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and how to take action.

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Picture this: a legally blind widower in his early nineties, living with dementia and severe mobility impairments. With the assistance of around-the-clock personal care services provided by Medicaid, he continues to reside in the comfort of his home of fifty years. However, a state agent recently reduced his 24/7 split-shift home care services to just eight hours per day. How could such a drastic reduction occur? Following a routine annual reassessment, contrary to all practical realities, the state assessor determined that no more than eight hours of care are medically necessary. This determination deemed a gentleman who cannot ambulate, bathe, toilet, or dress independently as capable of being left unattended for sixteen hours each day.

Across the nation, Medicaid stands as the essential safety net for vulnerable adults, providing critical access to healthcare and long-term care that would

otherwise be financially unattainable. Unfortunately, families and individuals struggle to navigate Medicaid's rules and procedures daily. For applicants and their families, a denial or reduction is more than a bureaucratic setback; it is a destabilizing, often frightening event, made worse when the reasons are opaque and the path forward unclear.

Understanding the common causes of denials is the first step toward preventing them, and, when necessary, challenging them. This article will explore the frequent reasons Medicaid applicants are denied benefits and outline the path to securing the care Medicaid recipients so critically require and deserve.

Types of Denials

Medicaid denials can be broken into two main categories: financial denials and service denials. Financial denials typically occur when an applicant does

not meet the income, asset, or residency requirements necessary for Medicaid eligibility. These denials may stem from incomplete documentation, transfers of assets, excess resources, or discrepancies in reported income. On the other hand, service denials relate to the specific assistance requested by a Medicaid beneficiary, such as medical treatments, care coordination, or home care services. These denials happen when a service is deemed not medically necessary, not covered under the Medicaid plan, or lacks proper authorization. Understanding the distinction between these two types of denials is crucial for effectively addressing and appealing, as each requires a different approach and set of supporting documentation.

Further, identifying the decision-maker is of critical importance. Medicaid eligibility rules must adhere to federal guidelines, but states are granted some flexibility in administering their programs and setting specific income and resource eligibility criteria. This allows states to tailor their Medicaid programs to meet local needs, and as a result, rules can vary from one state to another.

For example, many states opt to outsource the administration of their Medicaid programs to contractors such as private insurance companies. Often these Medicaid Managed Care Organizations (MCOs) play a central role in the Medicaid denial and appeal process. Pursuant to their contractual authority, MCOs may issue denials of services or decrease the amount of care provided.

Effectively navigating Medicaid denials requires not only a clear understanding of the distinction between financial and service-related issues, but also a keen awareness of the entities responsible for making those determinations, whether state agencies or contracted MCOs, since each operates under specific regulatory frameworks and procedural standards that directly impact the outcome of eligibility and service decisions.

FINANCIALLY BASED DENIALS

Financially based denials typically bar entry into the Medicaid program. These can include findings that an applicant is over-resourced or has made prohibited transfer of assets during a lookback period.

The Code of Federal Regulations (CFR) § 416.1201, provides essential guidance on what constitutes a “resource” under Medicaid. Resources are essentially all assets in an applicant’s and their spouse’s name. While not all assets are considered in determining Medicaid eligibility, it is imperative that each be examined to determine impact on Medicaid access. In addition to resources, Medicaid also assesses available income, which includes both earned and unearned

income. Individuals with assets and/or income above the Medicaid eligibility threshold may be disqualified from receiving assistance for long-term care.

In cases where an applicant faces a financially based denial, the reasons for the denial tend to be straightforward. As such, remedies become readily available. For example, an over-resourced applicant may utilize strategic gifting approaches that are either exempt from penalty imposition or structured to provide a source of payment during a calculated penalty period. Similarly, an applicant with surplus income may reside in a state where a Pooled Income Trust can be utilized. When the denial is numbers based, the problem and the solution are found quicker and typically resolved in consultation with a qualified elder law attorney.

However, formal appeals are available and may be necessary. Importantly, appeals of financially-based Medicaid denials must be directed to the state Medicaid agency, as required by 42 CFR §§ 431.200–431.250, which mandate that states provide a fair hearing process for individuals to challenge adverse eligibility decisions.

SERVICE-BASED DENIALS

In contrast, service-based denials can be subjective in nature and often require additional process and a higher standard of evidence. Under 42 CFR § 438.210, these determinations, typically made by MCOs, must be based on whether the requested services are “medically necessary.” Service-based denials often involve disputes over what care is considered “medically necessary.”

This is precisely the situation our widower faced. Despite overwhelming evidence of his need for around-the-clock support, his services were slashed after a reassessment. To the untrained eye, the reduction may appear justified on paper. For his family, it means sixteen hours a day when he is expected to live alone, unable to safely move, bathe, or even access the bathroom without assistance.

Unlike financial denials, these determinations require a greater degree of advocacy, medical documentation, and persistence to challenge. Additionally, where a MCO is the decision maker, the Medicaid recipient must exhaust internal appeals directly to the MCO prior to removal to the “fair hearing” process. To begin the appeals process, it is critical that internal and external appeals are exhausted first within the period provided on the notice. Appeals may have multiple levels of review. Without completing the internal and external appeals process first, you will be unable to proceed with the highest level of decision appeal, the fair hearing.



The Appeals Process

Section 1932(b)(4) of the Social Security Act provides a statutory right to appeal denial decisions, irrespective of whether the decision maker is the State or State agent. The Medicaid provider is required to provide written notice of any detrimental decision. Specifically, 42 CFR 431.211 requires at least 10 calendar days advanced notice of a discontinuance or reduction in previously authorized benefits where the decision is to deny or reduce previously granted benefits.

The landmark Supreme Court case, *Goldberg v. Kelly*, 397 U.S. 254 (1970), established that no proposed termination or reduction can take place prior to a full hearing. Medicaid recipients should take advantage of this procedural due process right by requesting aid to continue during the appeal process. This will ensure that benefits continue uninterrupted until a formal hearing occurs.

Medicaid fair hearings provide individuals with a formal process to challenge decisions made by Medicaid agencies regarding eligibility, services, or benefits. If an applicant or beneficiary disagrees with a

Medicaid decision, such as a denial of services or a reduction in benefits, they have the right to request a fair hearing. This hearing allows the individual to present evidence, clarify issues, and argue why the decision should be reconsidered.

To request a fair hearing, the individual must typically submit within a specific timeframe after receiving notice of the decision. The request is then reviewed, and a hearing date is set. The hearing is usually conducted by an administrative law judge. Both sides are afforded the opportunity to present evidence, call witnesses, and make legal arguments.

Gathering documentation demonstrating the inaccuracy of the denial is critical. This is especially so for service-based denials. For example, all assessments conducted by the state for care from the prior year and the current year should be examined and compared. Often, an assessor will state that a person requires assistance with many activities of daily living and then contrarily award minimal hours. Using the words of the assessor in an appeal helps drive home the point that care is necessary.

In addition, a comparison of the state assessment reports to the Appellant's private medical records such as physician progress notes, hospital discharge summaries, medication lists, and records from specialists that highlight the beneficiary's care needs can assist in illuminating the error of the service denial or reduction. Sworn affidavits from home health aides, doctors, or even family members who assist with daily care can further emphasize the beneficiary's need for assistance to complete their activities of daily living.

When preparing for a fair hearing, it is crucial to organize this documentation systematically. A well-structured evidence packet should include copies of the denial notices, medical records, and any supplemental testimony. Advocates can help highlight contradictions within the agency's own assessments and align the evidence with Medicaid's "medical necessity" standard. The fair hearing process provides the opportunity to tell a consistent, evidence-based story that demonstrates why the denial or reduction was wrong. For families like that of our widower, this preparation can mean the difference between unsafe isolation and the compassionate care Medicaid is designed to provide.

Following the hearing, the judge will issue a decision based on the facts and the law. If the decision is favorable to the individual, the Medicaid agency is required to implement the decision. If the outcome is unfavorable, the individual may have further options for appealing the decision to the judiciary.

Conclusion

When Medicaid denies or reduces benefits, it is a disruption that can place lives at risk. The widower's story illustrates this truth in the starkest terms: without constant care, a man in his nineties, blind and living with dementia, was suddenly expected to fend for himself for most of each day.

Families facing these decisions often feel powerless, but they do not have to stand alone. Just as this widower's circumstances highlight the dangers of an unchecked denial, they also underscore the importance of strong advocacy. With the right legal guidance, families can fight back against unjust determinations and secure the care their loved ones so urgently require. •CSA



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