

Medicaid Appeals and Fair Hearings: Strategies for Elder Law Counsel

Litigating Denials, Reductions or Terminations of Benefits in Administrative Agencies and in State and Federal Court

TUESDAY, JANUARY 22, 2019

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today's faculty features:

Shelley Dowell, Attorney, **Kentucky Elderlaw**, Louisville, Ky.
Misty Clark Vantrease, Attorney, **Kentucky ElderLaw**, Louisville, Ky.
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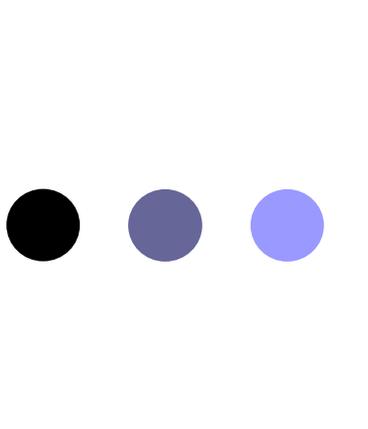
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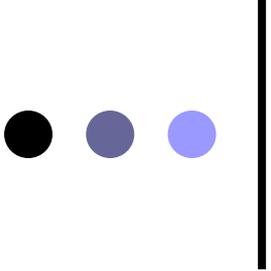


Overview of Common Reasons for Denial

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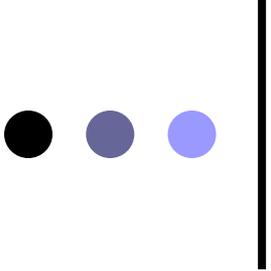
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Presentation for
Strafford Publications
January 22, 2019



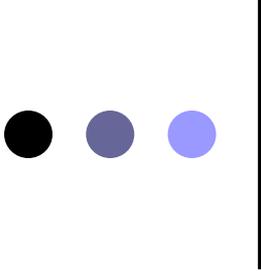
Understand the reason for the denial

- Is the denial requiring more information to be reported or due to an error or omission in the processing of the application
 - In Kentucky, we have seen an increase in denials because the State Medicaid office has failed to conduct timely bank checks
- You may be able to resolve these denials without appeal, but consider whether it is necessary to file to preserve right to appeal



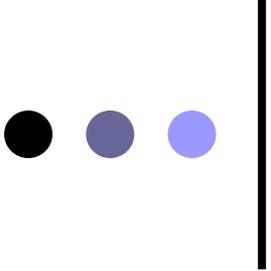
Common issues for denial that require an appeal

- Transfers
- Trusts
- Annuities



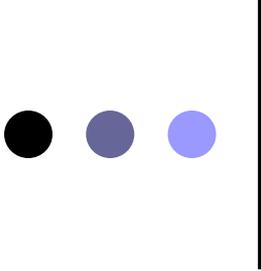
Common denial issues - Transfers

- If an institutionalized individual or the spouse of such an individual disposes of assets for less than fair market value on or after the look-back date (within 60 months before date of application) the individual is ineligible for medical assistance for services for a set period.
 - The period of ineligibility is equal to the value of all assets transferred divided by the average monthly cost to a private patient of nursing facility services in the State.
- 42 U.S.C. 1396p(c)(1)(A)-(E)



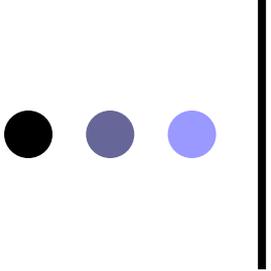
Common denial issues - Transfers

- Not all transfers result in a period of ineligibility
 - Transfers Between Spouses
 - Be cognizant of timing of the transfer - before or after institutionalized spouse is determined eligible for Medicaid
 - 42 U.S.C. 1396p(c)(2)(B)(i) appears to permit unlimited transfers to community spouse without penalty.
 - However, under 42 U.S.C 1396r-5(f) transfers of institutionalized spouse after the initial determination of eligibility limited by the community spouse resource allowance.



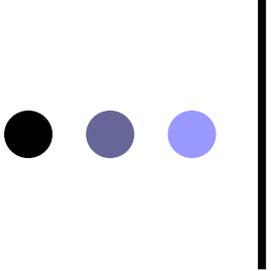
Common denial issues - Transfers

- Courts not consistent on treatment of timing issue
- State Supreme Court of Ohio found the transfer limit under 42 U.S.C. 1396r-5(f) to apply to transfers made **prior** to a determination of eligibility
 - *Estate of Atkinson v. Ohio Dept. of Job & Family Servs.*, 40 N.E. 3d 1121, 144 Ohio St.3d 70 (Ohio 2015)
- Sixth Circuit and Tenth Circuit found the transfer limit under 42 U.S.C. 1396r-5(f) to apply only to transfers made **after** a determination of eligibility
 - *Hughes v. McCarthy*, 734 F.3d 473 (6th Cir. 2013)
 - *Morris v. Okla. Dep't of Human Servs.*, 685 F.3d 925, 935¹⁰ (10th Cir. 2012).



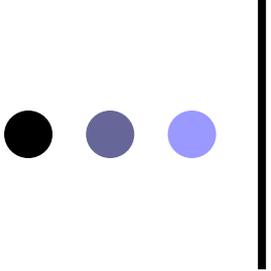
Common denial issues - Transfers

- Transfers to Adult Disabled Child
 - House and assets
- Transfers to Care Giver Child
 - House only
- Transfers to Sibling(s)
 - House only, requires sibling to have equity interest in house
- 42 U.S.C. 1396p(c)(2)



Common denial issues - Trusts

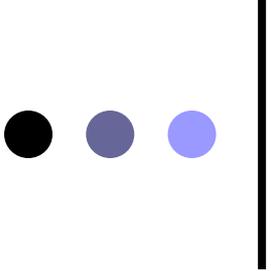
- Not all Trusts are countable resources
- Federal statute controls treatment of trusts established with assets of the individual
 - By a spouse through a will,
 - By a court, and
 - Certain trusts established for disabled individualsSee 42 USC 1396p(d)
- All other trusts are evaluated under the general definition of “resource”
 - See also, Social Security Administration Program Operations Manual System (POMS) SI 01120.200



Common denial issues – Trusts

- Recent case out of Connecticut provides good starting point for analyzing whether a trust is a resource
- The trust is a countable resource if the beneficiary can:
 - revoke or terminate the trust and freely use the funds;
 - direct the use of trust principal for his or her support or maintenance; or
 - sell his or her beneficial interest in the trust.

Simonsen v. Bremby, No. 15-CV-1399 (VAB), 2015 WL 9451031 (D. Conn. Dec. 23, 2015).

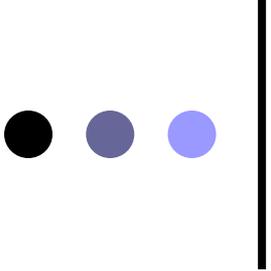


Common denial issues - Annuities

IN GENERAL-

Purchase of an annuity within 60 months of applying for Medicaid is a transfer of an asset for less than fair market value unless—

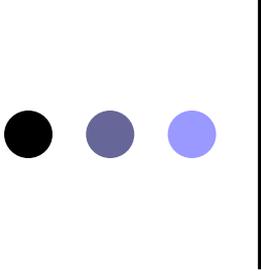
- the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or
 - the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.
- 42 U.S.C. 1396p(c)(1)(F)



Common denial issues - Annuities

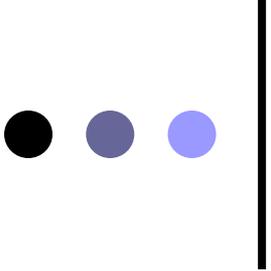
For the purpose of the transfer rule an annuity purchased by or on behalf of an annuitant is an “asset” unless the annuity is

- A tax qualified annuity as described in subsection (b) or (q) of section 408 of the IRC (i.e., an IRA or a qualified employer plan that is treated like an IRA); or
 - Purchased with proceeds from
 - an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;
 - a simplified employee pension (within the meaning of section 408(k) of such Code); or
 - a Roth IRA described in section 408A of such Code; or
 - irrevocable and nonassignable; actuarially sound (as determined in accordance with actuarial publications of the Social Security Administration); and one that provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.
- 42 U.S.C. 1396p(c)(1)(G)



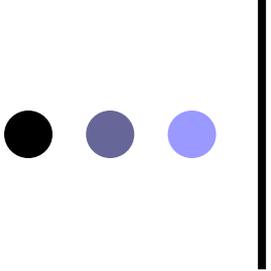
Common denial issues - Annuities

- Distinguish the purchase of an annuity as an impermissible transfer from the purchase of an annuity as an exception to the transfer penalty
 - (1) The purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless—
 - the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this subchapter; or
 - (ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.
- 16
- 42 U.S.C. 1396p(c)(1)(F)



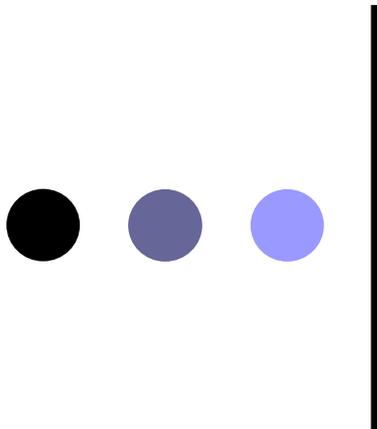
Common denial issues - Annuities

- Distinguish the purchase of an annuity as an impermissible transfer from the purchase of an annuity as an exception to the transfer penalty
 - (2) The purchase of an annuity that is otherwise an impermissible transfer will not be treated as such if
 - It was purchased for the **sole benefit** of the individual's spouse.
 - 42 U.S.C. 1396p(c)(2)(B)(i)
 - An annuity need not satisfy both 42 U.S.C. 1396p(c)(1)(F) and 42 U.S.C. 1396p(c)(2)(B)(i)
- *See, Hughes v. McCarthy*, 734 F.3d 473 (6th Cir. 2013).



Common denial issues - Annuities

- “Sole-benefit” requirement
 - The sole benefit rule doesn’t prohibit an annuity that names the institutionalized spouse as the first contingent beneficiary. *Hughes at 481.*
 - The sole-benefit requirement, in the context of an annuity, requires the annuity to be actuarially sound, but does not require the State MA office to be listed as the 1st contingent beneficiary. *Id.*
 - The actuarial-soundness requirement reasonably assures that the assets were transferred to a third party for the individual spouse's sole benefit. Any contingent interest becomes relevant only if the spouse dies early. To extend the sole-benefit requirement past a spouse's death is
18nonsensical. *Id.* at 483.



Discovery and appeals strategies

January 22, 2019

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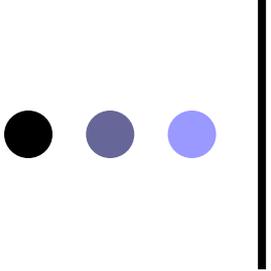
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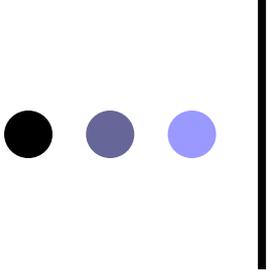
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Discovery

Know your procedural rights

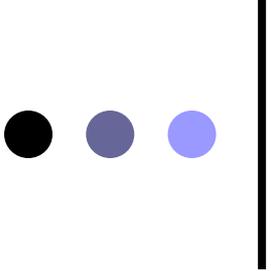
- Under Federal requirements the appellant must be given an opportunity to—
 - Examine at a reasonable time before the date of the hearing and during the hearing:
 - The content of the applicant's or beneficiary's case file; and
 - All documents and records to be used by the State or local agency or the skilled nursing facility or nursing facility at the hearing;



Discovery

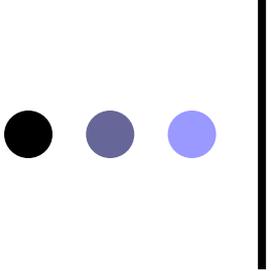
- Under Federal requirements the appellant must be given an opportunity to—
 - Bring witnesses;
 - Establish all pertinent facts and circumstances;
 - Present an argument without undue interference; and
 - Question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.

42 CFR 431.242



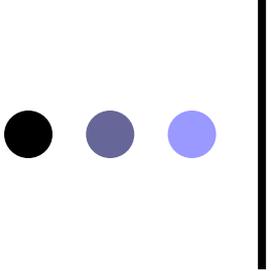
Discovery

- Get the complete case file
 - Determine if factual basis for denial is supported by case file
 - E.g., is there an obvious error / are basic facts overlooked
 - Determine legal basis (if any) for the denial
 - Identify State Medicaid staff and management that participated in the denial



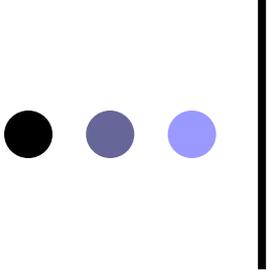
Discovery

- Consider having applicant or applicant's spouse participate as a witness
 - Take the problem out of the abstract
 - Create the record for court appeal



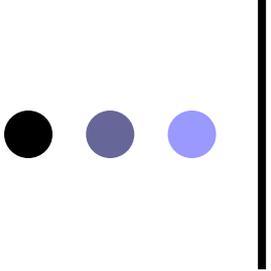
Discovery

- Subpoena the decision makers
 - Forcing the participation of supervisors can help rectify obvious errors or omissions by the State Medicaid agency prior to the actual hearing date



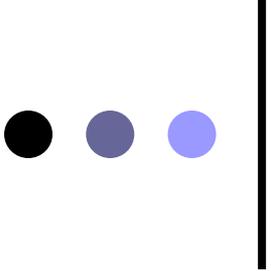
Discovery

- Request prior appeal decisions
- Federal regulations require prior appeal decisions to be made available to the public
 - 42 CFR 431.244(g)



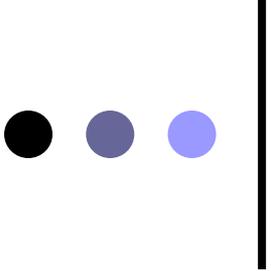
Appeals Strategies

- Prepare and submit for the record a written brief / memorandum of law
 - Aids in organizing your argument
 - Assists hearing officer by presenting applicable authorities
 - Don't assume that the hearing officer knows the law



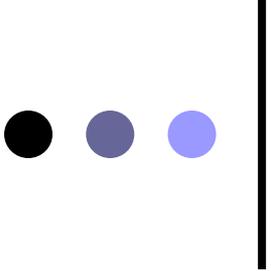
Appeals Strategies

- Is the denial consistent with Federal statute, regulation, and guidance?



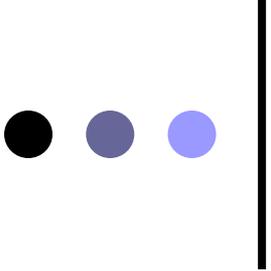
Appeals Strategies

- Consult the Center for Medicare and Medicaid State Medicaid manual (Publication 45)
 - Provides mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.
 - Serves to “fill the gaps” in State specific Medicaid manuals
 - Manual is available at:
<https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
 - Chapter 3 addresses eligibility



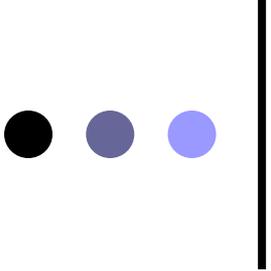
Appeals Strategies

- Is the State treatment of income and resources permissible under Federal law?



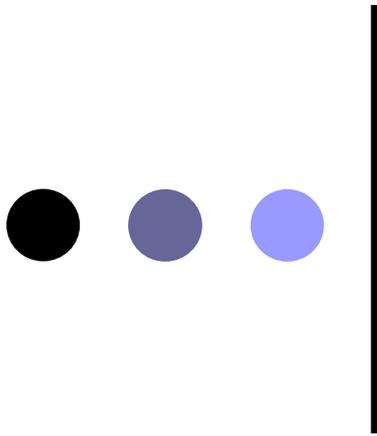
Appeals Strategies

- The State cannot employ a methodology for determining income and resource eligibility that is more restrictive than the methodology which would be employed under the SSI program as administered by the Social Security Administration. See, 42 U.S.C. sec. 1396a(r)(2).



Appeals Strategies

- SSA has detailed guidance on SSI treatment of income and resources
 - Policy Operations Manual System (POMS)
- POMS is to be given substantial deference.
 - See, *Lopes v. Dep't of Soc. Servs.*, 696 F. 3d 180, 186 (2d Cir. 2012).
- POMS available at: <https://secure.ssa.gov/apps10/>



Best practices for avoiding Medicaid denials

January 22, 2019

Presented by:

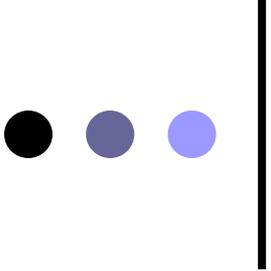
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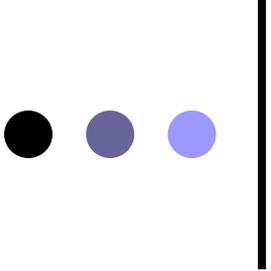
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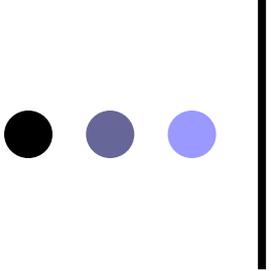
Strategies to Avoid a Denial

- Don't apply
 - Consider whether it may be advantageous to delay application
 - Will delay allow for a more complete / less complicated application



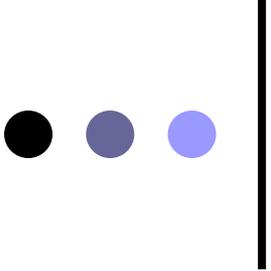
Strategies to Avoid a Denial

- Example of delayed application
 - In Kentucky, three months of bank statements are required to be submitted with the initial application
 - In one case the client did not have a bank account and was still receiving pension by paper checks, which the client was cashing and spending each month, without receipts
 - If an application was made it was likely that the State Medicaid office would have required a detailed accounting of applicant's expenses
 - Instead, we had the applicant establish a bank account and have the Social Security direct deposited
 - Applied after client had three months of bank statements



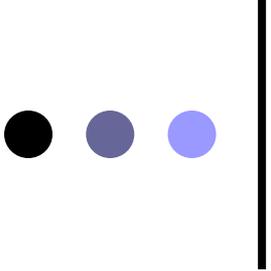
Strategies to Avoid a Denial

- Eliminate circumstances that are likely to result in greater scrutiny / denial
 - Consider terminating revocable living trusts prior to application
 - Have family members repay outstanding loans
 - If possible, have gifts repaid
 - Transfer residence into name of community spouse only



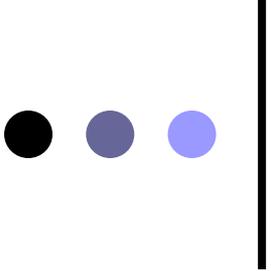
Strategies to Avoid a Denial

- Application materials should be complete and well organized
 - Make it as easy as possible for the caseworker to find the information needed for the assessment
 - Have a complete copy for the caseworker and a complete copy for your file



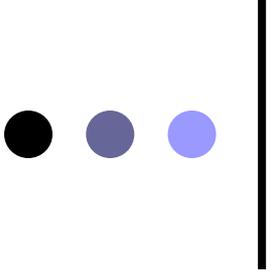
Strategies to Avoid a Denial

- Be honest and forthcoming
 - Identify issue to caseworker
 - Anticipate additional documentation required
 - E.g., additional bank statements, checks, receipts, invoices



Strategies to Avoid a Denial

- Provide memorandum of law with application
 - Walk the case worker through the State manual / CMS manual / POMS provisions that support a determination of eligibility
 - Case workers may find guidance documents more persuasive than underlying regulations or statutes



Strategies to Avoid a Denial

- Provide spreadsheets and flow charts
 - Showing gifts and their returns
 - Showing loans and their repayments
 - Showing Community Spouse Income and Shelter Expenses
- Make it easy for the caseworker to say YES

APPEALING A MEDICAID DECISION MEDICAID FAIR HEARINGS

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APPEALING A MEDICAID DECISION - MEDICAID FAIR HEARINGS

- Constitutional underpinnings:
 - *Goldberg v. Kelly*, 397 U.S. 254 (1970) held that the claims of both applicants and beneficiaries to Medicaid services are protected by the Due Process Clause of the U.S. Constitution.
 - Fundamental elements of Due Process:
 - Adequate notice.
 - Meaningful opportunity to be heard.



Legal protections of applicants and recipients

- 42 U.S.C 1396a(a)(3)
 - State must provide for an opportunity for a fair hearing before a State Medicaid agency when a claim for services is **denied** or is **not acted upon with reasonable promptness.**
- 42 CFR 431.205
 - State Hearing System must meet the due process standards set forth in *Goldberg v. Kelly* as well as any **additional standards set forth in the regulations.**
- CMS State Medicaid Manual sections 2900.1-2904.2.



Right to a Hearing

- 42 CFR 431.220
 - when a claim for services is denied or not acted upon with reasonable promptness.
 - When a beneficiary believes the agency has taken an **action** erroneously.
- 42 CFR 431.201: The term “**action**” means a termination, suspension or reduction in benefits.
- Please note that managed care enrollees may first have to exhaust internal appeals process before exercising rights to an administrative fair hearing.



Notice of Denial or Action Requirements

- 42 CFR 431.206
 - **Written Notice** of:
 - Right to a fair hearing.
 - Method to obtain a fair hearing.
 - Right to representation by counsel, a relative, a friend or other spokesperson.
- Agency must provide written notice of these rights to every applicant or beneficiary:
 - Upon application for benefits.
 - When the agency takes any action affecting the claim for services by an applicant or beneficiary.



Notice Requirements

- *Nt. Written notice is not a pre-requisite for an individual to request a fair hearing!*
- CMS State Medicaid manual 2900.4
 - Notice of appeal rights available to applicants and recipients unfamiliar with the English language must include a translation into a language understood by the individual.
 - Notice requirements are usually strictly construed.



Content of Notice

- 42 CFR 431.210 - Notice must contain:
 - A statement of what action the State intends to take.
 - Reasons for the intended action.
 - Specific regulations that support the action taken, or any changes in federal law that supports the action taken.
 - Right to a fair hearing.
 - An explanation of the circumstances under which Medicaid is continued if a hearing is requested (“aid continuing”).



Defective Notice

- A Notice that does not comply with the requirements set forth in 42 CFR 431.210 is defective, and thus in violation of your client's due process rights.
- A defective notice has been held to toll the statute of limitations for requesting a Fair Hearing: *Bryan v. Doar*, 38 A.D.3d 884 (2nd Dept. N.Y., 2007); *Bryant v. Perales*, 161 A.D. 2d 1186 (4th Dept. N.Y. 1990, lv denied, 76 N.Y.2d 710 (1990)).



Timing of Notice

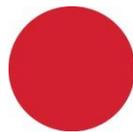
- 42 CFR 431.211- State or agency must send a notice at least ten (10) days before the date of action. (Nt. Regulation used to read “mail” instead of “send”- changed in Oct., 2013).
- Exceptions:
 - Death of beneficiary.
 - Request by beneficiary to terminate benefits.

PAY ATTENTION TO DEADLINES!



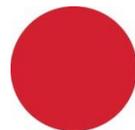
How to request a Fair Hearing

- 42 CFR 431.221
 - Agency may require that request be made in writing.
 - Requests by telephone (not recommended).
 - Requests via e-mail/internet.
 - Agency may not limit or interfere with the individual's **freedom to make a request for a hearing**.
 - Agency may assist in submitting and processing the request for a hearing.
 - Agency must allow a reasonable time, not to exceed ninety (90) days from the date that the notice is **mailed**, to request a hearing.
 - CMS considers less than 20 days notice after mailing to be unreasonable (State Medicaid Manual section 2901.3).
 - **Treat as a statute of limitations.**



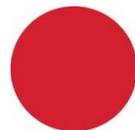
Right to Aid Continuing

- 42 CFR 431.231
 - Despite the receipt of a Notice of action, a beneficiary has a right to have his/her aid and services continued if a hearing is requested within ten (10) days from **the date that the beneficiary receives the notice.**
 - Date that the notice is received is presumed to be five(5) days after the date on the notice itself unless the beneficiary can prove that he/she did not receive the notice within the 5 day time period.
 - Reinstated services must continue until a decision is rendered.



Exceptions to Aid Continuing

- If the Agency determines that the sole issue is one of Federal or State law or policy, technically not required to grant aid continuing.
- If the hearing Examiner/ Administrative Law Judge determines at the hearing that the sole issue is one of Federal or State law or policy.- Example- change in federal law cuts out an entire class of beneficiaries.



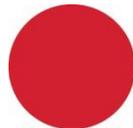
Denial of Dismissal of Request for a hearing

- 42 CFR 431.223
 - The applicant or beneficiary withdraws the request.
 - The applicant or beneficiary fails to appear at the scheduled hearing **without good cause**.



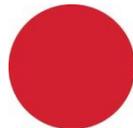
Fair Hearing

- 42 CFR 431.240
 - All hearings must be conducted:
 - at a reasonable time, place and date.
 - Only after adequate written notice.
 - By an impartial official or other individuals who have not been directly involved in the initial determination of the action in question.
 - State Medicaid Manual section 2902.6
 - Agency must make provisions for those that are homebound, in hospitals, or nursing homes for the convenience of the individual. Hearings may be conducted at home, or at the hospital.
 - Also, agency may conduct hearing by telephone when claimant is unable to attend in person (**not recommended**).
 - Video hearings?



Procedural Rights

- 42 CFR 431.242
 - Right to examine, at a reasonable time before the date of the hearing the case file and all documents used by the agency in taking the action from which the individual is appealing.
Exercise this right of discovery!
 - Litigating at a fair hearing without looking in advance at the case record is akin to walking into a dark alley without a flashlight.



Procedural Rights (cont.)

- Right to bring witnesses.
- Right to establish all pertinent facts and circumstances.
- Right to present an argument without undue interference.
- Right to question or refute, including right to confront and cross-examine.
- *Ortiz v. Eichler*, 794 F. 2d 889 (3rd Cir., 1986)- state welfare agency's practice of considering adverse statements from individuals not present for cross examination violates due process.



Rules of Evidence

- CMS interpretation of rights of claimants at fair hearings (State Medicaid Manual, section 2902.9).
 - “Do not use application of the rules of conduct of the hearing to suppress the applicant’s claim. Allow the claimant to present his case in the way he desires.”

Hearsay admissible?

Agency must make provisions for an interpreter if needed.

Submit a memorandum of law- if necessary, request that the record remain open to allow for submission of a memo.

Treat as a formal trial in a court of law.



Hearing Decisions

- 42 CFR 431.244
 - Must be based exclusively on evidence introduced at the hearing- *always make a complete record with an eye on an appeal if necessary!*
 - Must be in writing, summarizing the facts, and identifying the evidence and regulations in support of the decision.
 - Record consists of the transcript of the hearing, and all documents filed in the proceeding, as well as the decision itself.



Agency Action in Response to a Decision

- 42 CFR 244 (f)
 - On a request for a hearing, the agency must take final administrative action within ninety (90) days of the request for a fair hearing.
 - State Medicaid Manual, section 2902.10
 - “The requirement for prompt, definitive, and final administrative action means that all requests for a hearing are to receive prompt attention and will be carried through all steps necessary to completion.”



Appealing a fair hearing decision

- 42 CFR 431.245:
 - The agency must notify the applicant/beneficiary of the decision in writing and of his/her right to seek judicial review of the decision in state court to the extent available.
 - Be cognizant of deadlines for state appellate review.
 - Some states have internal review procedures- beware, however, that the statute of limitations for an appeal usually will not be tolled by such a request.
 - Never rely upon verbal (or written) word of a state official that your time to appeal will be tolled while you try to achieve a settlement!



Final tidbits

- **Treat the matter as a trial in a court of law.**
- Yes, the rules of evidence are relaxed (hearsay is admissible). Yes, you are appearing in a conference room instead of a courtroom without a stenographer and without a bailiff, and yes, the Administrative Law Judge has no robes to wear. A relaxed atmosphere does not mean you should relax yourself. Let the ALJ know through your body language and through your words that this case is vitally important to your client and that the Agency has acted incorrectly and contrary to the laws and policies of your State.



Final Tidbits

- **Relate the Client's Story**
- Personalize your client. How did he/she end up in this situation? What is your client's background? What did he/she do for a living prior to their health diminishing? Relating the client's story through testimony of the client, spouse, children etc. will serve as an appropriate introduction to the legal issue in dispute, and will help the ALJ to get to know your client.



Final Tidbits

- **Submit a Memorandum of Law**
- The best practice is to always request at the end of the hearing an opportunity to submit a memorandum of law for the judge's consideration. This will allow you an opportunity to digest what occurred at the hearing and gives you the freedom of time to cogently get your arguments down on paper.



Final Tidbit

- **Don't Leave the Administrative Law Judge Hanging out on a Limb**
- The seven words that every ALJ hates to hear are “this is a case of first impression.” I have not met an ALJ yet who wants to be a hero and make trail blazing new law for the State. Even if it is a new issue, let the judge know that the law is on your side and that any decision that he or she renders will have a sound legal basis in the laws of your State. Believe me - the opportunity to make new law, that may excite you, may not excite the ALJ.



MEDICAID APPEALS AND FAIR HEARINGS: STRATEGIES FOR ELDER LAW COUNSEL

Strafford Continuing Education Webinar
January 22, 2019

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CONSIDERATIONS ON WHETHER TO GO TO FEDERAL COURT & IF SO, WHEN



The art of representing people®

CONSIDERATIONS ON WHETHER TO GO TO FEDERAL COURT & IF SO, WHEN

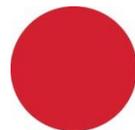
- Under the Eleventh Amendment, a federal court can only decide a claim based on a violation of federal law, not state law, so if you have a good state law claim you may be better filing an administrative review proceeding in state court where both claims can be decided. *Pennhurst State School & Hospital v. Halderman*, 465 U.S. 89 (1984).



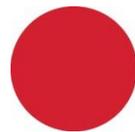
- The Eleventh Amendment provides a State official with immunity from a claim for retroactive benefits, so if substantial past benefits are at issue, or if there are no future benefits in dispute, you will need to bring a state court proceeding. There is a limited exception to this, but only for three calendar months prior to the month you obtain a federal court order. *Morenz v. Wilson-Coker*, 415 F.3d 230 (2d Cir. 2005).



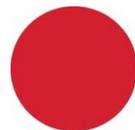
- You may be able to preserve retroactive benefits while having the merits decided in federal court by bringing a state court proceeding to review an adverse fair hearing decision while also bringing a federal court action. If the state court will stay its decision pending the federal court decision on the merits, once you win in federal court that will be binding in the state court proceeding where retroactive benefits will be available. The federal court would not need to abstain from ruling in favor of the state court proceeding. *Sprint Communications, Inc. v. Jacobs*, ___ U.S. ___, 134 S. Ct. 584, 187 L. Ed. 2d 505 (2013).



- That immunity against retroactive relief can be a sword for the plaintiff, not just a shield for the defendant. It provides a basis for showing that the plaintiff is being irreparably injured, one of the requirements for a preliminary injunction.



- In order to bring a claim in federal court, there must be a violation of a particular section of the federal Medicaid statute which is enforceable under 42 U.S.C § 1983. Not every section is enforceable because it may be just a general provision directing the Medicaid agency how to administer the program, as opposed to a section creating individual rights for the benefit of an applicant or recipient. It is important to research the enforceability of the particular section of the statute before filing a federal court case.



- You do not need to exhaust administrative remedies by having a fair hearing before bringing a federal court action. *Patsy v. Board of Regents*, 457 U.S. 496 (1982). By contrast, a fair hearing is required for a state court proceeding since such proceedings are reviews of final administrative decisions.



- If there are disputed questions of fact, the findings of the administrative law judge in a fair hearing will be binding in a subsequent federal court case, but conclusions of law will not be binding. *University of Tennessee v. Elliott*, 478 U.S. 788 (1986). In a proceeding in state court findings of fact in a fair hearing may be challenged, albeit with difficulty since generally they will be affirmed if there is merely substantial evidence to support the finding, not the more stringent preponderance of evidence standard.



- If the plaintiff prevails in an action in federal court the defendant will be liable for the plaintiff's attorneys fees pursuant to 42 U.S.C. § 1988 based on reasonably hourly rates in the community, but if the defendant moots the case by agreeing to his error without a court order, then a fee award may be foreclosed. *Buckhannon Board & Care Home v. W. Va. Dep't of Health & Human Res.*, 532 U.S. 598 (2001).

