien was only $14,089.29. Although the district court dismissed the action without prejudice as being filed against the wrong defendant (FRG, not WellCare), the court expressly granted leave to refile against the correct defendant.

In June, 2017, FRG communicated an increase in the amount of the Medicaid subrogation lien to the sum of $144,861.95. The plaintiff filed a declaratory judgment action in state court against FRG, but not WellCare, alleging detrimental reliance on the original lien amount and seeking to limit the amount of recovery by FRG to the sum of $14,089.79 on its claim. The defendant removed the matter to the federal district court and contended that the federal court lacked subject matter jurisdiction due to the plaintiff's failure to file an administrative challenge to the amount of the Medicaid lien under Florida's Medicaid Third-Party Liability Act, found at Fla. Stat. § 409.910(17)(b). The Florida Medicaid statute provides an administrative appeals process to challenge the computation of a Medicaid lien by the state of Florida on the grounds that the amount computed exceeds the amount permissible under federal law *under Wos v. EMA ex rel. Johnson,* [133 S.Ct. 1391 (2013)].

For the full text of this decision, go to http://business.cch.com/elr/VestalvFirstRecoveryGroup_0218.pdf

Viable Claim Re: IDEA Violation due to Failure to Fund Behavior Therapy Services After Eligibility Determination

Ruhl v. State of Ohio Health Dept. et als. Nos. 17-3420 and 17-3422 (6th Circuit, February 12, 2018). The Sixth Circuit Court of Appeals reviews two separate actions brought on behalf of the minor disabled plaintiff, who suffered from autism and other medical conditions. The plaintiff was determined financially eligible for services through Ohio's Help Me Grow Program, but failed to receive services through the program due to the lack of available therapists. The plaintiff received applied behavior analysis (ABA) therapy from private providers, paid for the services privately and then sought reimbursement. Both complaints alleged violations of the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1435(a)(10). The Sixth Circuit Court of Appeals affirmed the dismissal of the first complaint, but allowed the second complaint to proceed.

The plaintiff's first complaint challenged the denial of Medicaid coverage for behavioral therapy services due to excess resources during the period from May, 2013 through December, 2013, after which time the excess resources had been spend down on medical services for the minor plaintiff. The court of appeals affirmed that the plaintiff was required to apply for funding before making the private payments for behavioral therapy and noted that the defendants failed to identify payments that would have supported an earlier eligibility date. The plaintiff's claim was time-barred by the two-year limitations period in the IDEA regulations.

The second complaint was not time-barred and met the IDEA Part C pleading requirements. The plaintiff identified the service provider, stated that the plaintiff suffered from autism, would benefit from applied behavioral therapy, was financially approved for the therapy, and that the plaintiff failed to receive program services because the Help Me Grow Program had no authorized service providers and then just one or two, whose availability was delayed or intermittent. The court of appeals noted that money damages are not available for IDEA violations but that the IDEA does allow a plaintiff to request payment of expenses incurred due to an IDEA violation. As such, the plaintiff was entitled to continue the case on remand.

For the full text of this decision, go to http://business.cch.com/elr/RuhlvStateofOhioHealthDepartment_0218.pdf

Practice Tips

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in a nursing home. Suddenly, clients were saddled with tens of thousands of dollars in medical bills which had previously been covered by Medicare. The NOTICE Act (Public Law No. 114-42), which became law in 2015, requires hospitals to notify patients whether they are on observations status within 36 hours of admission.

Medicare's rules and regulations don't typically overlap with the Medicaid planning that we do for clients. Adding on information about admissions, spells of illness, coverages and residents' rights is an important way you can add value to your client services. It's a topic that lends itself to a seminar or panel discussion with community partners.

Note that the Medicare appeals are more likely to be formalized and take months of time for individuals who are seeking SSDI determinations of disability. Approval of SSDI benefits includes an award of Medicare coverage which begins 24 months from the date the first SSDI check is received (the first check is received 5 months after date of approval). The first challenge is approval for SSDI coverage (both medical eligibility and sufficient work history to receive benefits). An additional difficulty comes when clients finally get the SSDI coverage, but now must wait 24 months before medical coverage under Medicare begins. Coverage choices during that time include COBRA, private pay, private insurance (if pre-existing conditions are covered) or Medicaid. Medicaid is often the only avenue of coverage which brings the practitioner full circle from counseling about SSDI eligibility to making a Medicaid application for coverage until Medicare becomes available.

Finally, your clients should know that if a child has been disabled prior to the age of 22, he or she may be entitled to "Childhood Disability Benefits", or "CDB". CDB provides a higher amount of income in most cases, and like SSDI, also brings Medicare coverage after 24 months. Parents of children with special needs and adults who have capacity but have disabilities need to gather and preserve the records to substantiate a childhood disability, be those records individualized educational plans (IEP's), medical records and sometimes, anecdotal recollections of unrelated third parties who are familiar with your disability.

Learning and remaining up to date with Medicaid regulations is an unending task. However, as benefits diminish and dollars dry-up, elder law attorneys and special needs planners must now highlight the role that Medicare can play in the lives of our clients as well.

PRACTICE TIPS

Practice Tips for Medicare and Medicaid Matters

By Mary Alice Jackson

Mary Alice Jackson, Esq., of Austin, Texas, generously shared her time and expertise regarding incorporating both Medicare appeals (and Medicaid Fair Hearings as discussed in the feature article) into an elder law practice. She prefaced her discussion with praise for the staff of the Centers for Medicare Advocacy, and the vast amount of information on their website (*www.medicareadvocacy.org*), which guides both individuals and attorneys through the Medicare maze.

Ms. Jackson points out that in our practices there are two general categories of Medicare work: those for elderly individuals and those for individuals with special needs. With respect to Medicare appeals for the elderly, you need to know whether the prospect has been hospitalized and, if so, what was their chief complaint and discharge diagnosis. This information can be requested on your client intake forms or requested as part of the screening process. The information is needed to determine the likelihood that the client will be discharged to a nursing home and will be entitled to coverage under his or her Medicare number (remember, not all clients have paid into Medicare so it shouldn't automatically be assumed that he or she is a Medicare recipient. If the resident's Medicare days run out but more skilled care is needed, elder law practitioners will be planning for Medicaid eligibility if there is no other source of payment (e.g. private payment or long-term care insurance). It's a good idea to request written confirmation of the number of days left for skilled nursing care from the admission office, because clients are often confused by Medicare coverage. Explain to the client verbally or via a separate information sheet what it means to have Medicare days and use those days. Explain to the client that it's possible that Medicare days will not be completely used during a nursing home stay.

Experienced elder law attorneys will often counsel clients to wait if the medical situation is unstable or unknown. Public benefits planning is expensive and exhausting. If there is a reasonable likelihood that the resident may return home or pass away, gather intake information and have the client keep you posted on the resident's progress.

When do you need to help a client appeal an adverse Medicare decision? Two issues have dominated the Medicare landscape in recent years – the "improvement standard" and "observation status." The Center for Medicare Advocacy sued the federal government regarding the improvement standard in *Jimmo v. Sebelius*. The *Jimmo* decision addresses whether Medicare coverage can be discontinued if a covered nursing home resident is no longer making "improvements" in therapy; a subjective standard that often frustrates residents and their families who want continued therapies so that the advances that come from therapy can be maintained. The *Jimmo* Settlement confirms that therapy services are covered by Medicare, Parts A and B, and by Medicare Advantage Plans in skilled nursing facilities, home health, and outpatient therapy, when the services are necessary to maintain a patient's current condition or to prevent or slow a patient's further decline or deterioration. An add-on to an elder law attorney's practice can be representing clients who run into this roadblock, and the work can be uncomplicated once the *Jimmo* standard is explained to most nursing home administrators.

Observation status goes together with the Medicare regulation that a patient who is admitted to a hospital for three consecutive days and then is discharged to a nursing home is entitled to up to 100 days of full-partial coverage by Medicare. This regulation, which was followed for many years, began being disregarded by hospitals who made separate determinations for patients about whether they were admitted to the hospital, or whether they were merely on "observation status"—a classification that didn't qualify for post-hospitalization Medicare coverage

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