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Including Special Needs Planning

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New Rules for Needs-Based Veterans' Programs

By Jane M. Fearn-Zimmer

Many veterans and their spouses with cognitive impairment or who require assistance with their activities of daily living rely on the Veterans Improved Pension to pay for their care. The benefit is a needs-based monthly payment as high as $1,176 per month for a surviving spouse and up to the maximum monthly rate of $2,169.96 for a veteran in need of Aid and Attendance with one dependent in 2018. This rate is the maximum annual pension rate, or "MAPR." Based on its amount, the benefit is suitable to fund an assisted living co-pay or care in the home.

Eligibility depends in part on the claimant's net worth. Until and including October 17, 2018, prospective claimants can transfer assets to family or to a trust, without any penalty or a lookback period. But on ***October 17, 2018,*** the old rules will sunset and new rules, which will make it more difficult to qualify for the Improved Pension, will go into effect on the following day. The new rules will bring about major changes to the eligibility rules for several means-tested benefits, one of which programs is the Improved Pension for veterans, and will bring about planning strategies, including the purchase of partnership long-term care insurance policies.

The proposed new rule incorporated a lookback period for asset transfers, a new penalty divisor based on the MAPR (which is currently the sum of $2,169 per month in 2018); the final rule adopted a 5- year maximum transfer penalty for gifts made during the lookback period, and a restriction on the size (but not the value) of residential lots owned by the claimant. When the final rule takes effect on October 18, 2018, uncompensated or undercompensated transfers made prior to that date will not result in any penalty. [*38 C.F.R. §3.276(e)*]. In addition, there will not be any transfer penalty on transfers for less than fair market value of assets which were either exempt (*i.e.*, a primary residence) or on transfers by those claimants whose aggregate net worth would have been was less than the $123,600 standard, with or without the gift. [*38 U.S.C. 3.276(a)(2)(III)*].

The means-tested programs impacted include: (1) the Improved Pension, (2) the non-service connected disability and death pension available to claimants prior to July 1, 1960, and (3) the parents' dependency and indemnity compensation (DIC) benefit, which is a tax-free monetary benefit to eligible survivors of military members who died in the line of duty or who died from a service-connected injury or disease. [*83 FR 47247*]. The final rule does not apply to DIC for veterans or their surviving spouses or children, to family caregiver benefits, or to general caregiver benefits authorized under 38 USC § 1720C because these programs are not needs-based benefits programs. [*83 FR 47247*].

Bright-Line Net Worth Test. One major change is the introduction of a bright-line net worth threshold in the sum of $123,600. (Net worth means the sum of a claimant's or a beneficiary's assets and annual income.) [*38 C.F.R. § 3.274(a)(1)*]. The program excludes from eligibility those claimants whose net worth is projected to outlast the claimant's lifetime. The "excess" net worth is to be applied to the claimant's personal maintenance and care. Prior to October 18, 2018, adjudicators took into consideration a variety of factors (such as a claimant's age, disability, life expectancy, rate of depletion of assets, liquidity of assets, normal living expenses for healthy dependents, nursing home status, and medical expenses in relation to income) in determining whether there were "excess" assets with subjectivity, which could place very elderly claimants with brief life expectancies at a disadvantage in qualifying for the improved pension. [*83 FR 47248*].

Under the final rule, a claimant or a beneficiary will be determined eligible for the means-tested benefit when his or her net worth falls below the $123,600 threshold. This figure is linked to the annually adjusted maximum Community Spouse Reserve Allowance for Medicaid. Transfers of assets before October 18, 2018 are disregarded in computing whether the $123,600 net worth threshold is exceeded; as mentioned, the old rules sunset on October 18, 2018. [*83 FR 47272*]. The following examples illustrate the net worth computation under the new rule.

Example 1. Tex is age 86. Ever since he retired, he has had difficulty with his wife and they reside in separate homes. His assets and his wife's assets total $117,000 and their annual income is $9,000. The couple's income and assets add up to the sum of $126,000, which exceeds the strict $123,600 limit, meaning that Tex is ineligible for the benefit. It is Tex's assets and income, rather than his age, that renders him ineligible for the Improved Pension. The good news is that Tex and his wife may be able to "spend down" their net worth by purchasing assets or services at fair market value. The expenditures are not limited to basic living expenses or educational or vocational rehabilitation. If Tex wanted to purchase a television or a vacation, this would be a permissible spend down under the new rule. [*83 FR 47250*]. For purposes of the net worth computation, it does not matter that Ted and his wife are living apart. [*83 FR 47252*].

The spend down strategy will not work if the new asset acquired is a valuable available resource itself and, thus, a component of net worth. To illustrate:

Example 2. On December 1, 2020, Tex's net worth is $126,000, as computed in Example 1. Tex's wife bought a small vacation home, spending $50,000. The couple uses another residence as their primary residence. There is no mortgage on the new vacation home. The value of the second home is factored into the net worth computation, and Tex remains in excess of the $123,600 countable resource limit. Note that the same result would occur with the purchase of government bonds instead of the second home.

Penalty periods. The new rule incorporates a monthly penalty corresponding to the MAPR currently in effect for the calendar year, divided by 12 and rounding the quotient down to the nearest whole number. In 2018, the MAPR for a veteran in need of Aid and Attendance with one dependent is $26,036. Divided by 12, the monthly divisor applicable in 2018 is $2,169.96. Partial monthly penalties are rounded down to the nearest whole number.

Example 3. If on or after October 18, 2018, Tex *et ux* owned countable assets in the sum of $130,000 and, to spend down, they voluntarily invested $10,000 in an irrevocable annuity, which they were unable to liquidate. Tex (or his wife) would be subjected to a penalty since they purchased an annuity that they unable to liquidate. The payments on the annuity will be treated as income. [*See 38 C.F.R. § 3.276(a)(5)(ii)*]. If one assumes that the MAPR in effect at the time of the annuity purchase was $24,000 annually, that is a monthly penalty divisor of $2,000. Based on this MAPR, the penalty is computed at 5 months ($10,000 divided by $2,000 per month equals 5 months). If the final uncompensated transfer was made on November 15, 2018, then the penalty will begin to run on December 1, 2018. [*38 C.F.R. § 3.276(e)(2)*]. However, Tex and his wife might be able to avoid any penalty period

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if they can show by the benefit of the doubt that they were duped into buying the irrevocable annuity due to fraud, then they could be exempt from the penalty.

Example 4. On December 1, 2020, Tex's net worth is $126,000, as computed in Example 1. Under the terms of his retirement plan, Tex was required to convert his deferred accounts into an irrevocable annuity. Because the mandatory conversion is required under the terms of Tex's qualified retirement plan, no penalty results.

Example 5. Tex has an adult, helpless child, who became permanently incapable of self-support prior to the child's 18th birthday. Tex and his wife could establish an irrevocable trust for the child after October 18, 2018, make a transfer to the trust, and Tex and his wife would not be subject to a penalty. In order to receive the benefit of this exception, however, the child must have become disabled prior to age 18.

Example 6. Tex has countable assets over the $123,600 threshold and, on or after October 18, 2018, Tex transfers the excess assets to a trust. The principal and income from the trust are available for Tex's support. No penalty will result because the transfer did not diminish Tex's net worth. However, he is still in excess of the resource limit because he can use the assets and income from the trust to pay for his care.

Example 7. Tex has a second home, which was appraised at $50,000. Under the new rules, a penalty will generally apply if Tex sells the home for less than fair market value after October 17, 2018. Fair market value is the price at which the home will sell as between a willing buyer and a willing seller who are not under compulsion to sell. [*38 C.F.R. § 3.276(a)(4)*]. If Tex is required to sell the home for $45,000 because a buyer cannot be found for the property at the appraised value, no penalty would apply. But Tex would not be eligible for a general hardship exclusion. The Veteran's Administration will use the best available information regarding value and would consider such a sale to be for fair market value.

Recalculation of Penalties. Under the new rules, claimants may request the recalculation of their penalty periods within strict time limits. Claimants will have 60 days after a penalty period decision to cure or partially cure a transfer. They will be allowed 90 days after a penalty period to notify the Veteran's Administration of the cure.

Medical Spend Down with Unreimbursed Expenses. Title 38, U.S.C. 1503(a)(8), permits claimants to deduct amounts paid by a veteran, veteran's spouse, or a surviving spouse or child for unreimbursed medical expenses to the extent that such amounts exceed 5 percent of the MAPR rate of pension (including any amount of increased pension payable on account of dependents, but not including any amount of pension payable because a person is in need of regular aid and attendance or because a person is permanently housebound) payable to such veteran, surviving spouse, or child. In determining asset values, the Veteran's Administration does not deduct the value of future expenses from current assets, but rather deducts projected unreimbursed medical expenses from income when the medical expenses are reasonably predictable.

Example 8. If Tex's net worth after October 18, 2018 exceeds the sum of $123,600 as of December 31, 2018, even though Tex's projected medical expenses have reduced his 2018 income to zero, the actual payment of those medical expenses in 2019 may cause the assets to decrease and Tex may potentially qualify for the pension in 2019.

Medical expenses are not defined in the statute or regulation, but some guidance was issued in *Fast Letter 12-23, Room and Board as a Deductible Unreimbursed Medical Expense.* The new rule defines health care providers, custodial care, activities of daily living, and independent activities of daily living for purposes of determining which unreimbursed medical expenses may be deductible. The unreimbursed expense must constitute a payment for an item or service that is medically necessary; improves the disabled individual's functioning; or prevents, slows, or eases an individual's functional decline. [*38 C.F.R. § 3.278(c)*].

Medical expenses may include care by a health care provider, *i.e.*, someone who can only be an individual appropriately licensed by the state or country in which the service is provided to provide health care in that state or country. [*38 C.F.R. § 3.278(b) ((1)*]. The Department of Veterans Affairs commented that while it is essential that health care providers be appropriately licensed, in-home care providers are not always subject to licensure.

The definition of "health care provider" in the final rule incorporates a licensure requirement and the term may include, but is not limited to, a doctor, physician's assistant, psychologist, chiropractor, registered nurse, licensed vocational nurse, and a physical or occupational therapist. Other categories of deductible medical expenses (to the extent not reimbursed) include medications, medical supplies, medical equipment and medical food, vitamins, and supplements if prescribed or directed by a health care provider authorized to write prescriptions, adaptive equipment, or service animals, including the cost of any veterinary care, used to assist a person with an ongoing disability; the cost of transportation for medical purposes, *i.e.,* to and from a health care provider's office; health insurance premiums; smoking cessation products; and institutional forms of care and in home care, including hospitals, nursing homes, medical foster homes, and inpatient treatment centers.

Best Practices for Legal Services Engagement Agreements

A recent, published decision by the New Jersey Appellate Division, *Balducci v. Cige*, [No. A-3068-16T2, __ N.J. Super. ___ (Aug. 30, 2018)] illustrates what not to do in a legal services engagement. The attorney's retainer agreement was voided and the counterclaim for fees and costs of over $286,000 was also dismissed.

The underlying action was one for recovery by the plaintiff as the legal representative of her child in an action filed under New Jersey's Law Against Discrimination (LAD), which is a fee-shifting statute. The problems seemed to begin with the attorney's fee agreement, which required the client to pay the greatest of three amounts which were defined based on other factors. Under the agreement, the attorney bore virtually no risk of nonpayment. The appellate division found the agreement unenforceable and void and potentially misleading because it failed to explain that the statutory fee provision may be the only option of the three under which the plaintiff receives full compensation.

The appellate division concluded that an attorney is ethically bound to clearly explain the consequences on recovery and the availability of other competent counsel willing to undertake the same representation based on a flat fee. The appellate division took issue with the attorney's failure to explain the agreement's material terms in a manner such as to enable the plaintiff to make an informed decision about retaining him. For a copy of the *Balducci* decision, *see http://business.cch.com/elr/Balducci_1018.pdf*

Example 9. Corporal King has assets of $115,000 and annual income of $9,000. Adding Corporal King's assets to his income produces net worth of $124,000, exceeding the $123,600 net worth limit. However, Corporal King is a resident of a nursing home and pays annual unreimbursed nursing home fees of $29,000. Assume that the annual MAPR in effect is $12,000. Five per cent of the MAPR is therefore computed as $600. Under the final rule, the VA will subtract from Corporal King's annual income, the sum of $28,400, which is the amount by which Corporal King's reasonably projected current year's unreimbursed medical expenses of $29,000 exceeds 5 per cent of the MAPR ($600). The subtraction of $28,400 from Corporal King's current year income of $9,000 causes his income to be disregarded for purposes of the net worth test, and his net worth is computed at $115,000. So, Corporal King satisfies the net worth test.

Primary Residence. In determining net worth, the value of the claimant's residence and up to two acres worth of property are disregarded from the claimant's assets. The actual fair market value of the residence and up to two acres of the property on which the home is situated are not considered in the net worth computation, nor is the value of an outstanding mortgage against the primary residence taken into consideration in determining net worth. Only the excess of the property value over the residence and two acres of property are includible in the net worth computation. The following examples show how the primary residence is treated under the final rule in determining the claimant's net worth.

Example 10. Sergeant Max resides in a tiny home in Arlington, Virginia, that has been passed down in his family for generations. Even though the house is meagre, and the lot is small, the fair market value of the property has skyrocketed in value over the past few decades and the home and surrounding quarter-acre lot have a fair market value of approximately $670,400. Sergeant Max's $670,400 in equity in his home is disregarded in the net worth analysis under the final regulation. [*83 FR 27351*].

Mortgages, liens and encumbrances on real property other than the claimant's primary residence. A different rule applies to allow the claimant or beneficiary to deduct the amount owed on mortgages, liens, and encumbrances on property that is not the claimant's primary residence in computing the value of that property in assessing net worth. [*83 F.R. 47251*].

Example 11. In 2019, in addition to the home and bank accounts listed above in example 6, Tex owns an unprofitable ranch valued at $100,000, subject to a mortgage of $30,000. The $30,000 mortgage offsets the $100,000 value of the ranch and the $50,000 bank account, reducing Tex's countable assets to for the net worth test to the sum of $120,000. Assuming that after deducting his unreimbursed medical expenses in excess of 5 per cent of the MAPR, Tex's income is less than $3,000 in 2019. Tex meets the net worth test, provided that he is otherwise eligible for the improved pension.

The final rule requires claimants who sell their primary residence after establishing eligibility for the needs-based pension to roll over the net sale proceeds by purchasing a

Comprehensive Care for Seniors Act

On September 17, 2018, H.R. 6561, the Comprehensive Care for Seniors Act of 2018, was referred to the Senate Committee on Finance. Sponsored by Indiana Congresswoman Jackie Walorski, the bill would require the secretary of Health and Human services to issue a final regulation relating to the Programs of All-Inclusive Care for the Elderly (PACE) under the Medicare and Medicaid programs on or before December 31, 2018. The proposed regulation would update the PACE's program's original guidelines from 2006, to customize their interdisciplinary team according to the needs of each enrollee, providing more services in the community with greater flexibility. The PACE program provides funding for the delivery of high quality health care and social services for seniors living in the community at 123 PACE organizations in 31 states. The text of the current bill is available online at https://www.google.com/search?q=govtrack.us+congress+bills+115+hr6561&sourceid=ie7&rls=com.microsoft:en-US:IE-Address&ie=&oe.

On September 21, 2018, the Department of Homeland Security issued a notice of proposed rulemaking requiring aliens who seek to adjust their immigration status or visa, or who are applying for admission to the United States, to establish that they are not likely to depend on public benefits to meet their needs but can instead rely on their own abilities, their family's support, and the support of private organizations willing to assist. The public benefits referred to in the proposed rule concern the Supplemental Security Income (SSI), Medicaid (with limited exceptions for Medicaid benefits paid for an emergency medical condition). and the Medicare Part D low-income subsidy ("extra help"). The proposed rule permits a congressional waiver or exemption. DHHS would also require all aliens seeking an extension of stay or a change of status to demonstrate that they have not received and are not likely to receive public benefits.

new house in the same calendar year. If eligibility has not yet been established and the claimant's home has sold during the three-year lookback period, the claimant may use the net sale proceeds to purchase a new home at any point during the lookback period.

Example 12. Sergeant Hulka is receiving the Improved Pension, In July 2017, he receives proceeds from the sale of his home rendering him net worth excessive. His pension will be discontinued as of January 1, 2018. To remain eligible for the Improved Pension, Sergeant Hulka must either spend down the funds or purchase a new home before December 31, 2017.

Example 13. Colonel Glass sells his residence in December 2018. Assume that the net sale proceeds is the only factor that renders him ineligible for the Improved Pension as of January 1, 2019. Colonel Glass then spends down the net worth and purchases a new home in February 2019. Colonel Glass's pension is discontinued as of January 1, 2019 and resumes on March 1, 2019, assuming that Colonel Glass is otherwise entitled to the pension and has spent down before the VA's decision discontinuing him for the improved pension as of January 1, 2019 becomes final.

As can be seen from the examples above, the new rule presents a dramatic change in operative rules, while presenting new planning opportunities for the VA-certified practitioner.

KEEPING CURRENT

Eleventh Amendment Does Not Foreclose Official Capacity Action for Medicaid Benefits

Burke v. Hill, No. 2:17-CV-1-FL, ____ (Dist. N.C., August 27, 2018) (unpublished). In this pro se official capacity suit against the North Carolina Medicaid Supervisor, the district court denies in part the defendants' motion to dismiss under Fed. R. Civ. Proc. 12(b)(6). The district court allows the plaintiff to proceed with a procedural due process claim that the defendant allegedly failed to issue any Medicaid denial notice and the plaintiff failed to receive such notice.

The Eleventh Amendment of the federal Constitution does not bar the plaintiff's claim. The prospective availability of authorization of payment under the state Medicaid plan for future treatment upon the submission of proper documentation does not moot the procedural due process claim of the plaintiff. A suit to require the agency to pay the expenses it should have paid in the first instance had it developed a proper rule is properly characterized as a prospective relief claim not barred by the Eleventh Amendment. However, the court dismisses the plaintiff's claims insofar as retroactive damages are sought, because retroactive damages are unavailable in an official capacity suit.

For the full text of this decision, go to http://business.cch.com/elr/Burke_0918.pdf

Sixth Circuit Upholds Reduction of In-Home Nursing Care Hours

Carpenter-Barker v. Ohio Dep't. Medicaid, No. 17-4301, ___ Fed. Appx. ___ (S.Dist. Ohio, August 31, 2018). The federal appellate court sustains the reduction of in-home nursing care hours for a severely disabled plaintiff. The sixth circuit rules that the Ohio Medicaid agency did not violate the plaintiff's rights the integration mandate and *Olmstead v. L.C.*, [527 U.S. 581(1999)] with private duty nursing (PDN) service hour reductions, placing her at risk of institutionalization. The reductions were proper because they were based on individualized determinations of the proper level of care given to a single individual. As such, the proposed reductions did not violate the Americans with Disabilities Act or the Rehabilitation Act of 1973. The decision leaves open the possibility (on a showing of impermissible discrimination and a likelihood of success on the merits) of injunctive relief to prevent future decreases in weekly private duty nursing (PDN) hours.

The plaintiff is a severely ill, non-verbal individual diagnosed with a life-threatening condition. Ohio law requires annual pre-authorization of private duty nursing hours. Prior to 2008, the plaintiff was authorized to receive 24/7 PDN care. Beginning in 2008, the Ohio Medicaid agency repeatedly attempted to reduce the patient's PDN hours. Several proposed reductions were successfully challenged through the administration process. In 2013, the PDN hours for the plaintiff were reduced to 56 hours, with personal care aides to replace the nurses in providing personal care of the plaintiff. On appeal of the final agency decision reducing the PDN hours to the court of common pleas, the parties entered into a settlement not to reduce the PDN hours from 128 hours weekly, subject to future assessments.

Two months later, the defendants re-evaluated the plaintiff, again recommending reduction of the PDN to only 56 hours per week. The plaintiff filed lawsuit in the federal district court alleging violations of her procedural due process rights, the Americans with Disabilities Act (ADA), and the Rehabilitation Act of 1973 and seeking injunctive relief and attorneys' fees.

For the full text of this decision, go to http://business.cch.com/elr/Carpenter-Baker_0918.pdf

Class Certification Denied in Challenge to Computerized Medicaid Determinations

Darjee v. Betlach, No. CV-16-00489-TUC-RM (DTF) (Dist. Ariz., September 5, 2018). The district court denies the plaintiffs' motion for putative class action certification, where the plaintiffs did not show commonality of their claims. The plaintiffs alleged that they were "at risk" of an incorrect benefit reduction due to the state's use of a computer program which stored information needed to determine the correct benefit level at the Medicaid application level and did not automatically populate the information into a subsequent Medicaid application. A Medicaid supervisor is required to review any decrease in Medicaid eligibility to program with reduced benefits. The plaintiffs did not show that that the benefit reductions identified were attributable to the computer program and thus did not meet the commonality requirement.

The plaintiffs were legal permanent residents whose Medical Assistance benefits were improperly reduced by the Arizona Medicaid agency, but later restored. The plaintiffs alleged ongoing and systemic improper Medicaid benefit reductions in violation of the due process clause of the Fourteenth Amendment and the federal Medicaid Act, based on the use, by the Arizona Medicaid agency, of a computer program to determine the applicant's eligibility for certain Medicaid programs.

Using the Health-e-Arizona Plus computer program, a Medicaid caseworker enters data regarding the applicant, including immigration information impacting benefit eligibility, and automatically generates a benefit eligibility response. The plaintiffs allege improper reductions in benefit eligibility because the program only stores certain information at the application level and does not automatically populate this information into a subsequent Medicaid application. If the caseworker does not manually enter the immigration information on each successive Medicaid application, the applicant may be assessed at a lower level of coverage than otherwise he or she is eligible for.

For the full text of this decision, go to http://business.cch.com/elr/Darjee_0918.pdf

Voluntary and Enforceable Arbitration Agreement With Nursing Home

Massey v. Oasis Health and Rehabilitation of Yazoo City, L.L.C., No. 2017-CA-00086-COA, __ So.3d ___, (Ct. App. Mississippi, September 4, 2018). The Mississippi appeals court upholds the trial court's ruling that an arbitration agreement entered into between a resident and her surviving spouse was voluntary, valid, and enforceable. As such, the trial court did not err in compelling the resident's husband to submit to arbitration of his claims for the alleged wrongful death due to the facility's negligent care of his wife, who died less than six months following her admission to the facility and after multiple falls in the facility. The appellate court rejects the plaintiff's claim that the arbitration agreement was unconscionable under Mississippi law, when the arbitration agreement was an optional agreement that the resident and her spouse were free to reject without any loss of services or other consequences.

In March 2014, the resident was admitted to the nursing facility. Around that time, she and her husband signed an agreement to arbitrate any dispute with the facility. The resident's husband initialed each page of the agreement, including a notice of the right to cancel the agreement. The arbitration agreement was contained in a separate document from the application for admission. On the cover page of the arbitration agreement, there was a statement that any agreement to arbitrate was not a pre-condition for admission to the nursing home. There was no fine print in the agreement. The arbitration agreement provided a period of 30 days from the date of signing of the arbitration agreement to withdraw consent to arbitrate. In opposition to the facility's motion to compel arbitration, the surviving spouse did not introduce any information regarding the circumstances of the resident's admission, or the age or physical and mental health of the resident or her husband.

For the full text of this decision, go to http://business.cch.com/elr/Massey_0918.pdf

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A.F., who was a severely disabled individual. The administrative law judge re-instated A.F.'s Medicaid eligibility on Fair Hearing, but the state Medicaid agency director reversed this decision, forcing A.F.'s attorney to challenge the decision of the agency director in the Appellate Division. Fortunately, A.F. prevailed in the Appellate Division, but justice delayed can be justice denied. A.F. was represented in this matter by my colleague, Lawrence S. Berger, Esq., of Morristown, New Jersey.

Another viable alternative may be to bring a federal court action to enjoin the underlying state Medicaid policy of refusing to re-open a denied Medicaid application. But federal court litigation tends to work best when the facts of the case are not in dispute, are very favorable to the plaintiff, and the only issue presented is a legal question under federal law.

Earlier this month, a federal district court Medicaid case focused on the use, by the Arizona Medicaid agency, of the Health-e-Arizona Plus computer program in processing welfare benefit applications. The case was brought on behalf of multiple Medicaid enrollees, who argued that the computer programs placed them at risk of undue delays in the proper processing of their applications, in violation of the federal Medicaid Act.

Apparently, once their important information was entered into the Health-e-Arizona Plus program, the information was accessible only within the Medicaid application it was entered on, and the software program did not import the missing information into a subsequent Medicaid application for the same individual. The result was that information entered on earlier Medicaid applications was not considered on subsequent ones, resulting in inadvertent decreases in benefit entitlements. A federal lawsuit was filed on behalf of those Medicaid enrollees, whose welfare benefits were improperly reduced by the Health-e-Arizona program. Their benefits, however, were later restored. The plaintiffs alleged ongoing and systemic improper Medicaid benefit reductions in violation of the due process clause of the Fourteenth Amendment and the federal Medicaid Act, based on the use of the computer program.

The case is *Darjee v. Betlach,* [No. CV-16-00489-TUC-RM (DTF) (Dist. Ariz., September 5, 2018)]. Because the Arizona Medicaid agency required a Medicaid supervisor to review any computer-generated decrease in their Medicaid benefit before the new determination was implemented, the plaintiffs could not satisfy the commonality requirement for class action status.

As the *Darjee* case shows, even computer programs have their limits. Computers do not have empathy, do not care about fairness, will not always identify additional information needed to determine Medicaid eligibility, and will certainly not go the extra mile to obtain the necessary documents for the applicant. While artificial intelligence can be helpful, it remains critical to timely identify, gather and organize all the financial documents needed to establish Medicaid eligibility to facilitate the success of your client's application.

PRACTICE TIPS

Medicaid Red Flags and Due Diligence in the Information Age

Technological advancements have brought the Medicaid application process from the dark ages into the future. Computer programs have become an integral part of the Medicaid eligibility determination process. High volume Medicaid practices are using software programs such as Autocaid to scan five years of bank statements and identify transactions requiring further verification. Many states require online Medicaid applications.

The law is an honorable profession and caseworkers are duty-bound to preserve public welfare benefits for needy individuals. One sometimes encounters a difficult individual who attempts to "game" the system by omitting material information, misreporting their marital status, underreporting uncompensated gifts, and explaining to you how simple the Medicaid application process really is. Medicaid fraud is real and not why any of us went to law school. While caseworkers can weed out these applications with thorough improved access to income information and monthly bank balances via government databases replete with otherwise private financial information, it is important to respond very promptly to clarify any potential misunderstandings and, if there are none, to document any questionable behavior or communication and your ethical response in writing. Wherever possible, offer clients solutions, but never compromise your integrity.

Red flags to avoid can include prospective clients who are "shoppers," prospects with a history of multiple changes of accountants, or attorneys, or physicians; prospects who isolate the elderly parents or will not allow you to communicate with the prior counsel accountants, or medical professionals, or certain family members. Also, be on the look-out for cash or credit card transactions that seem to have no valid business purpose and may potentially implicate money laundering. Other red flags include prospects who have sued other attorneys, that provide inconsistent or incomplete information, that refuse to comply with domestic income tax reporting requirements, or that behave in a manner that is bizarre, entitled, impulsive, or excessively needy or demanding. Over the years, prospects who charged their cellular mobile telephones in the office, prospects who present documents printed on paper that does not appear to be its stated age, and prospects who insist on calling only on Friday afternoons after 3:00 p.m. or outside normal business hours stand out. Such prospects can be quoted a comparatively high fee. On the other hand, honest but difficult individuals who don't observe the normal boundaries may be able to be "trained" by setting strong limits in a pleasant manner, although this can take a long time.

Another problem area in Medicaid applications can be presented when the verification requests are cast too broadly, resulting in an unjust denial of Medicaid to an eligible individual. A recent unpublished state appellate court decision presents the dilemma of how the practitioner in the information age can best rise to the challenge of establishing Medicaid eligibility on an adverse computer-generated determination.

The case, *A.F. v. D.M.A.H.S,* [No. A-2163-16T1 (N.J. Super., App.Div., July 23, 2018)], emanated from my home state of New Jersey, where Medicaid eligibility denials for "failure to verify" are inexplicably commonplace. In *A.F.*, after many years of eligibility renewals, on redetermination, the Morris County Board of Social Services terminated the Medicaid benefits of a quadriplegic who for years had been completely dependent on the personal care financed by the terminated Medicaid benefit. In an Orwellian twist, "Big Brother" cited as the reason for terminating benefits the alleged failure to verify two life insurance policies, neither of which was owned by A.F. and as to which no further details were revealed.

Because A.F. held no incidents of ownership in the policies, A.F. could have not verified the policies on a timely filed Medicaid eligibility redetermination. Although the policy was ultimately revealed on Fair Hearing to be a term life insurance policy with no cash surrender value, the agency refused to waive a few weeks' delay to reinstate benefits for

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