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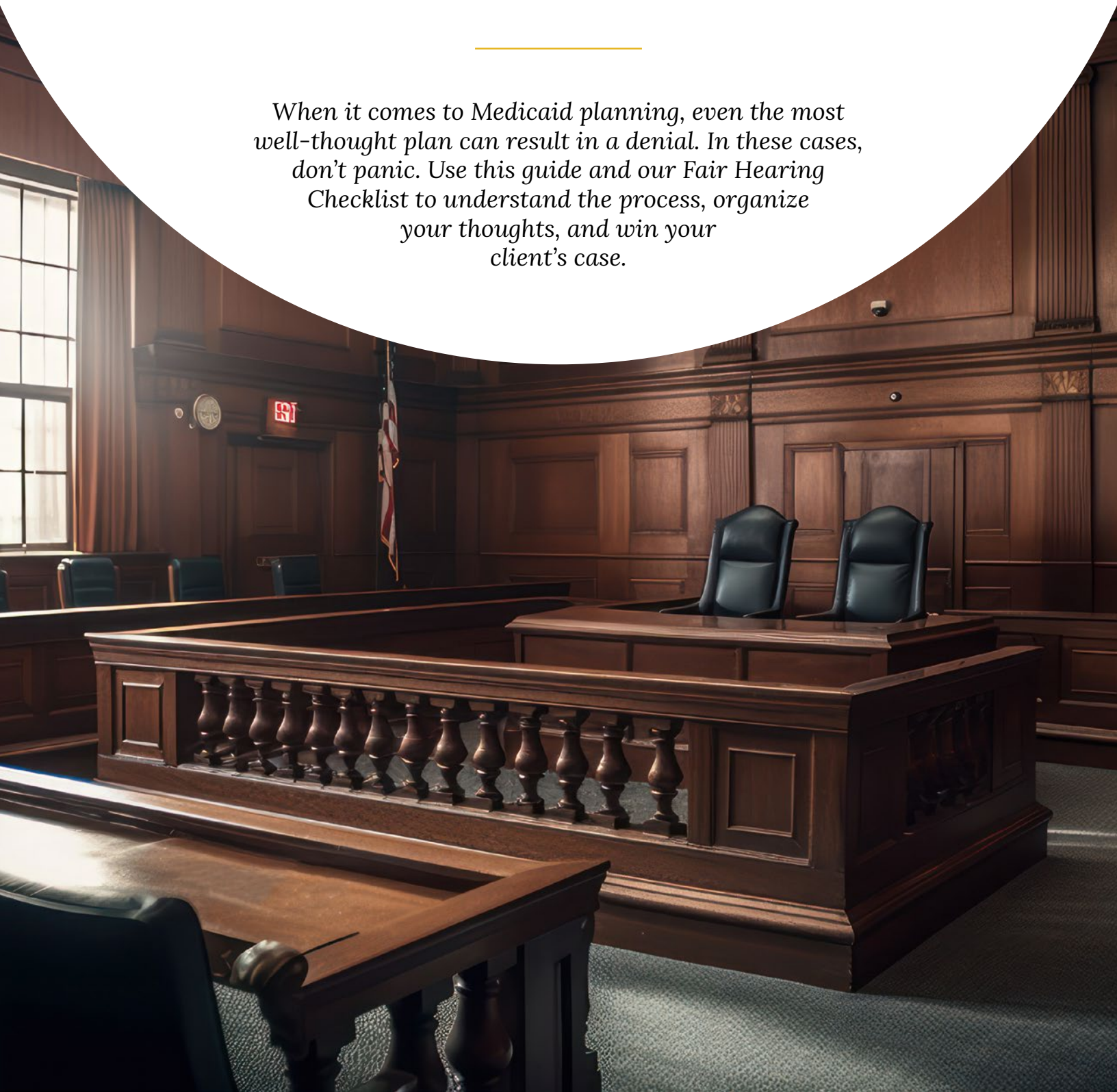
MEDICAID DENIAL & FAIR HEARING GUIDE

When it comes to Medicaid planning, even the most well-thought plan can result in a denial. In these cases, don't panic. Use this guide and our Fair Hearing Checklist to understand the process, organize your thoughts, and win your client's case.



What to Do When You Receive a Medicaid Denial

- After submitting a Medicaid application, the state Medicaid agency will review it for anything that may disqualify your client. If they deem an applicant ineligible for Medicaid benefits, they will issue a denial notice.
- Upon receiving a Medicaid denial and notifying your client, the first thing you need to do is determine the reason for the denial.
- Review your client's agency file to get a complete picture of why their application has been denied. Make sure the denial applies to the facts of the case and use the attached checklist to ensure all information has been provided. If any information is missing, you may argue it's a deficient notice.
- In some cases, you may be able to provide additional information or paperwork to resolve the issue at the case worker level. In other cases, you'll face a fair hearing.

What Are the Most Common Reasons for a Medicaid Denial?

The following are a few common reasons for a Medicaid denial. Regardless of the State's reason for denying your client's application, you should provide additional documentation to support your stance.

ISSUES WITH A DIVESTMENT OR ASSET TRANSFER

If your client is found to have made a sale for less than fair market value or some other type of divestment in the last five years, additional documentation may be required to prove the eligibility of the transfer If the penalty period or its start date are inaccurate, the case worker may have miscalculated and all that's needed is a simple correction.

TOO MANY ASSETS

Typically, when an applicant is denied on the basis of being over-resourced, the case worker may have mistaken an exempt asset for a countable asset or assigning the wrong value to a specific asset. In most cases, these are interpretation errors that can be resolved with simple explanations or supporting documentation.

TOO MUCH INCOME

Similar to being over-resourced, denials based on being over the Medicaid income limits are typically interpretation errors resolved by further explanation and supporting documentation. Issues can also arise if initial calculations are incorrect, which is why it's crucial to ensure you have a complete understanding of your client's finances.

"NAME ON THE CHECK" RULE

The "Name on the Check" rule stipulates the individual whose name is on the check is the sole owner of that income. In states where an IRA is a countable asset for the institutionalized spouse, this strategy can be used to annuitize the account and direct the income to the community spouse. A Medicaid denial may result if the Medicaid agency instead attributes the income to the institutionalized spouse.

How to Prepare for a Fair Hearing

Although many cases can be resolved at the case worker level, a fair hearing may be required. If you find yourself facing a fair hearing for a Medicaid denial, your preparations should include the following:

THOROUGHLY REVIEW THE CLIENT'S FILE.

Examine it in person, if possible, and take comprehensive notes. You may also be able to make copies.

REQUEST A FAIR HEARING.

You must request the fair hearing within 20 days of the denial notice, but the timeline can vary by state.

SUBMIT A BRIEF OR MEMORANDUM TO THE ADMINISTRATIVE LAW JUDGE AHEAD OF THE FAIR HEARING.

The brief should include any applicable laws and supporting documents as well as your stance and reasoning on the case.

PREPARE YOUR WITNESSES.

Witnesses may include experts on the applicability of the law or personal witnesses who may speak to the medical needs of the applicant. Develop a line of questioning.

What to Expect During a Fair Hearing

Although fair hearings may vary by state and judge, the overall process is typically as follows:

1. **First,** the Medicaid agency will give their testimony.
2. **Next,** you can call witnesses and examine them on the stand.
3. **Then,** the Medicaid agency has the opportunity to cross-examine the witnesses, and the administrative law judge may also ask questions for clarification.
4. **Following a fair hearing,** the administrative law judge has 90 days to make a decision. In the interim, you can submit any additional information as well as provide a follow-up brief detailing why the hearing supports your case.

Tips for Medicaid Fair Hearings

During the fair hearing, we recommend adhering to these best practices to increase the likelihood of a successful outcome:

NARROW FOCUS

Ensure the focus of the administrative law judge's review remains on the specific legal issues and relevant

TEST KNOWLEDGE

If the decision-maker of the Medicaid denial (typically, a supervisor) does not appear at the hearing and instead sends a different case worker to testify, cross-examine the case worker on their personal knowledge and impeach their ability to apply law to the case.

DISPEL LOOPHOLES

Rebuke any implication that your case is an exploitation of a loophole in the law. Your planning methods are grounded in federal and state statutes that have been upheld by the courts.

Fair Hearing Support

If your client receives a Medicaid denial due to a product purchased through our office, we offer complimentary support through the fair hearing process, including an expert testimony from one of our in-house attorneys.

FAIR HEARING SUPPORT

We'll review your client's case, discuss possible solutions, and work to resolve the issue at the case worker level. If a fair hearing is required, we will assist you through the process.

EXPERT TESTIMONY

Our in-house attorneys can speak to the Medicaid compliance of our carrier's annuities and other Medicaid planning products, and they are available to provide expert testimony when necessary.

ADVICE FOR SUCCESS

Since we've had success assisting with dozens of fair hearings across the country, we can provide verified advice as you prepare for a successful result for your client.

How to Use Our Checklist

The following checklist allows you to keep a detailed record of a client's Medicaid denial, including the cause of the denial, the notice information required for the state, and your client's procedural rights.

THE CAUSE OF THE DENIAL

This section serves as a record for you as you work with your client on their Medicaid denial. You can log notes relating to the denial and, in some cases, find pertinent laws for disputing the denial.

DENIAL NOTICE REQUIREMENTS FOR THE STATE

This section outlines the required components the state must provide in the event of a Medicaid denial, including written notices and a fair hearing. If any of these pieces is missing, the Medicaid agency is denying your client their right to due process.

PROCEDURAL RIGHTS

This section explains your client's rights through the Medicaid denial and fair hearing process. Similar to the state requirements, if the Medicaid agency has not complied with these stipulations, your client is being denied their due rights.

This checklist is for informational purposes and is not intended to identify all potential issues in a Medicaid denial.

Fair Hearing Checklist

COMMON DENIAL ISSUES

☐ **Transfer/Divestment Issues**

☐ ***Items Improperly Considered a Transfer***

Item Description: _____

_____

_____

_____

_____

Penalty Assessed: _____

Agency's Legal Basis: _____

_____

_____

_____

☐ ***Incorrect Penalty Period:***

☐ Incorrect/Agency Penalty:

Duration: _____

Calculation: _____

☐ Correct Penalty Period: _____

☐ ***Incorrect Penalty Start Date:*** _____

Incorrect/Agency Start Date: _____

Correct Start Date: _____

Authority: 42 U.S.C. § 1396p(c)(1)(D)(ii). When an institutionalized spouse or community spouse dispose of an asset for less than fair market value within the five-year look back period, the penalty period is the later of the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance but for the penalty period (the "otherwise eligible" date).

☐ **Over-Resourced (Assets)**

☐ ***Single Individual/Institutionalized Spouse*:**

Resource Limit: _____

State's Resource Calculation: _____

Excess Resources: _____

☐ ***Community Spouse*:**

Resource Limit: _____

State's Resource Calculation: _____

Excess Resources: _____

☐ **Over Income**

☐ ***Single Individual/Institutionalized Spouse*:**

Income Limit: _____

State's Income Calculation: _____

Excess Income: _____

☐ ***Community Spouse*:**

Income Limit: _____

State's Income Calculation: _____

Excess Income: _____

☐ **"Name on the Check" Rule: Income Payable to CS Attrubuted to IS**

Authority: 42 U.S.C. § 1396r-5(b)(2)(A)(i). Payment of non-trust income made solely in the name of the institutionalized spouse or the community spouse shall only be considered available to that respective spouse.

***Note*:** In income cap states requiring the use of a Qualified Income Trust (QIT, also known as a "Miller Trust"), if the agency does not properly attribute the name on the check income to the CS, they will typically deny the applicant for excess income AND failure to place excess income in a QIT. It is important to analyze the issue fully and explain why proper attribution of the income renders use of a QIT unnecessary (assuming other income sources do not require the use of a QIT).

☐ **Other:** _____

_____

DENIAL NOTICE REQUIREMENTS

- ☐ **The State must provide a fair hearing. 42 U.S.C. § 1396a(a)(3). See also 42 C.F.R. § 431.220.**
- ☐ **The State Agency must provide written notice of:**
  - ☐ Method of obtaining hearing. 42 C.F.R. § 431.06.
  - ☐ Right to a spokesperson. 42 C.F.R. § 431.06.
  - ☐ Reason for action taken. 42 C.F.R. § 431.210.
    - ☐ "A clear statement of the specific reasons supporting the intended action." 42 C.F.R. 431.210(b).
    - ☐ "The specific regulations that support, or the change in Federal or State law that requires, the action." 42 C.F.R. § 431.210(c).

PROCEDURAL RIGHTS

- ☐ Claims of applicants for and beneficiaries of Medicaid services are protected by the Due Process Clause of the 14th Amendment. Goldberg v. Kelly, 397 U.S. 254 (1970). See also 42 C.F.R. § 431.205 and CMS State Medicaid manual sections 2900.1-2904.2.
- ☐ Notice must be sent ten (10) days before the State/Agency action occurs. 42 C.F.R. § 431.211.
- ☐ Reasonable time to request a fair hearing must be allowed, but this time period is not to exceed 90 days. 42 C.F.R. § 431.221(d). Less than twenty (20) days is unreasonable per CMS Manual § 2901.3. Twenty (20) days should be treated as a deadline unless more time is granted by state law.
- ☐ The Applicant/Appellant has the right to examine the content of their case file and all documents and records used by the agency at the hearing. 42 C.F.R. § 431.242(a).
- ☐ Hearing decisions must be based exclusively on evidence introduced at the hearing. 42 C.F.R. § 431.244.
- ☐ Agency must make final decision within 90 days from date fair hearing request is received by the agency. 42 C.F.R. § 431.244.
- ☐ The public must have access to all fair hearing decisions. 42 C.F.R. § 431.244(g).
- ☐ The agency must notify the Applicant/Appellant of its decision in writing. 42 C.F.R. § 431.245(a).
- ☐ The agency must notify the Applicant/Appellant of their right to seek judicial review. 42 C.F.R. § 431.245(b).

SCHEUDLE A CALL

Schedule a call with one of our advisors to discuss your case in more detail.

krausefinancial.com/schedule-call

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