



STETSON LAW

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*Center for Elder Justice*

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**2025**

**Fundamentals of  
Special Needs Trusts  
Administration Webinar**

**Friday, May 30, 2025**



STETSON LAW

Stetson University College of Law  
Gulfport, Florida

# **2025 Fundamentals of Special Needs Trusts Webinar**

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**STETSON LAW**

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Center for  
Elder Justice

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## **The Fundamentals of Special Needs Trust Administration Webinar**

**Friday, May 30, 2025**

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**12:30-12:40 pm EDT**

### **Welcome and Announcements**

*Professor Rebecca Morgan*

**12:40-1:30 pm EDT**

### **Uncertainty of Public Benefits: Current Trust Administration and Future Planning**

*David Goldfarb*

Navigating the complexities of public benefits can be challenging for trust administrators and planners. This session will delve into the current landscape of public benefits, examining the uncertainties that impact trust administration and future planning. Participants will gain insights into the structure of public benefits, the politics of entitlement reform, and the demographic changes that will impact future planning.

**1:30-2:20 pm EDT**

### **Federal Protections for Medicaid Appeals**

*Eric Einhart and Vincent Russo*

This session delves into federal Medicaid appeal protections, encompassing constitutional underpinnings, key legal authorities, and the implications of *Loper Bright v. Raimondo*. Attendees will gain practical strategies to navigate the evolving appeals landscape, avoid common pitfalls, and effectively advocate for beneficiaries.

**2:20-2:30 pm EDT**

### **Sponsor Break – TrueLink Financial**

**2:30-3:20 pm EDT**

### **Protecting Beneficiaries from Financial Mismanagement**

*Peter Wall and Bradley Frigon*

Bradley J Frigon, JD, LL.M (Tax), CELA and Peter J Wall will explore potential solutions for protecting Special Needs Trust (SNT) beneficiaries from financial mismanagement. Mr. Frigon and Mr. Wall will review SNT drafting language, the use of trust protectors and co-trustees, and the ABA Model Rules of Professional Conduct. Conflicts of interest, delegated fiduciary duties oversight, and referral best practices will also be covered - including case law review.

**3:20-3:55 pm EDT**

### **AI: From Hype to Hope—Harnessing The Tools**

*Jeremy Sapriel*

Curious about AI? This interactive session offers a practical overview of artificial intelligence. We'll discuss the substance behind the hype and focus on real-world uses. Through live demonstrations, we'll explore how AI tools can support day-to-day tasks in a safe, effective, and mission-aligned ways. You'll leave with a better understanding of AI's capabilities and how to integrate it responsibly within your organization.

**3:55-4:45 pm EDT**

### **Using AI. It's a tool, not a co-worker...**

*Ashley Krenelka Chase*

This session will discuss the benefits and challenges of utilizing AI in practice, including ethical implications for opting in or opting out.

**4:45-5:00 pm EDT**

### **Q&A Session**

*All Webinar Speakers*

Join the webinar speakers for an interactive Q&A session.



## **The Fundamentals of Special Needs Trust Administration Webinar**

**Friday, May 30, 2025**

### **~Speakers~**

#### **Rebecca Morgan**

Rebecca C. Morgan is a Professor of Law at Stetson University College of Law, where she teaches a range of elder law courses. A nationally recognized expert in the field, Professor Morgan is the co-author of several leading legal texts, including *Tax, Estate and Financial Planning for the Elderly* (Lexis), *The Fundamentals of Special Needs Trusts*, and *Elder Law in Context* (Aspen). She has also published numerous articles on elder law and frequently presents on related topics.

A trailblazer in elder law advocacy and education, Professor Morgan is a past president of both the National Academy of Elder Law Attorneys (NAELA) and the National Senior Citizens Law Center. She has served in key leadership roles with the American Association of Law Schools, the Florida Bar Elder Law Section, and as a faculty member of the National Judicial College. Her policy work includes serving as the reporter for the Uniform Guardianship and Protective Proceedings Act and contributing to Florida state task forces on elder abuse and guardianship reform.

Her professional contributions have earned her numerous honors, including the Rosalie Wolf Memorial Elder Abuse Prevention Award, the NAELA President's Award, and the Theresa Award for humanitarian achievements. In 2018, she was inducted into the Stetson University College of Law Hall of Fame and received the Ben C. Willard Alumni Award. Most recently, she was honored with a lifetime achievement award by the Florida Bar Elder Law Section in 2021.

Professor Morgan is a Fellow of the American College of Trusts & Estates Counsel (ACTEC), a member of the American Law Institute, and serves on advisory boards and boards of directors for multiple organizations dedicated to aging and elder rights, including the Center for Medicare Advocacy and the American Society on Aging.

#### **David Goldfarb**

David Goldfarb is the Senior Director of the Jewish Federations of North America's Strategic Health Resource Center, where he leads advocacy efforts to support the network's partner agencies in health and human services—including nonprofit hospitals, family and children's service agencies, long-term care communities, and vocational organizations. Previously, David was Director of Long-Term Supports and Services Policy at The Arc of the United States, the largest national community-based organization advocating for and with people with intellectual and developmental disabilities. Before The Arc, he spent nearly eight years directing advocacy for the National Academy of Elder Law Attorneys, the leading professional association for lawyers serving older adults, people with disabilities, and their families. David began his policy career as the Economic Policy Fellow for former Senator Bill Nelson of Florida.



## **Eric Einhart**

ERIC J. EINHART, ESQ. is a Partner with Russo Law Group, P.C. of Garden City, Lido Beach, and Islandia, New York. He focuses on the areas of Estate Planning, Elder Law, Special Needs Planning, Trust and Estate Administration, Guardianship, Tax Law, and Real Estate. Eric is a member of the New York State Bar Association (NYSBA), the National Academy of Elder Law Attorneys (NAELA), New York Chapter of NAELA (NY NAELA), ElderCounsel, the American Bar Association, and the Nassau County Bar Association. He is admitted to the New York and New Jersey Bars.

Eric serves as the Vice President of the National Academy of Elder Law Attorneys (NAELA) Board of Directors, an Officer for the Board of Directors for New York NAELA, and as the Treasurer of the Board of Trustees for the NAELA Foundation. He is the former Editor-in-Chief of NAELA News, and is on the Board of Editors of the NYSBA Elder and Special Needs Law Journal.

Additionally, Eric uses his legal expertise to give back to his community by serving as an Officer on the Board of Directors for the Nassau Cerebral Palsy Guardianship Corp.

Eric earned his law degree at New York Law School, where he graduated cum laude. While in law school participated in NYLS's Guardianship Clinic and created and authored an Elder Law blog, which featured articles that have been re-published in multiple publications. Eric gives back to his alma mater by serving on the board of directors for the New York Law School Alumni Association.

Eric is a sought-after writer and speaker. He has written articles and blog posts for the NAELA News (Top 10 blog post of 2024), NYSBA Elder and Special Needs Law Journal, Nassau Lawyer, MassMutual Special Care Planners, The Student Appeal, and the Russo Law Blog. Eric has also presented lectures, seminars, and webinars to both consumers and professionals locally and throughout the country on topics such as Medicaid Planning, Special Needs Planning, Guardianships, Tax law (as it relates to the practice of Elder Law), Real Estate, and Fiduciary Responsibility.

## **Vincent J. Russo**

Vincent J. Russo, Managing Shareholder of Russo Law Group, P.C., has been a champion for seniors and individuals with special needs since 1985. Based on Long Island, his firm is a leader in elder law, special needs, and estate planning, with offices in Garden City, Islandia, and Lido Beach, New York.

A founding member and past president of the National Academy of Elder Law Attorneys (NAELA), Vincent has received the organization's prestigious President's Award twice and is a member of the elite NAELA Council of Advanced Practitioners. He is also a founding chair of the National Elder Law Foundation and has held leadership roles in the New York State Bar Association, ElderCounsel, and the Academy of Special Needs Planners.

Vincent's advocacy has reached the national stage, including testimony before the U.S. Senate Committee on Aging and an invitation to the 2005 White House Conference on Aging. He has been a visible media presence, appearing on NBC's Today Show, CBS Sunday Morning, CNN, Fox News, and more. He co-created and hosted Family Comes First, a cable TV series recognized with three Telly Awards, and currently serves as the Legal Correspondent for Catholic Faith Network's In The Legal Know.

A prolific writer and thought leader, Vincent has contributed to major publications such as The New York Times, Wall Street Journal, Trust and Estate, and NAELA Quarterly. He co-authored New York Elder Law and Special Needs Practice, a key resource for attorneys, along with two consumer books on elder law and estate planning.

Vincent holds a J.D. from Fordham University School of Law and an LL.M. in Taxation from Boston University School of Law. He is admitted to practice in New York, Massachusetts, and Florida, and is a Certified Elder Law Attorney (CELA) by the National Elder Law Foundation.

## **Peter J. Wall**

Peter J Wall is the Director of Fiduciary Services at True Link Financial Advisors. With more than 20 years of trust administration experience at national bank trust companies, he is well known throughout the country for his deep understanding of special needs and Elder Law issues. Prior to joining True Link, Mr. Wall developed and led a

dedicated Elder Law and SNT division of a nationally chartered \$80B trust bank. This division coordinated fiduciary management, banking needs, unique asset management, tax preparation, and investment management for SNTs, PSNTs, and other fiduciary appointments. Mr. Wall currently serves on the Board of Directors for Easter Seals, as well as several other estate planning and charitable organizations; he is also a member of the Academy of Special Needs Planners. A frequent presenter on the topics of special needs trusts, estate planning, taxation, and trust administration, he is also a published author, most notably in the Elder Law in Colorado Red Book, Fourth Edition. He is licensed with a Series 65 by the Financial Industry Regulatory Authority (FINRA).

### **Bradley Frigon**

Practicing elder law for over 40 years, Mr. Frigon has experience in all aspects of estate planning and special needs, estate and probate litigation, guardianship and conservatorship matters, Medicaid, probate administration and tax matters.

Mr. Frigon is licensed to practice law in Colorado, Wyoming and Kansas, is the Past-President of the National Academy of Elder Law Attorneys, an appointed member of the Special Needs Alliance, special counsel for the Colorado Fund for People with Disabilities, a Fellow of the American College of Trust and Estate Counsel (ACTEC), a Certified Elder Law Attorney (CELA), and a member of the Council of Advanced Practitioners (CAP).

In addition to his practice, Mr. Frigon is a nationally recognized speaker, author of numerous publications including co-author of Fundamentals of Special Needs Trusts, and has been quoted in the Wall Street Journal, MSN Money, Kiplinger Retirement Report, and Bloomberg.

He is recognized as a Colorado Super Lawyer and is rated AV Preeminent by Martindale-Hubbell

### **Jeremy Sapriel**

Jeremy Sapriel leads Product at True Link. Jeremy brings over 15 years of executive product management, product operations, and product strategy experience. Jeremy previously held leadership positions in fintech and edtech serving nonprofit clients at Kaleidoscope, Vanco, and Blackboard. Prior to that, Jeremy led product strategies and delivery at Deloitte Consulting. Jeremy holds a BA from The George Washington University and an MBA from The McCombs School of Business at The University of Texas, Austin.

### **Ashley Krenelka Chase**

Professor Ashley Krenelka Chase currently teaches legal research and writing, after nearly a decade of teaching advanced research and technology courses.

Previously, Ashley was the Associate Director of the Dolly & Homer Hand Law Library the Coordinator of Legal Practice Technology at Stetson, where she worked with faculty to identify technology competencies for incoming and outgoing students and to ensure student success during law school and in the practice of law. Ashley's scholarship focuses on the intersection of research, technology, and access to justice for incarcerated litigants.

Professor Chase received her B.A. degree from Bradley University, her M.A. from the University of South Florida, and her JD from the University of Dayton School of Law.



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# **2025 Fundamentals of Special Needs Trusts Administration Webinar**

**Friday, May 30, 2025**

**12:40-1:30 pm**

## **Uncertainty of Public Benefits: Current Trust Administration and Future Planning**

**Presenter: David Goldfarb**

- PowerPoint



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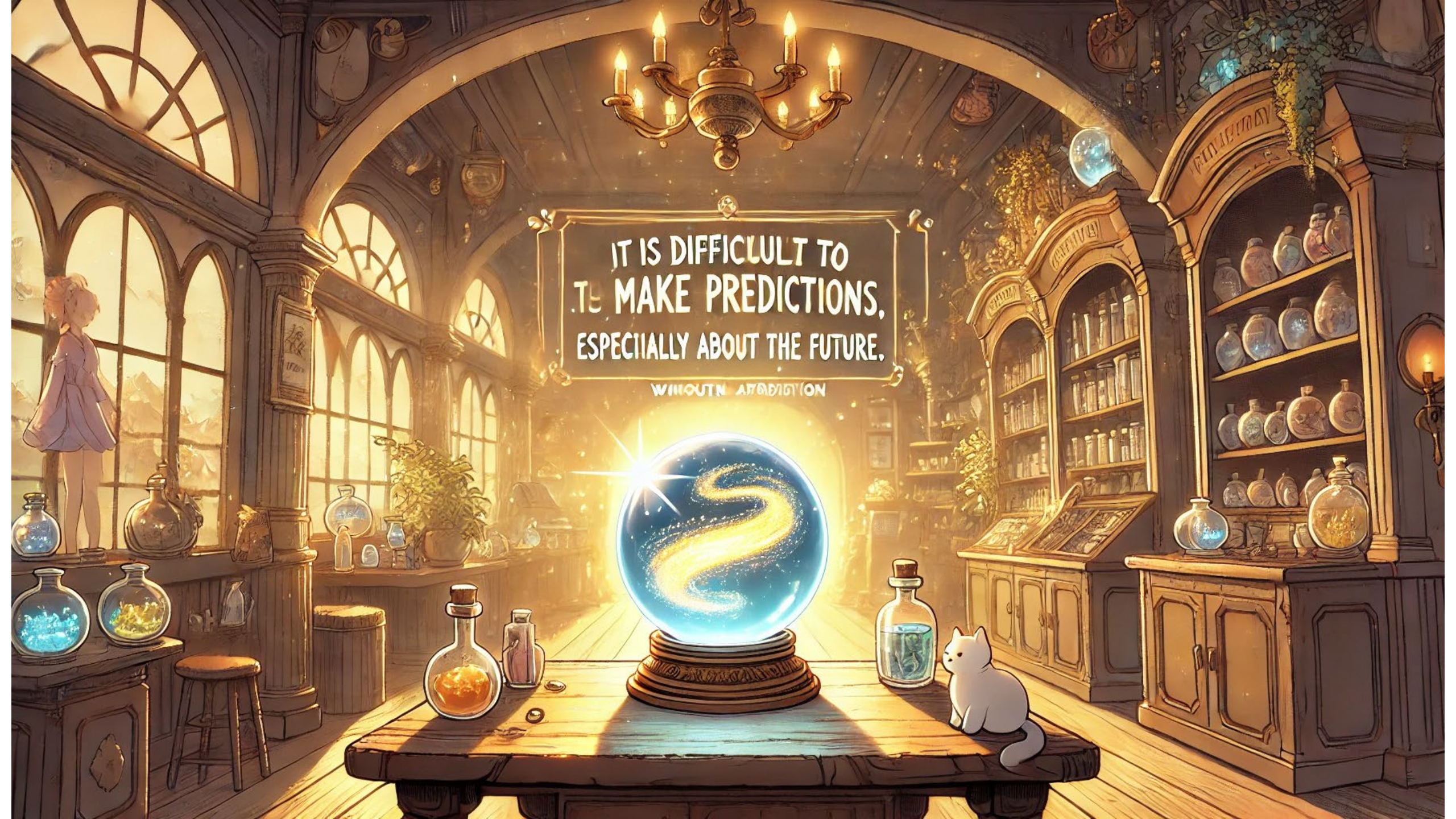
# **Uncertainty of Public Benefits**

**Current Trust Administration and Future Planning**







A whimsical illustration of a wizard's shop. In the center, a large, glowing crystal ball sits on a wooden table, displaying a bright yellow and blue swirling pattern. A small white cat sits on the table to the right of the crystal ball. To the left of the crystal ball are two small glass bottles, one containing orange liquid and the other purple. The shop is filled with various magical items: shelves on the right hold numerous glass bottles and jars, some labeled 'POTION' and 'CONJURATION'. A chandelier with lit candles hangs from the ceiling. Large arched windows on the left show a view of a city. A small figure of a person in a purple robe stands near the windows. The overall atmosphere is warm and magical, with golden light streaming in from the windows.

IT IS DIFFICULT TO  
TO MAKE PREDICTIONS,  
ESPECIALLY ABOUT THE FUTURE.

WITHOUT ATTENTION



# Risk Assessment

Political

Economic

Demographic





# Political Risks







# Mandatory Spending

Medicare

Medicaid

Supplemental  
Nutrition  
Assistance  
Program (SNAP)

Supplemental  
Security Income

Social Security  
(Disability &  
Retirement)

V.A. Aid and  
Attendance

# Discretionary Spending

Older Americans Act programs

Individuals with Disabilities Education Act (IDEA)

Public Housing

Low-Income Home Energy Assistance Program (LIHEAP)

Vocational Rehabilitation



# Executive Branch

President's have enormous power to set policy and personnel.

Agency rules have the force of law.

Agency guidance holds great weight – Ignore the POMS are your PERIL!

# HHS Restructuring

- This year the Department of Health and Human Services (HHS) is undergoing a department-wide restructuring, which included staff cuts and consolidation of agencies.
- 25% decrease in staff—from 82,000 to 62,000 positions .
- Administration for Community Living disbanded.







# Judicial Risks



Adjudicator of claims



Determine when a  
State has violated  
Federal Law

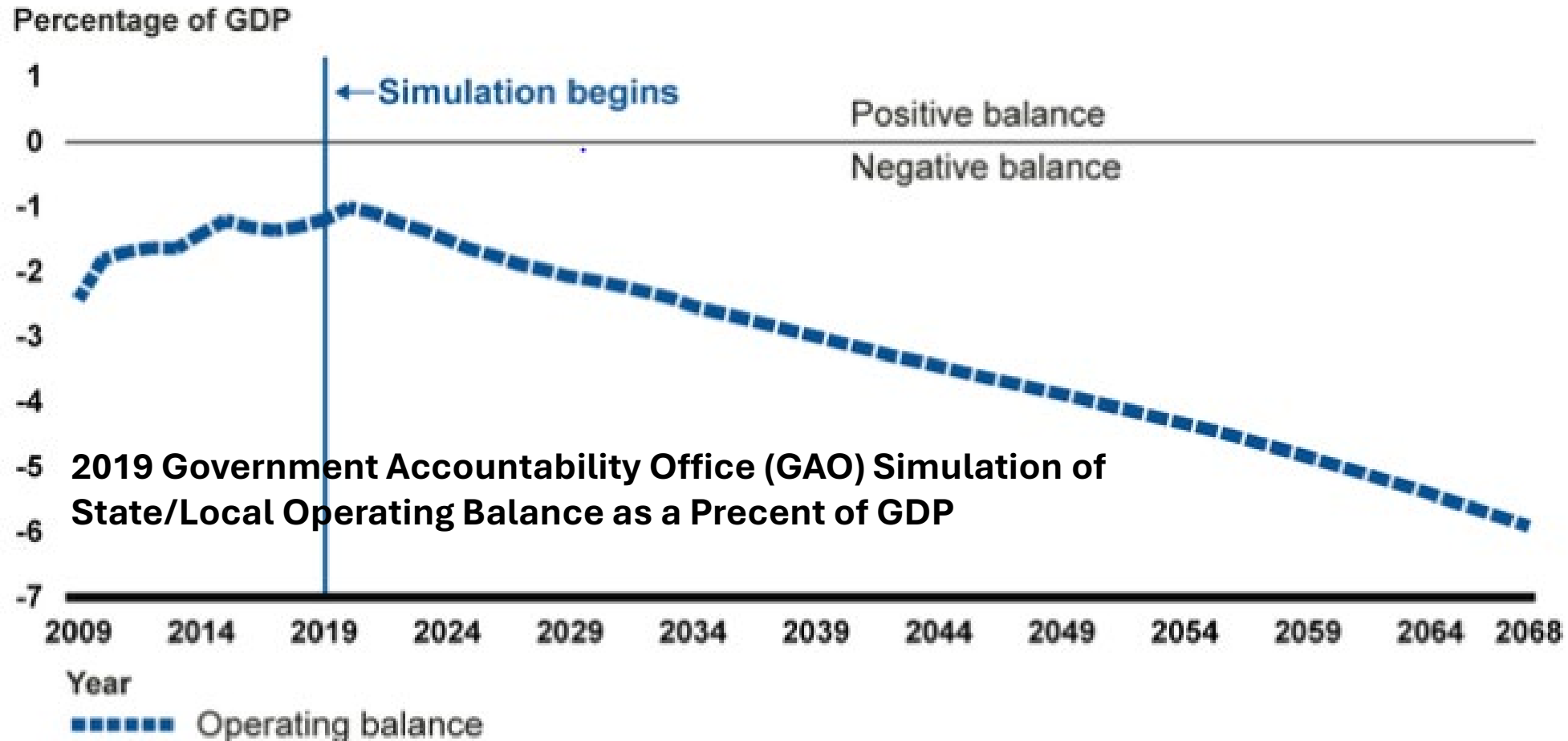


Can Block or  
Enable Major  
Policy Shifts



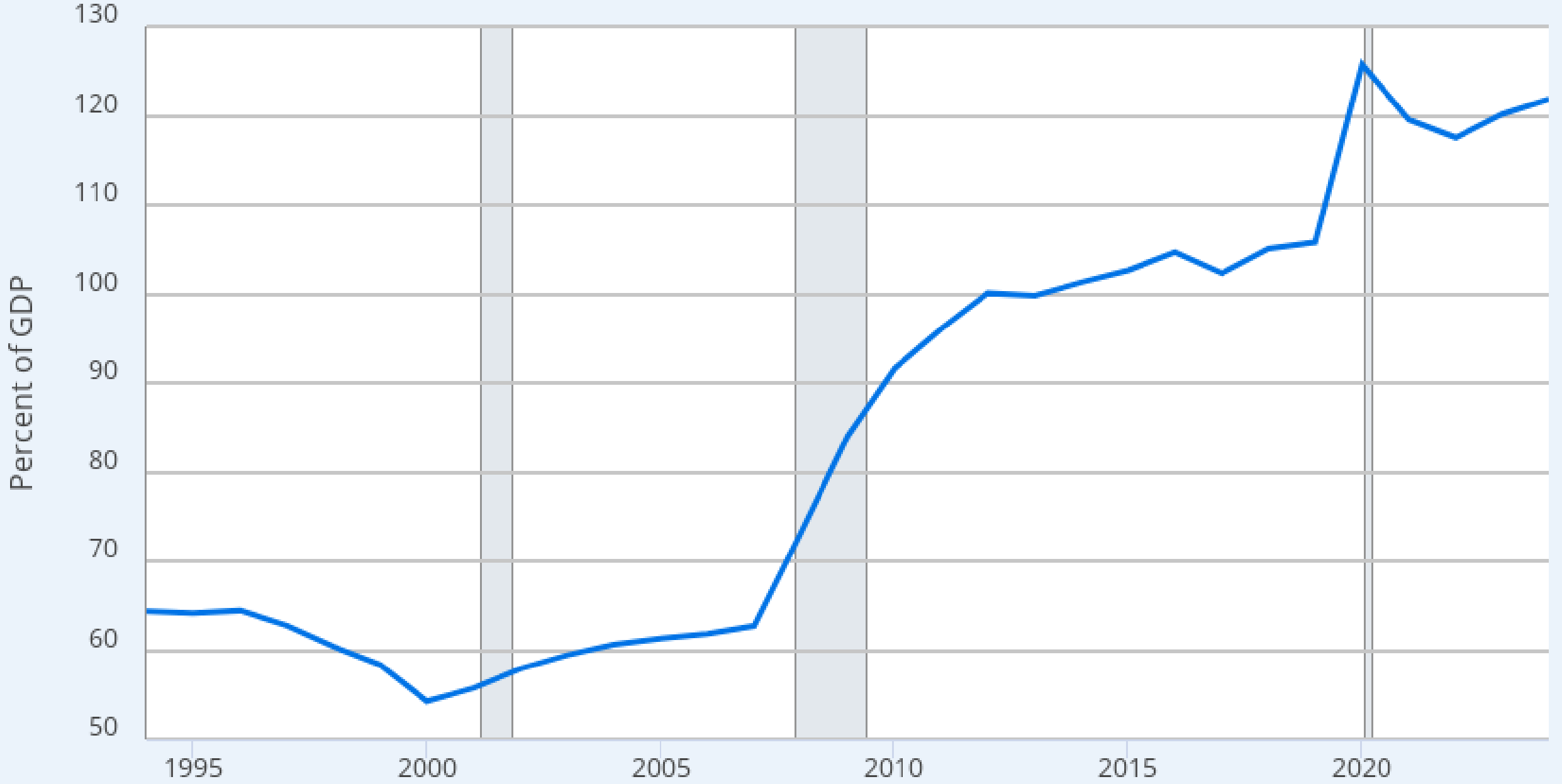
# Economic Risks

# Worsening State Budgets Over Time



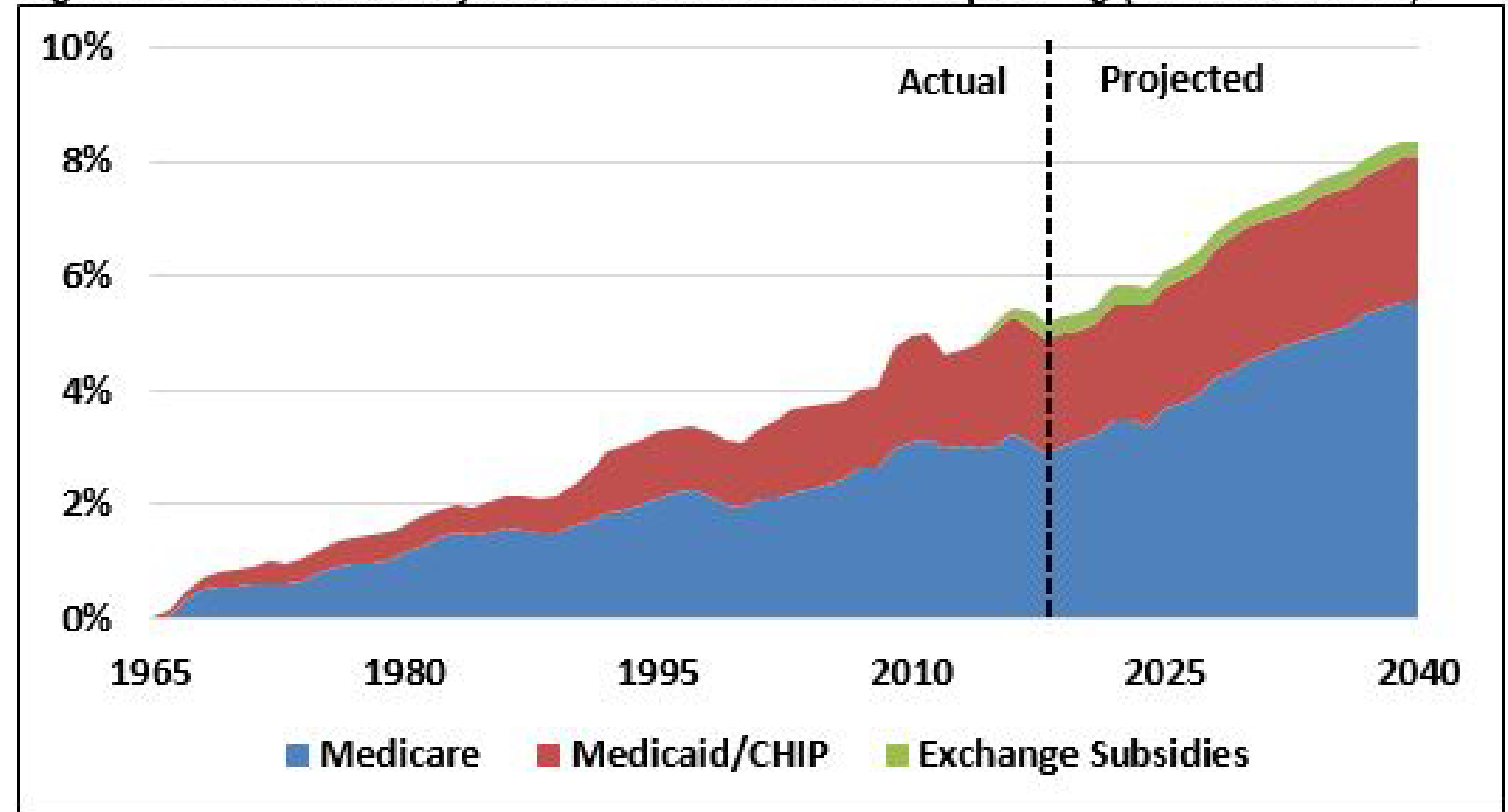


Federal Debt: Total Public Debt as Percent of Gross Domestic Product

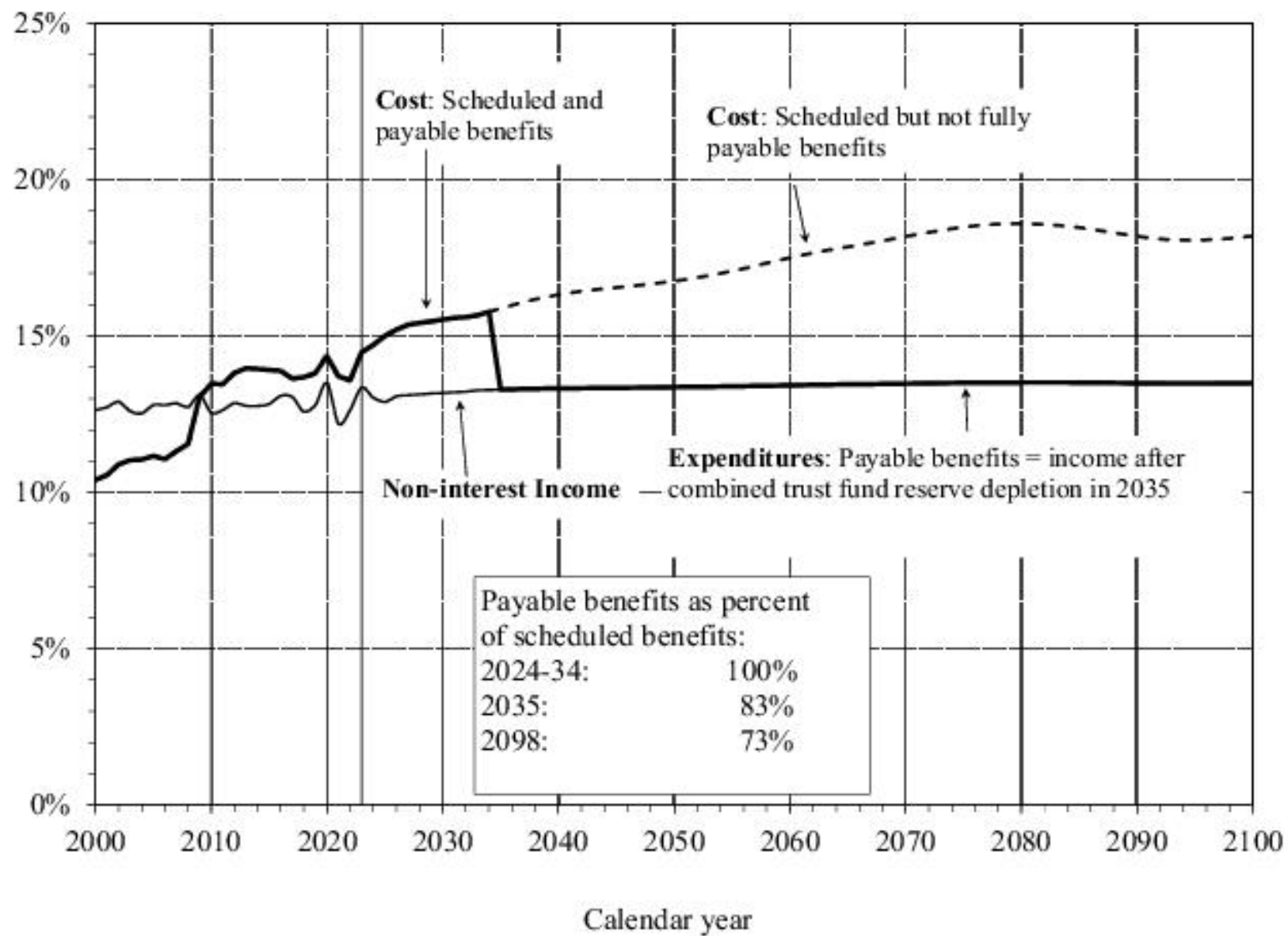


# Rising Federal Health Care Costs

Fig. 2: Historical and Projected Federal Health Care Spending (Percent of GDP)

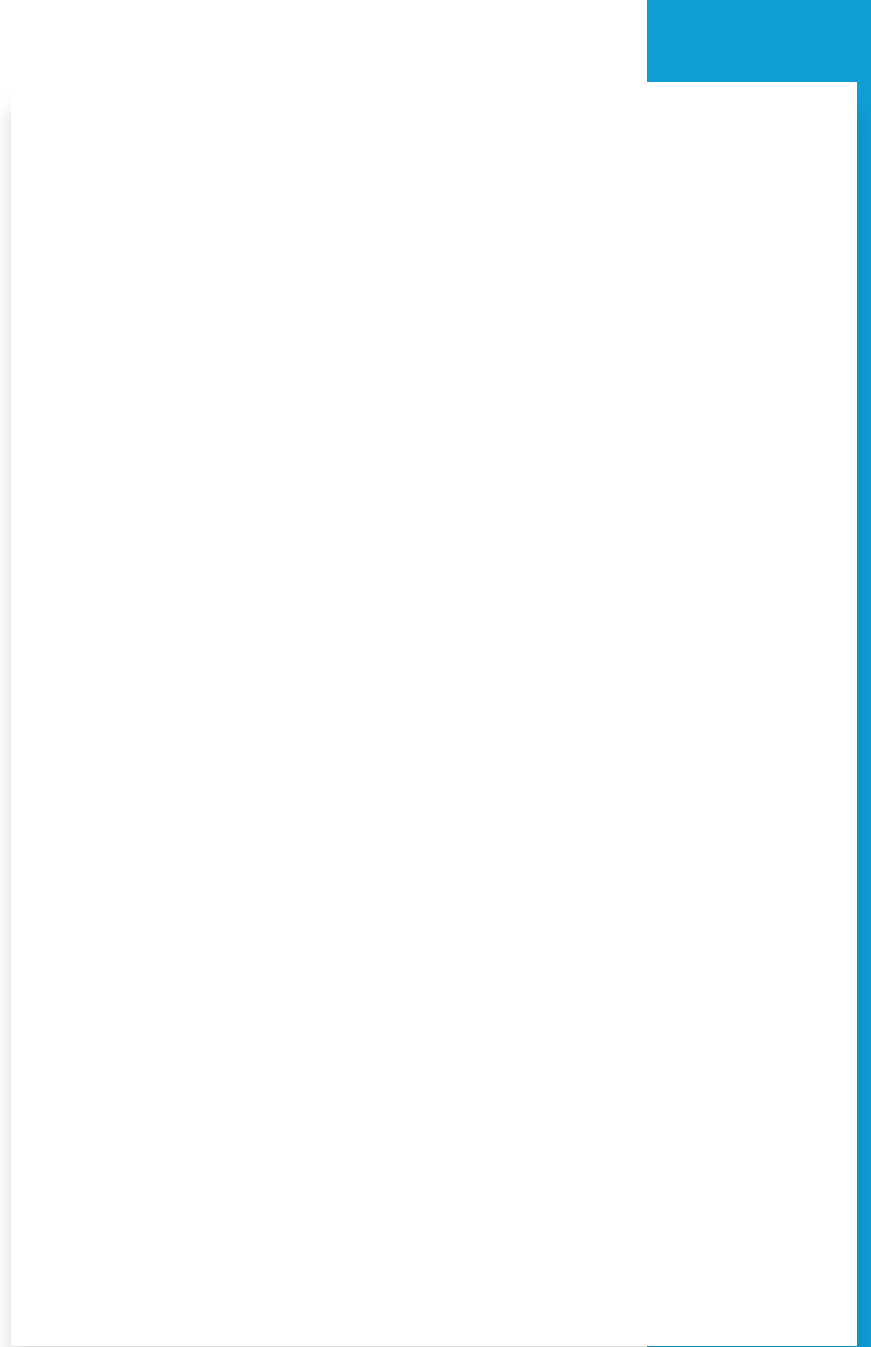


Source: Office of Management and Budget, Congressional Budget Office, CRFB calculations.





# Demographic Risks

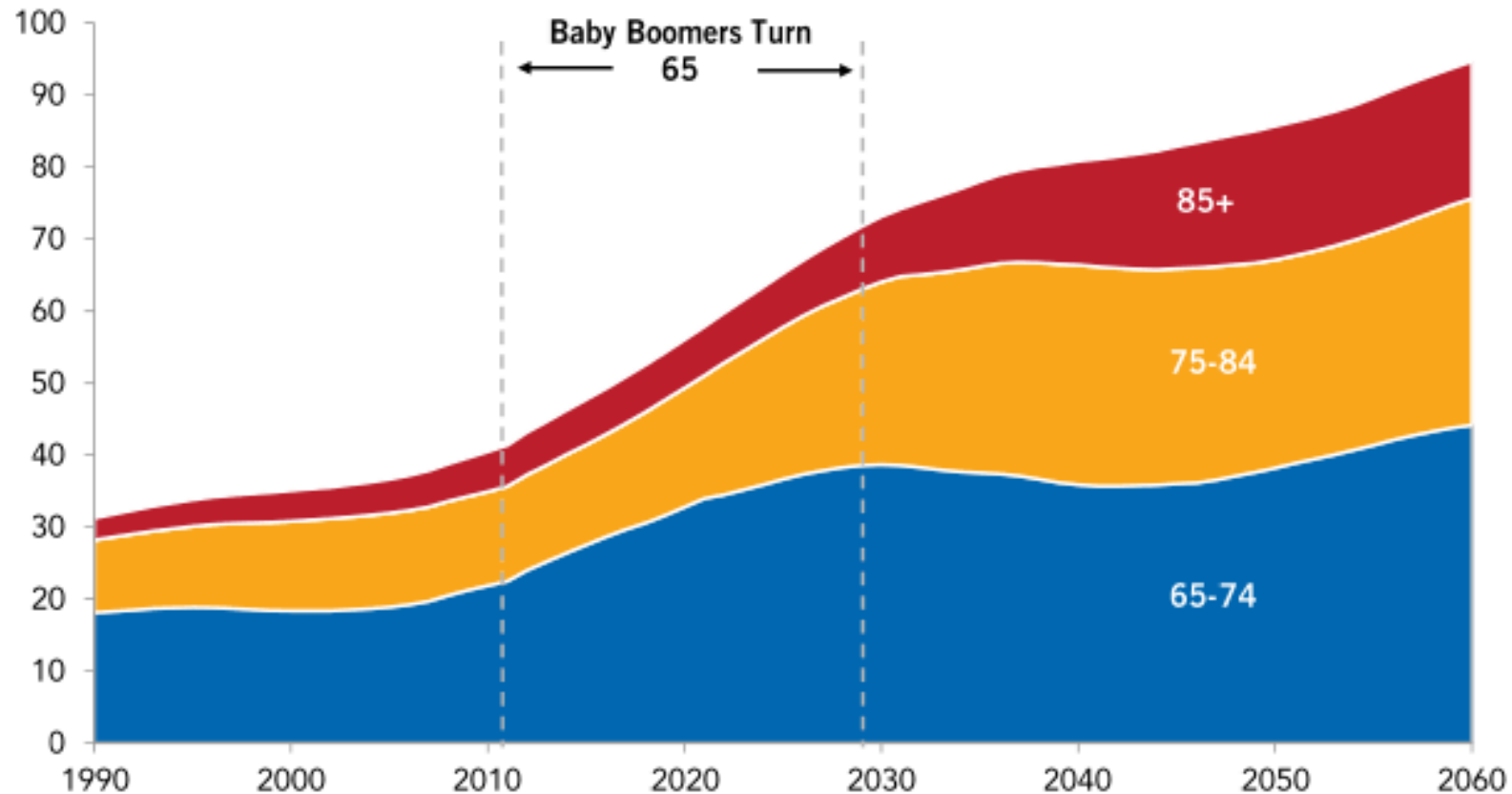




PETER G.  
PETERSON  
FOUNDATION

## The elderly population is growing rapidly and living longer

U.S. POPULATION AGE 65+ (MILLIONS)



SOURCE: U.S. Census Bureau, *National Intercensal Estimates*; *2016 Population Estimates*, June 2017; and *2017 National Population Projections*, September 2018. Compiled by PGPF.

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[PGPF.ORG](http://PGPF.ORG)

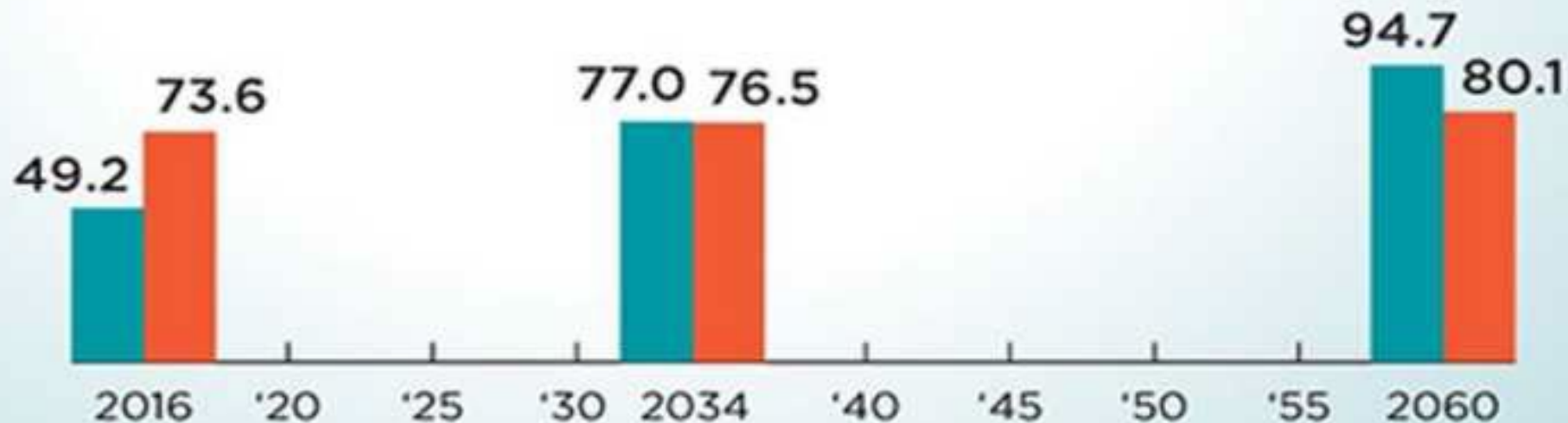


## For the First Time in U.S. History Older Adults Are Projected to Outnumber Children by 2034

**Projected  
percentage  
of population**

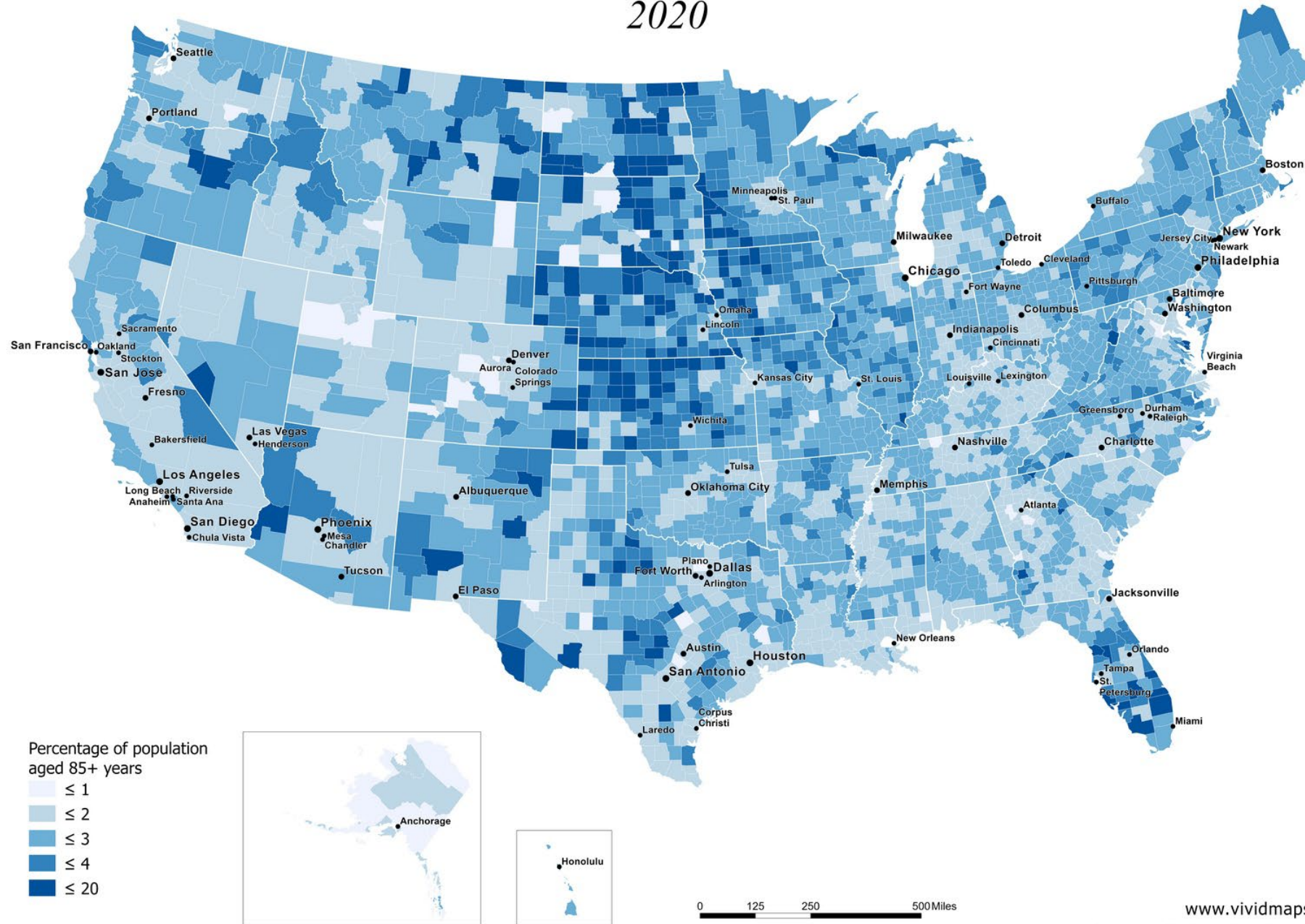


**Projected  
number  
(millions)**



# Population 85 Years and Older by County

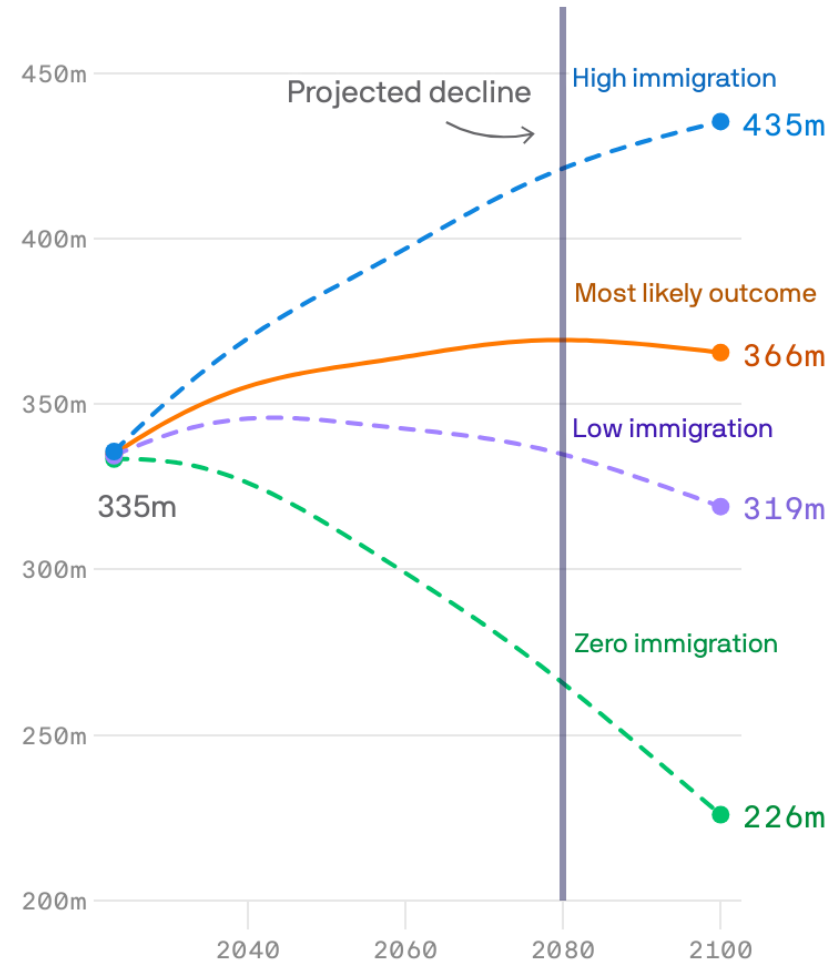
2020



# Future Growth: Immigration A Big Factor

## Projected U.S. population

2023-2100; By immigration scenario







# Medicaid Long-Term Care

**Low reimbursement rates, leading to workforce shortages (median wage: \$15.18/hr)**

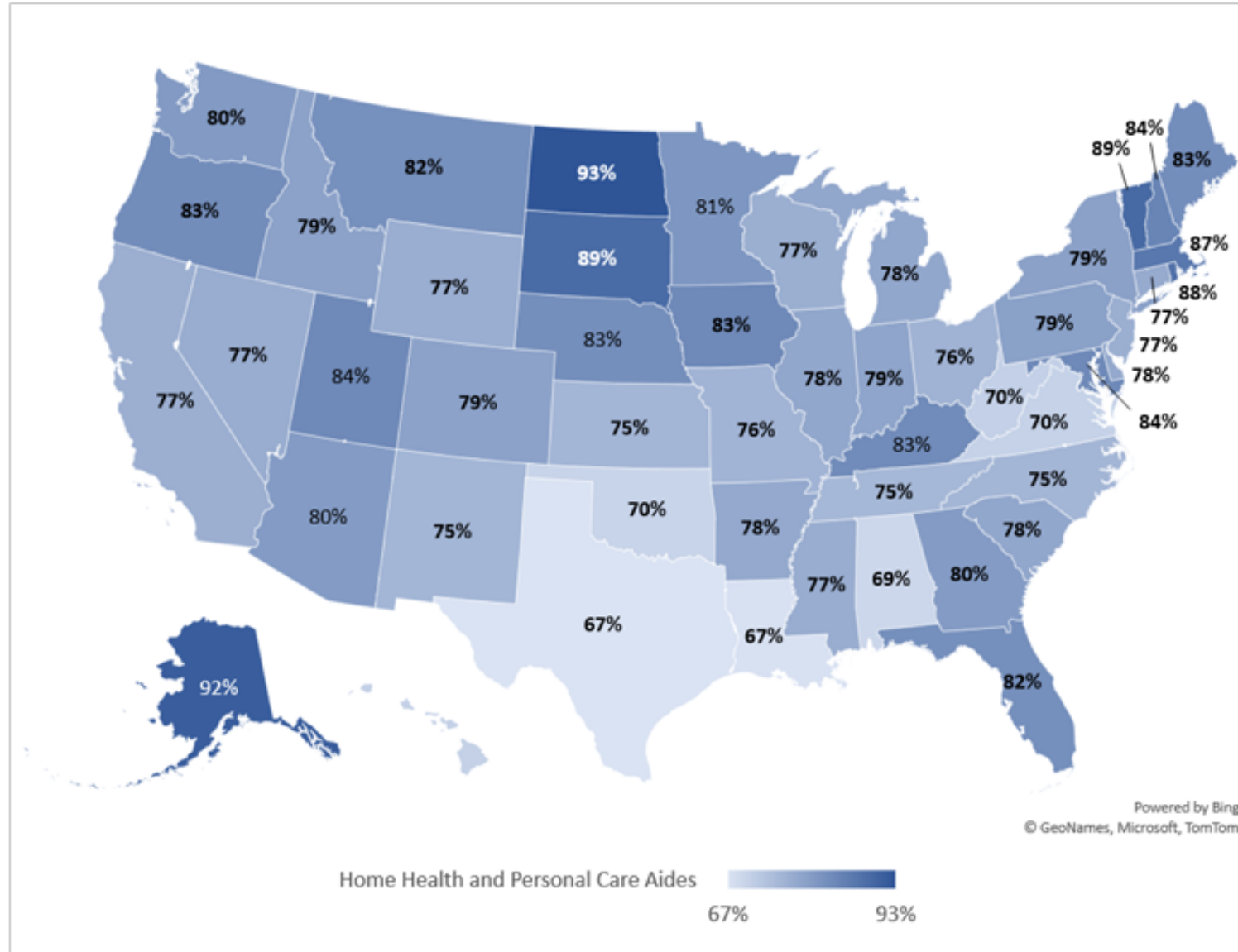
**Access crisis: Nursing homes are closing & home care agencies are turning away patients**

**Limited Home & Community-Based Services: 700,000+ on waitlists**

**Broken eligibility model for long-term care**

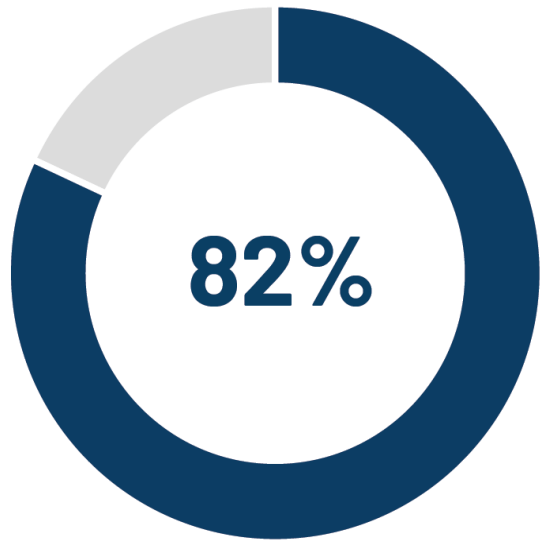


**Figure 1. Wages of Home Health and Personal Care Aides  
as Percentage of Wages of Other Entry-level Jobs (2019)**

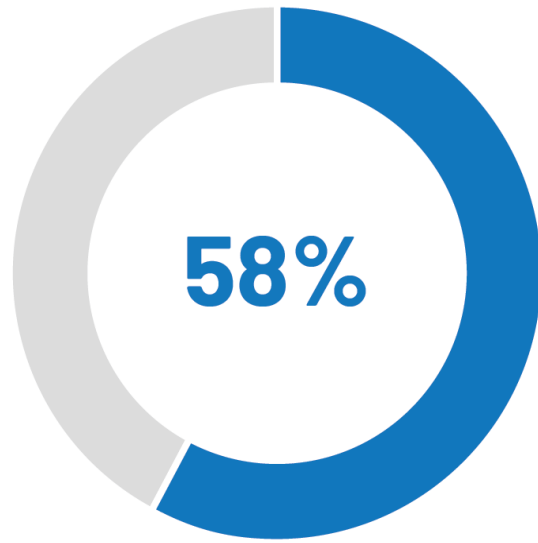


**NOTES:** State-level median wages were obtained from the BLS OEWS program for the May 2019 reference period. DCW wages were normalized relative to wages of other entry-level jobs to reflect the fraction of the wages of other entry-level jobs made by DCWs. For example, a value 80% indicates that DCWs made 80% of wages made by other entry-level jobs or, in other words, DCWs make \$0.80 for every \$1.00 made by other entry-level workers.

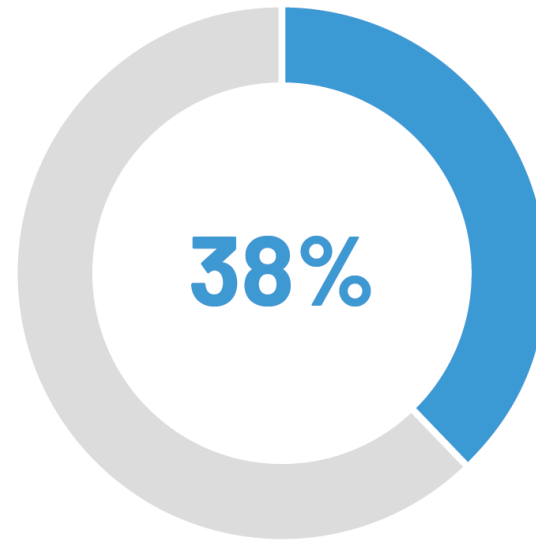
# The Long-Term Care Workforce is Predominantly Female and Low Wage; Nearly 4 in 10 are Age 50+ and 1 in 4 are Black



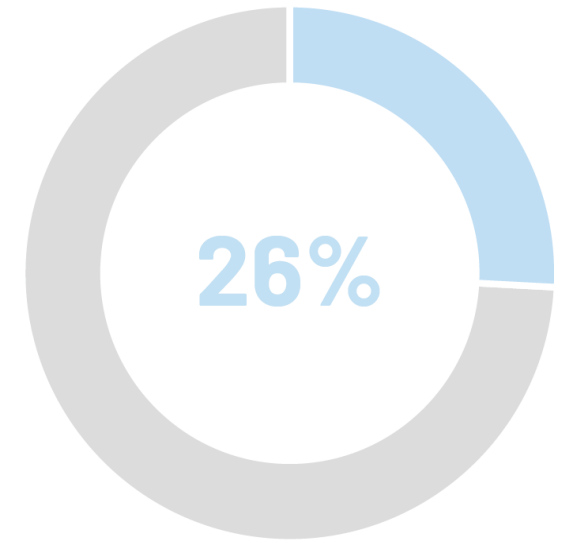
Women



Annual wages less than \$30,000



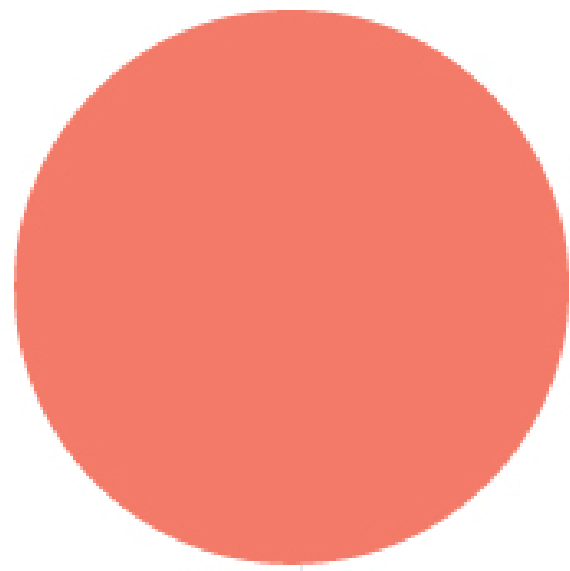
Age 50+



Black non-Hispanic

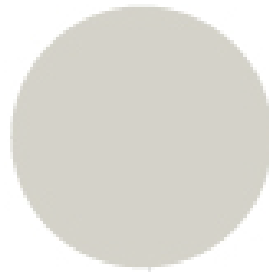
Long-Term Care Workforce in 2018 = 4.5 million

## By 2025, the US will likely face a shortage of...



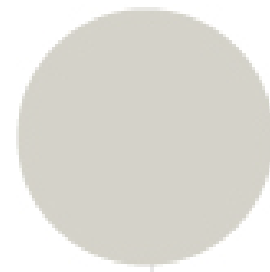
**446,300**

Home health  
aides



**98,700**

Medical and lab  
technologists and  
technicians



**95,000**

Nursing  
assistants



**29,400**

Nurse  
practitioners



# BUDGET DEAL





# Medicaid Topline

- **Likely \$710 billion+ in reduced Medicaid expenditures over ten years.**
- *How will these policies impact state budgets?*
- **Loss of Medicaid Coverage for about 8.7 million people.**
- *Medicaid expansion beneficiaries and unauthorized immigrants take the biggest hit.*

# Biggest Items By Savings

- **Community Engagement Requirements:** An estimated 4.8 million adults without dependents on Medicaid expansion will lose coverage by meeting the community engagement requirements. *\$300 billion over ten years.*
- **Delay of Biden Era Rules to 2035.** *\$162 billion over ten years.*
- **Provider Tax Moratorium and Other State Financial Changes.** *Minimum expected \$86 billion over ten years.*
- **Increasing eligibility redeterminations in Medicaid expansion.** *\$49+ billion over ten years.*

# Medicaid Long-Term Care



Repeal of retroactive coverage in Medicaid.



Provider taxes and other state financing issues.



New \$1,000,000 home equity limit that does not adjust for inflation.



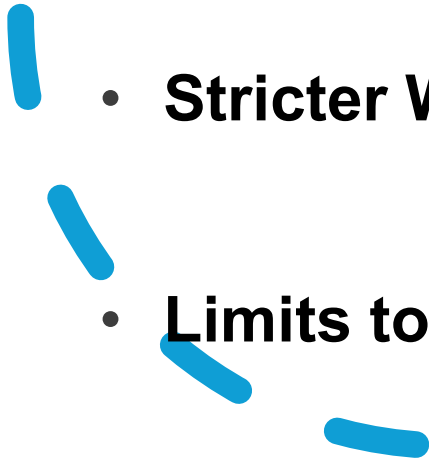
Community engagement requirements impact.



Repeal of nursing home staffing ratio rule (support!)



# Food Insecurity Programs

- **Cuts to SNAP Benefits & Amending the Thrifty Food Plan:** Average SNAP benefit may drop from \$6.20 to \$4.80 per person/day.
  - **State Funding Requirements for SNAP**
  - **Stricter Work Requirements.**
  - **Limits to Shelter Expense Deductions:**
- 









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## **Federal Protections for Medicaid Appeals**

**Presenter: Eric Einhart and Vincent Russo**

- PowerPoint
- Materials



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# medicaid and the uninsured

## A Guide to the Medicaid Appeals Process

*Prepared by:*

*MaryBeth Musumeci*

*Kaiser Commission on Medicaid and the Uninsured*

*The Henry J. Kaiser Family Foundation*

**March 2012**

# kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

James R. Tallon  
*Chairman*

Diane Rowland, Sc.D.  
*Executive Director*

# kaiser commission on medicaid and the uninsured

## **A Guide to the Medicaid Appeals Process**

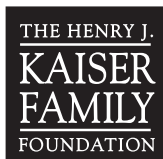
*Prepared by:*

*MaryBeth Musumeci*

*Kaiser Commission on Medicaid and the Uninsured*

*The Henry J. Kaiser Family Foundation*

**March 2012**







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## Executive Summary

A fundamental attribute of health insurance is the existence of enforceable protections to ensure that applicants will get coverage if they meet the eligibility requirements and enrollees with coverage will receive medically necessary services within their benefits package. Beneficiaries' ability to contest an adverse determination is a basic right recognized by law in all types of health insurance, including private insurance, Medicare, and insurance available to federal employees and members of the military, as well as Medicaid. The Medicaid appeals process, however, is different from the appeals processes available through the Medicare program and private health insurance.

The Medicaid program is a vital source of health insurance for nearly 60 million people with low incomes, people with disabilities, and seniors. But, none of the services offered by the Medicaid program are meaningful unless people who are eligible are able to enroll and, once enrolled, can access covered services. Given the number of beneficiaries and the constant fiscal pressure for cost containment, it is inevitable that sometimes coverage is denied and mistakes are made. Resolving these issues fairly and expeditiously is critical to the Medicaid program's ability to achieve its coverage goals. Due to the nature of the program, Medicaid appeal rights have both constitutional and statutory underpinnings. This background paper describes the appeals system available to Medicaid applicants and beneficiaries, including the fair hearing process and the appeals process required for Medicaid managed care organizations (MCOs).

### *State Agency Appeals Process*

Medicaid applicants and beneficiaries are entitled to adequate notice of state agency actions and a meaningful opportunity for a hearing to review those decisions whenever their claim for benefits is denied or not acted upon with reasonable promptness. This includes any action, or inaction, that affects *either* the person's eligibility to be enrolled in Medicaid *or* the person's receipt of a particular medical service covered by the program. The administrative agency hearings in the Medicaid appeals system are often called "fair hearings." The same notice and hearing rights apply to both disputes regarding Medicaid eligibility and to disputes regarding whether an eligible Medicaid enrollee has a medical need for a particular service, whether the benefits are administered through the fee-for-service system or an MCO. The fair hearing process must be accessible to people with limited English proficiency and people with disabilities. State costs of conducting fair hearings are matched by the federal government at 50 percent, while appeals costs incurred by applicants or beneficiaries and their advocates are not.

#### **Example of a Medicaid Eligibility Denial Fair Hearing – Susan's Story, Part 1 – Notice and Hearing Request**

Susan is pregnant with her first child and living in a domestic violence shelter. She applied for Medicaid, and the state agency required her to produce information about her own income and that of her estranged husband. The agency notified her that she is ineligible because the couple's combined income exceeds the Medicaid income limit. Susan appealed and asked for an expedited hearing, based on the urgency of her need for prenatal and obstetrical care.



The state Medicaid agency must provide written notice of appeal rights when a person applies for benefits and whenever the state agency takes an action that affects a person's claim for benefits. All notices must advise the person of her right to a hearing, describe the method for requesting a hearing, and explain that the person may represent herself or be represented by legal counsel or someone else. Notice must be provided 10 days before a proposed termination, suspension or reduction of a person's Medicaid eligibility or covered services. Hearings must be requested within a reasonable period of time established by the state agency, not to exceed 90 days from the date that the notice is mailed. Beneficiaries who are currently receiving services generally have the right to request that services continue during an appeal until a hearing decision is issued, by requesting a hearing within the 10 day advance notice period.

#### **Susan's Story, Part 2 – State Fair Hearing**

At her fair hearing, the case worker who had handled Susan's Medicaid application testified about how Susan's financial eligibility was calculated. Susan was accompanied by her parents and a former neighbor, all of whom testified that Susan's husband had physically abused her. Each side had the chance to ask questions of the other side's witnesses, and the hearing officer also asked questions. In a written decision mailed after the hearing, the hearing officer ruled that the husband's income should not have been counted when determining Susan's Medicaid eligibility and reversed the state agency's decision to deny coverage. Susan was found eligible retroactive to the beginning of her pregnancy when she had first applied for coverage, and Medicaid reimbursed the clinic for the cost of the visits she already received, in addition to covering her future medical care.

The state Medicaid agency decides whether to offer only an administrative fair hearing or a local level evidentiary hearing with the right to appeal to an administrative fair hearing. Beneficiaries have a number of important procedural rights at hearings. Hearing decisions must be in writing and based exclusively on the evidence introduced at the hearing. If a hearing decision is favorable to the beneficiary, the agency must promptly implement it. The agency also must notify beneficiaries of their right to seek judicial review in state court to the extent it is available. The agency must take final administrative action on appeals within 90 days of the date that the beneficiary asked for a fair hearing.

#### ***MCO Appeals Process***

In addition to the state fair hearing process, Medicaid MCOs must establish both internal appeal procedures for enrollees to challenge the denial of coverage or payment for medical assistance and a grievance process. A fair and efficient appeals process is especially important in the context of capitated managed care, where there are economic incentives to underserve and the majority of beneficiaries are mandatorily enrolled. Medicaid MCO

#### **Example of an MCO Service Termination Appeal - John's Story, Part 1 - Notice**

John is a 15-year-old boy with cerebral palsy and cognitive limitations. He receives Medicaid benefits through an MCO. John's primary care doctor prescribed physical therapy services twice a week to help improve John's mobility and ability to assist in transferring from his wheelchair. John has received physical therapy for several years. Recently, John's Medicaid MCO sent a notice that says John's physical therapy services are no longer considered medically necessary and will be discontinued.

enrollment is expected to grow dramatically in the next few years due to the Affordable Care Act's Medicaid expansion in 2014, and the Centers for Medicare and Medicaid Services' demonstrations to integrate care for people dually eligible for Medicare and Medicaid, both of which will affect populations with complex and costly health care needs.

An MCO notice must contain certain elements. Different timeframes apply to the mailing of MCO notices, depending upon the type of decision. MCOs have flexibility in designing their internal appeals process, provided that enrollees have a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. Federal regulations provide certain rights to enrollees during MCO appeals, govern the timing and content of required notices and the timeframes within which MCOs must resolve appeals, and require MCOs to maintain an expedited appeals review process.

For appeals not resolved wholly in the enrollee's favor, the MCO's written notice of appeal resolution must advise the enrollee about the right to request a state fair hearing and how to do so. The state agency may permit MCO enrollees to request state fair hearings directly in response to MCO notices of action, or the state agency may require MCO enrollees to first exhaust the internal MCO appeal process before requesting a state fair hearing. Federal regulations govern the standard and expedited timeframes within which the state agency must take final administrative action on fair hearing requests by MCO enrollees.

### *Looking Ahead*

The Medicaid appeals process provides important protections for individual applicants and beneficiaries seeking eligibility for the program and coverage of prescribed services.

### **John's Story, Part 2 – Internal MCO Appeal**

John's parents decide to appeal the MCO's denial. Their state requires exhaustion of the MCO appeals process before a state fair hearing. John's parents file a written request for an MCO appeal. Because John's parents ask for the appeal within 10 days of the date of the termination notice, they also are able to ask for John's benefits to continue while the appeal is pending. John's parents receive a letter with a date for them to meet with the MCO. John's parents attend the appeal meeting, which is run by one of the MCO's medical directors who was not involved in the initial decision. The MCO's nurse case manager also is there to explain why the MCO wants to discontinue physical therapy. John's parents have the chance to explain why they think therapy should continue. A few days later, John's parents receive a letter saying that the MCO has upheld its decision to discontinue services.

### **John's Story, Part 3 – State Fair Hearing**

John's parents decide to ask for a state fair hearing. Again, they appeal in time to request that John's benefits continue. They also call the local legal aid office, and an attorney there agrees to take their case and represent John at the hearing. At the fair hearing, the MCO is represented by a lawyer, too. The MCO medical director and nurse case manager testify about why the MCO decided to terminate physical therapy, and John's parents also testify about why John needs services to continue. In addition, John's doctor and physical therapist provide testimony about why they believe physical therapy continues to be medically necessary for John. All witnesses are cross-examined by the opposing lawyers, and the hearing officer also asks questions. The hearing officer takes a couple of months to issue a written decision. The decision finds that the MCO has to continue to authorize physical therapy for John under Medicaid's Early and Periodic Screening Diagnosis and Treatment benefit. Because John's benefits continued while the appeal was pending, his services have not been disrupted during the appeal.

Monitoring of appeals at a systemic level can provide useful management insights into program performance and opportunities for quality improvement. At the same time, the appeals process is multi-layered and can be complex to navigate, with relatively few beneficiaries represented by legal counsel. The features of the Medical appeals system are increasingly significant as health reform is implemented, including challenges in designing an integrated appeals system in new initiatives that seek to integrate Medicare and Medicaid benefits for people who are eligible for both programs and the new single streamlined application process that must assess each person's Medicaid eligibility before considering eligibility for other insurance affordability programs, the denial of which triggers Medicaid notice and appeal rights.

## Introduction

A fundamental attribute of health insurance is the existence of enforceable protections to ensure that applicants will get coverage if they meet the eligibility requirements and enrollees with coverage will receive medically necessary services within their benefits package. Beneficiaries' ability to contest an adverse determination is a basic right recognized by law in all types of health insurance, including private insurance subject to ERISA, private insurance regulated by states, Medicare, and insurance available to federal employees and members of the military, as well as Medicaid.

Medicaid, the country's publicly financed health and long-term care insurance program, covers a range of people with low incomes, including children and parents, people with a variety of physical and mental health disabilities, and seniors. Beginning in January, 2014, Medicaid's coverage will expand under health reform to include nearly all adults under age 65 with incomes up to 133 percent of the federal poverty level. Medicaid's benefits package includes an array of services, including those typically not offered by private health insurance, such as long-term services and supports for people with disabilities and comprehensive screening, diagnosis and treatment services for children under age 21. None of the services offered by the Medicaid program are meaningful, however, unless individuals who are eligible for Medicaid are able to enroll and, once enrolled, can access covered services. Given the number of beneficiaries and the constant fiscal pressure for cost containment, it is inevitable that sometimes coverage is denied and mistakes are made. Resolving these issues fairly and expeditiously is critical to the Medicaid program's ability to achieve its coverage goals for its nearly 60 million beneficiaries.

The Medicaid appeals process is an important way for applicants and beneficiaries to seek review of decisions about whether a person is eligible for the program and what services will be provided. Due to the nature of the program, Medicaid appeal rights include some specific protections arising from the Due Process Clause of the U.S. Constitution and the federal Medicaid statute. This background paper describes the appeals system available to Medicaid applicants and beneficiaries, including the state agency administrative hearing process and the appeals process required for Medicaid managed care organizations (MCOs).<sup>1</sup>

## Constitutional Requirements of the Medicaid Appeals Process: Notice and Hearing

Applicants' and beneficiaries' claims to services under the Medicaid Act are protected by the Due Process Clause of the U.S. Constitution.<sup>2</sup> The two fundamental elements of the constitutionally required Medicaid appeals process are adequate *notice* of state agency actions and a meaningful opportunity for a *hearing* to review those decisions. These foundations of the Medicaid appeals system were articulated by the U.S. Supreme Court in its landmark 1970 *Goldberg v. Kelly* decision, and federal statute and regulations require that the Medicaid appeals system meet the *Goldberg* standards for notice and hearing. In *Goldberg*, the Court acknowledged that beneficiaries rely on programs like Medicaid to meet basic needs, without any other options. The Court observed that "[b]y hypothesis, [such beneficiaries are] destitute, without funds or assets. . . Suffice it to say that to cut off a



[beneficiary] in the face of. . . ‘brutal need’ without a prior hearing of some sort is unconscionable unless overwhelming considerations justify it.”<sup>3</sup> Consequently, the Court ruled that “‘the stakes are simply too high for [these beneficiaries], and the possibility for honest error or irritable misjudgment too great, to allow termination of aid without giving the [beneficiary] a chance, if he so desires, to be fully informed of the case against him so that he may contest its basis and produce evidence in rebuttal,’”<sup>4</sup> thus establishing the essential elements of notice and hearing.

The administrative agency hearings in the Medicaid appeals system often are called “fair hearings.” In addition to the requirements of *Goldberg*, the federal Medicaid Act since its enactment in 1965 has required states that choose to participate in the Medicaid program to offer the opportunity for a state fair hearing to any person whose claim for benefits is denied or not acted upon with reasonable promptness. That includes any action – or inaction – that affects *either* the person’s eligibility to be enrolled in Medicaid during the initial application process or redetermination *or* their receipt of a particular medical service covered by the program. The same notice and hearing rights apply to both disputes regarding Medicaid eligibility and to disputes regarding whether an eligible

Medicaid enrollee has a medical need for a particular service, whether the benefits are administered through the fee-for-service system or a managed care organization. However, as described below, the state may require Medicaid managed care enrollees to first complete the internal managed care organization appeals process before beginning the state fair hearing process.

Generally, there are two broad issues considered at fair hearings: Medicaid applicants can appeal the state agency’s decision to deny their *eligibility* for the program, and Medicaid beneficiaries can seek review of the state agency or a managed care organization’s decision to deny or discontinue coverage of particular *services*. In both contexts, decisions of the state Medicaid agency include actions by its agents and contractors. Beneficiaries also may request a hearing if they believe the state agency or a managed care organization has acted erroneously in suspending, terminating or reducing services. State agencies may not limit or interfere with an individual’s freedom to request a hearing. The instances in which the opportunity for a hearing must be provided are summarized in Text Box 1, and managed care appeals are discussed in more detail below.

**Text Box 1:**

**Required Opportunities for a Fair Hearing**

- Applicant’s claim for services is denied or not acted upon with reasonable promptness
- Beneficiary believes that agency has acted erroneously in terminating, suspending or reducing Medicaid eligibility
- Beneficiary believes that agency has acted erroneously in delaying the delivery of, terminating, suspending or reducing Medicaid covered services (e.g., on grounds of medical necessity)
- Nursing facility resident believes that facility’s decision to transfer or discharge is erroneous
- Individual believes that state’s determination regarding preadmission screening and annual resident review is erroneous
- Managed care enrollee wishes to challenge the denial of coverage of, or payment for, services

In addition to the constitutional and statutory underpinnings of Medicaid fair hearings, a variety of sources, listed in Text Box 2, provide further detail about Medicaid appeals procedures.<sup>5</sup> The Centers for Medicare and Medicaid Services (CMS, the federal agency overseeing the Medicaid program) requires that state Medicaid agencies issue and publicize their hearing procedures and recommends that state hearing procedures be published and widely distributed in the form of rules and

regulations or a clearly stated pamphlet. In addition to federal fair hearing requirements, the Americans with Disabilities Act requires that the Medicaid appeal process afford such accommodations as are reasonably necessary to ensure that the appeal process is accessible to individuals with disabilities.<sup>6</sup>

State costs of conducting fair hearings are matched by the federal government at 50 percent. The costs of applicants or beneficiaries or their advocates or witnesses during appeals are not subject to federal matching. Federal Medicaid matching funds also are available for payments for services continued pending the appeal, to carry out hearing decisions, for corrective action taken prior to a hearing, and for services provided within the scope of the federal Medicaid program and made under court order.

### **Adequate Notice of State Agency Actions**

The Medicaid state agency appeals process typically begins when the agency sends a notice of action to an applicant or beneficiary (see Figure 1, p. 9). Written notice of appeal rights is required at the time of an application for benefits and any time the state agency takes an action that affects a person's claim for benefits. Notice also is required when a nursing facility proposes a resident's transfer or discharge and when the state makes an adverse determination in the preadmission screening and annual resident review process. However, notice is not a prerequisite for an individual to appeal, and individuals can ask for a hearing without waiting to receive a notice. Time limits for an individual to submit an appeal (discussed below) do not begin to run until a required notice has been issued. All notices must advise the individual of the right to a hearing, describe the method for requesting a hearing, and explain that the individual may represent herself or be represented by legal counsel, a relative, a friend, or another spokesperson. CMS recognizes that beneficiaries may have difficulty representing themselves at hearings and directs state agencies to be informed and advise beneficiaries about legal services agencies or other sources of representation.<sup>7</sup> CMS also directs that written notices of appeal rights should contain a translation in a language understood by beneficiaries who are not familiar with English and that face-to-face interviews should include an oral explanation of appeal rights in understandable language.<sup>8</sup>

#### **Text Box 2:**

##### **Sources of Medicaid Appeals Procedures**

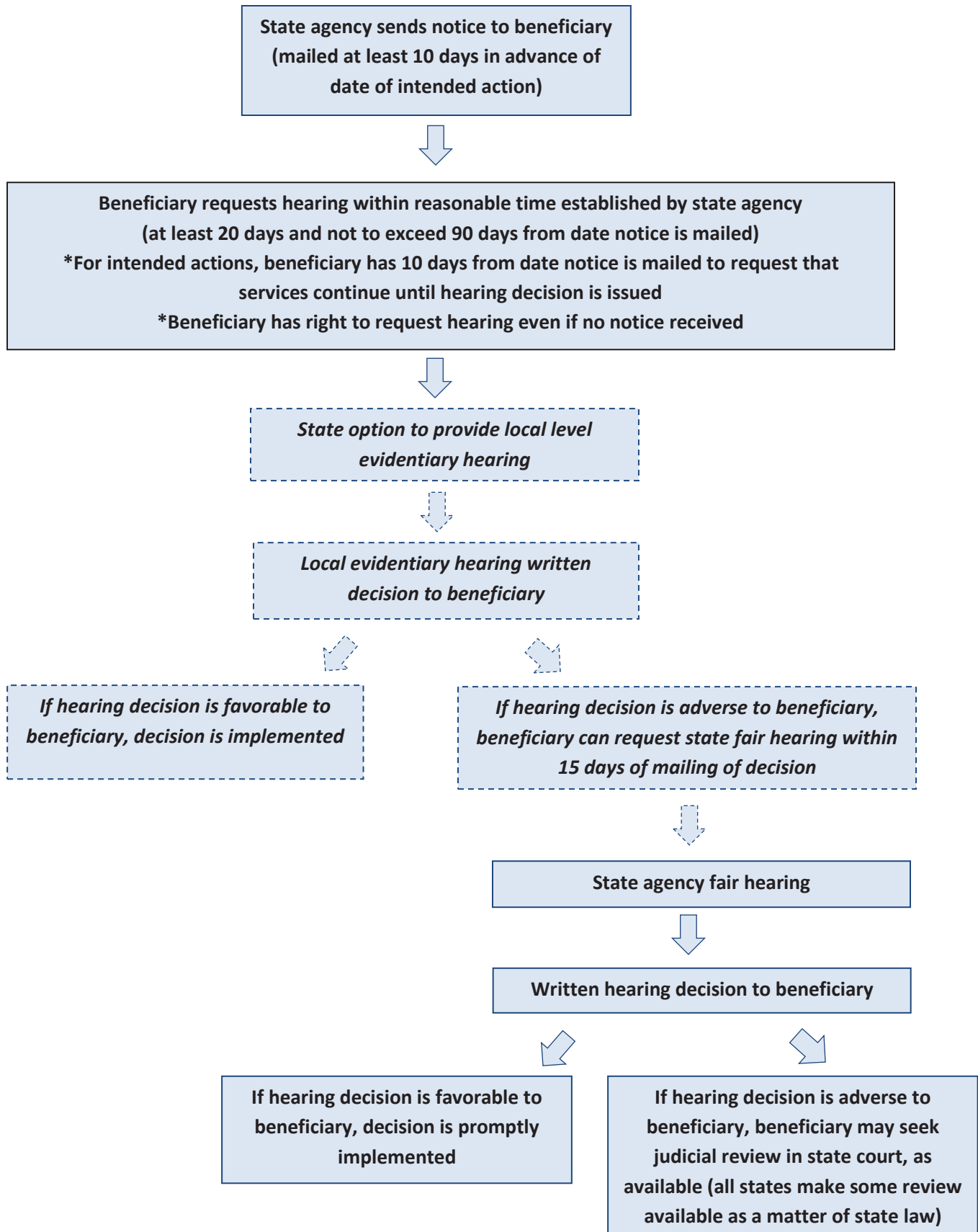
- Federal Medicaid Act, 42 U.S.C. § 1396a(a)(3)
- Federal regulations, 42 C.F.R. § § 431.200-431.246 (state agency appeals) and 42 C.F.R. §§ 438.400-438.424 (managed care appeals)
- CMS State Medicaid Manual, §§ 2900.1 -2904.2
- State statutes, if any
- State regulations and/or policy manuals
- Federal and state court decisions

When a state agency intends to terminate, suspend or reduce an individual's Medicaid eligibility or covered services, the agency must provide a notice that describes the action the state intends to take, the reasons for the intended action (including *both* the law or policy supporting the proposed action *and* the individual facts that make such law or policy applicable), the specific regulations or law that support or require the action, the individual's right to request a hearing, and the circumstances under which benefits will continue if a hearing is requested. For intended actions, the state agency generally must mail the notice to the beneficiary at least 10 days before the date of the action, except in limited circumstances.<sup>9</sup> The required elements and timing of adequate written notice are summarized in Table 1.

**Table 1:**  
**Required Elements and Timing of Written Notice**

	<b>When applying for benefits</b>	<b>When agency intends to take action affecting claim for benefits, such as termination, suspension, or reduction of eligibility or covered services</b>
Statement of intended action		X
Reasons for intended action		X
Citation to specific regulations that support, or change in law that requires, action		X
Explanation of right to request a hearing	X	X
Method by which hearing can be requested	X	X
Right to represent oneself or be represented by legal counsel, relative, friend or other spokesperson	X	X
Explanation of circumstances under which benefits will continue if hearing requested		X

**Figure 1:  
State Agency Appeals Process**





## Hearing Requests and Continuing Benefits Pending Appeal

The next step in the state agency appeals process is for the beneficiary to request a hearing (Figure 1, p. 9). A case example involving a fair hearing request in response to a Medicaid eligibility denial is described in Text Boxes 3 and 4 below. While a hearing request typically is made in response to a notice of action, it is important to note that a beneficiary has the right to request a hearing in the circumstances listed in Text Box 1 (p. 6), regardless of whether a notice is received. A hearing request is a clear statement by a beneficiary or her authorized representative for the opportunity to present her case to a reviewing authority. The state Medicaid agency may require hearing requests to be in writing and may assist applicants and beneficiaries in submitting hearing requests. Hearings must be requested within a reasonable period of time established by the state agency, not to exceed 90 days from the date that the notice of action is mailed. CMS considers time periods of less than 20 days from the date of mailing of the notice to be unreasonable. Hearing requests may be denied or dismissed by the state agency only if the individual withdraws the request in writing or if she fails to appear at a scheduled hearing without good cause. The state agency must be able to document that an individual's decision to withdraw a hearing request, or to waive any other due process right (e.g., to a decision within specified time limits) is voluntary and is informed by an awareness of the person's rights and the consequences of the decision.

Beneficiaries who are currently receiving services have the right to request that services continue during an appeal until a hearing decision is issued. This is often called “aid paid pending” or “continued benefits.” To invoke this right, a beneficiary must request a hearing before the date of the state agency's intended action, within the 10 day advance notice period. However, aid pending an appeal is not available if the sole issue at the hearing is one of federal or state law or policy, as opposed to issues of fact or judgment such as the proper application of state law or policy to the facts of an individual's case. For example, if the federal law were to change and no longer provide Medicaid benefits for people with incomes above an amount that is currently covered, continued benefits would not be available because the termination of benefits resulted from a change in federal law.

After the 10 day advance notice period expires, a beneficiary still may ask for a hearing, until the expiration of the time period to do so, but the state agency may implement its decision to reduce or discontinue services while the appeal is pending. The state agency may reinstate and continue services until a hearing decision is issued, if a beneficiary requests a hearing within 10 days after the date of action. Services also must be reinstated if the state agency takes action without issuing the required notice. If a beneficiary receives

### **Text Box 3:**

#### **Example of a Medicaid Eligibility Denial Fair Hearing – Susan's Story, Part 1 – Notice and Hearing Request**

Susan is pregnant with her first child and living in a domestic violence shelter. She applied for Medicaid, and the state agency required her to produce information about her own income and that of her estranged husband. The agency notified her that she is ineligible because the couple's combined income exceeds the Medicaid income limit. Susan appealed and asked for an expedited hearing, based on the urgency of her need for prenatal and obstetrical care.

continued services while the appeal is pending, and the state agency's decision ultimately is upheld at the hearing, the agency may seek to recoup from the beneficiary the cost of any services provided while the appeal was pending. The availability of aid pending appeal is summarized in Table 2.

**Table 2:**  
**Availability of Aid Pending Appeal**

	<b>State agency <u>must</u> continue benefits pending appeal</b>	<b>State agency <u>may</u> continue benefits pending appeal</b>
Beneficiary requests hearing within 10 day advance notice period, before date of agency's intended action, unless sole issue of federal or state law or policy	X	
Beneficiary requests hearing within 10 days after date of agency action		X
State agency takes action without issuing required notice	X	

### **State Agency Hearing Process and Decisions**

The state Medicaid agency decides whether to offer only an administrative fair hearing, as required by *Goldberg*, or a local level evidentiary hearing with the right to appeal to an administrative fair hearing (Figure 1, p. 9). State agencies may offer local level evidentiary hearings only in some political subdivisions and not in others. A local evidentiary hearing may provide an additional opportunity to obtain relief more quickly than a fair hearing, or it may be an additional hurdle, delaying beneficiary access to a fair hearing. If a beneficiary loses at a local level evidentiary hearing, the state agency must provide a written hearing decision that summarizes the facts and identifies the regulations supporting the decision. A beneficiary has the opportunity to request a state fair hearing in writing within 15 days of the mailing of an adverse evidentiary hearing decision. The beneficiary also has the option to request that the state fair hearing be *de novo*, meaning that the state fair hearing will begin anew with the opportunity to present testimony and evidence. If the beneficiary does not request a *de novo* hearing, the state fair hearing may consist only of a review of the local evidentiary hearing record to determine whether that decision is supported by substantial evidence, without considering any new testimony or evidence.

All hearings must be conducted at a reasonable time, date and place and only after adequate written notice of the hearing is provided. CMS directs state agencies to make special provisions for the convenience of beneficiaries, such as holding hearings at client homes for people who are homebound or live far away from the usual hearing site.<sup>10</sup> If beneficiaries are unable to attend hearings in person, telephone hearings are permissible provided that due process rights, such as those listed in Text Box 5 (p. 14), are observed. If a hearing involves medical issues, such as a diagnosis, an examining physician's report, or a medical review team decision, the state agency must pay for a medical assessment other than the assessment performed by the individual who made the original decision, if the hearing officer considers such an assessment necessary. CMS directs that medical sources in these assessments shall

be satisfactory to the beneficiary.<sup>11</sup> Independent medical assessments become part of the hearing record either through a written report or expert testimony.

Applicants, beneficiaries and their representatives have a number of important procedural rights associated with state fair hearings. They must have the opportunity to examine the contents of their case file and all documents and records to be used by the agency at the hearing, both at a reasonable time before the hearing date and during the hearing. The state agency also must make available the specific policy materials necessary for an applicant, beneficiary or her representative to determine whether to request a hearing and to prepare for a hearing. At the hearing, applicants and beneficiaries must be allowed to bring witnesses, establish all pertinent facts and circumstances, present an argument without undue interference, and question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses. CMS advises state agencies to refrain from using the rules for the conduct of the hearing to suppress beneficiaries' claims.<sup>12</sup> State agencies must make provisions to secure an interpreter for beneficiaries with limited English proficiency.<sup>13</sup> The state Medicaid agency may respond to a series of individual hearing requests by conducting a group hearing in cases in which the sole issue is one of federal or state law or policy, provided that each person is able to present her own case.

Hearing officers need not be lawyers but must be impartial individuals who have not participated in the initial determination of the action in question. Hearing decisions must be in writing. Decisions must be based exclusively on the evidence introduced at the hearing, which means that the hearing officer cannot be influenced by *ex parte* communications received outside the hearing. (This ban on *ex parte* communications may pose challenges for hearing officers who are not lawyers, because they must resolve issues of law or evidence without resort to legal counsel outside of the hearing.) The hearing record consists of only the transcript or recording of the testimony and exhibits, or an official report of the substance of what happened at the hearing, all papers and requests filed in the proceeding, and the hearing officer's recommendation or decision. Hearing decisions may be made by the highest executive officer of a state agency, a panel of agency officials, or the hearing officer. Beneficiaries must have access to the hearing record at a convenient time and place. *De novo* state fair

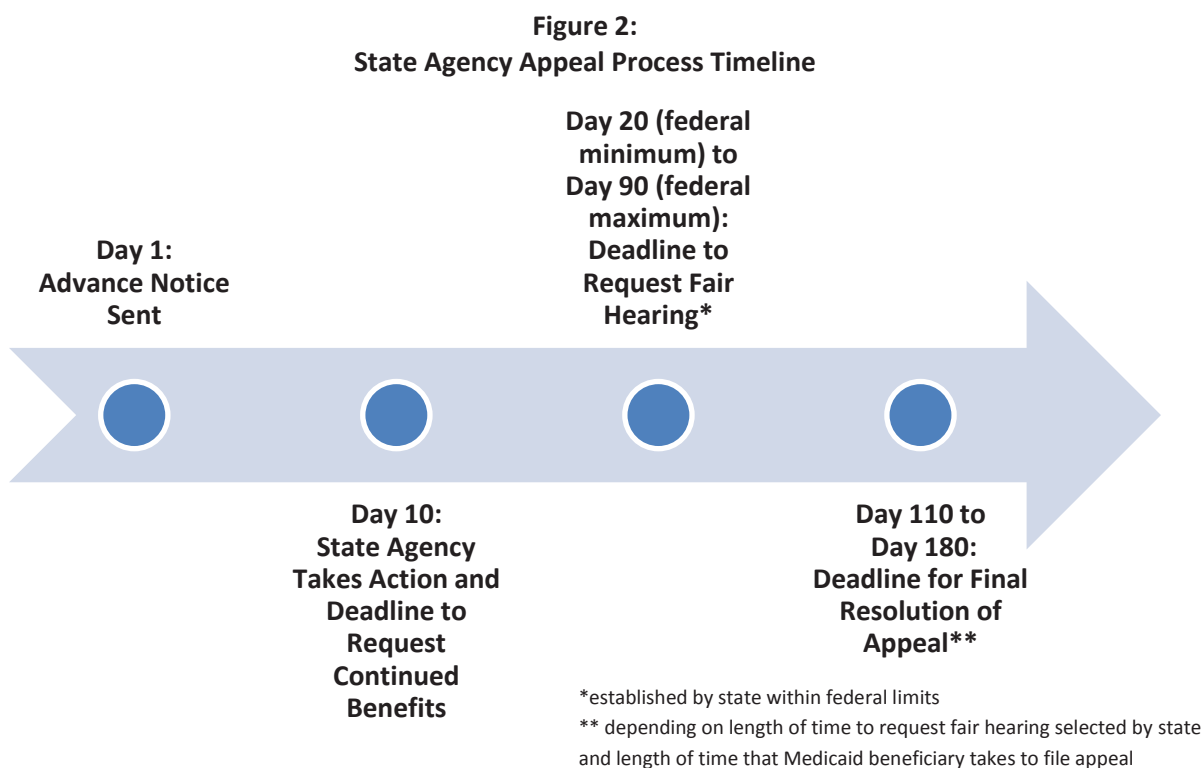
#### **Text Box 4:**

##### **Susan's Story, Part 2 – State Fair Hearing**

At her fair hearing, the case worker who had handled Susan's Medicaid application testified about how Susan's financial eligibility was calculated. Susan was accompanied by her parents and a former neighbor, all of whom testified that Susan's husband had physically abused her. Each side had the chance to ask questions of the other side's witnesses, and the hearing officer also asked questions. In a written decision mailed after the hearing, the hearing officer ruled that the husband's income should not have been counted when determining Susan's Medicaid eligibility and reversed the state agency's decision to deny coverage. Susan was found eligible retroactive to the beginning of her pregnancy when she had first applied for coverage, and Medicaid reimbursed the clinic for the cost of the visits she already received, in addition to covering her future medical care.

hearing decisions (after local evidentiary hearings) must specify the reasons for the decision and identify the supporting evidence and regulations.

Hearing decisions are binding on state agencies. If a hearing decision is favorable to the beneficiary, or if the agency decides in the beneficiary's favor before the hearing, the agency must promptly make corrective payments, retroactive to the date the incorrect action was taken. If the hearing decision is not favorable, the agency also must notify beneficiaries of their right to seek judicial review in state court to extent it is available (all states make some judicial review of administrative hearing decisions available as a matter of state law). The agency must take final administrative action on appeals within 90 days of the date that the beneficiary asked for a fair hearing. However, the hearing officer has the discretion to grant delays up to 30 days at the beneficiary's request or if necessary medical evidence cannot be obtained within 90 days. The timeline for an appeal of a state Medicaid agency decision through the fair hearing process is illustrated in Figure 2.



CMS advises state agencies that they may reopen and revise final eligibility determinations upon the written request of an applicant, beneficiary, or her representative alleging good cause within one year or when the state agency has information that the prior determination is incorrect or there is other good cause.<sup>14</sup> Good cause means the existence of new and material evidence that was not considered at the time of the prior determination and that demonstrates facts that may result in a different conclusion, even though the prior determination was reasonable when made; or clerical error in mathematical computations; or error apparent from the face of the evidence. State agencies may reopen prior decisions at any time if there is evidence of fraud.



The public must have access to all agency hearing decisions, although confidential beneficiary information must be safeguarded. Applicant and beneficiary rights associated with state fair hearings are summarized in Text Box 5.

**Text Box 5:**  
**Applicant/Beneficiary Appeal Rights**

- To a state fair hearing, if requested within applicable time limits
- To receive adequate written notice of state agency decisions
- To represent oneself or be represented by legal counsel, a relative, friend or other spokesperson
- To request that services continue until a hearing decision, if requested within applicable time limits
- To receive written notice of the hearing, which is to be scheduled at a reasonable time, date and place
- To have appeals decided by an impartial hearing officer
- To examine the case file and all documents and records to be used by the agency at the hearing, before and during the hearing
- At the discretion of the hearing officer, to obtain an independent medical assessment, at the program's expense, of the medical issues presented by the appeal
- To bring witnesses
- To establish all pertinent facts and circumstances
- To present argument without undue interference
- To question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses
- To receive a written hearing decision based exclusively on the evidence at the hearing
- To access the hearing record at a convenient time and place
- To receive corrective payments retroactive to the date of an incorrect action
- To seek judicial review as available

### **Medicaid Managed Care Appeals Process**

A fair and efficient appeals process is especially important in the context of capitated managed care, where there are economic incentives to underserve and where the majority of beneficiaries is mandatorily enrolled and realistically cannot “vote with their feet.” States are increasingly administering their Medicaid programs through capitated managed care delivery systems, and Medicaid managed care enrollment is expected to grow dramatically in the next few years due to the Affordable Care Act’s Medicaid expansion in 2014, and CMS’s demonstrations to integrate care for people dually eligible for Medicare and Medicaid, both of which will affect populations with complex and costly health care needs.

In addition to the state fair hearing process described above, supplementary appeal procedures are available to Medicaid managed care enrollees. These additional appeals procedures apply only to Medicaid managed care organization (MCO) enrollees and not to beneficiaries enrolled in primary care case management models. The MCO's obligations regarding appeal procedures should be specified in the MCO's contract with the state Medicaid agency, which should be available as a matter of public record. Enrollees can learn about their MCO's specific process through their member handbook, the MCO's website, or by calling the MCO's customer service department.

The federal Medicaid Act requires MCOs to establish internal appeal procedures for enrollees to challenge the denial of coverage or payment for medical assistance. These internal appeal procedures may provide an additional opportunity to obtain relief more quickly than a fair hearing, or they may be an additional hurdle, delaying beneficiary access to a fair hearing. MCO actions subject to appeal include the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner as defined by the state agency; the failure of an MCO to resolve grievances and appeals within the required timeframes; and for residents of rural areas with only one MCO, the denial of an enrollee's request to obtain services outside the network. MCOs also must provide access to the state fair hearing system and establish a grievance process. MCO enrollees may file grievances to express dissatisfaction about matters that are not subject to appeal, such as the quality of care or services provided or a provider or employee's rudeness or failure to respect enrollee rights. It is important to note that many actions, or inactions, that might be characterized as "quality" issues, such as delays in treatment, are in fact adverse actions affecting Medicaid benefits and thus are subject to the notice and hearing requirements of appeals. The types of review available to MCO enrollees in various circumstances are summarized in Table 3 below.

**Table 3:**  
**Types of Review Available to Managed Care Enrollees**

	<b>MCO Appeal</b>	<b>State Fair Hearing</b>	<b>MCO Grievance</b>
MCO denial or limited authorization of requested service	X	X	
MCO reduction, suspension or termination of previously authorized service	X	X	
MCO denial of payment for a service in whole or in part	X	X	
MCO failure to provide services in timeframe established by state	X	X	
MCO failure to resolve grievances or appeals in timeframe established by state	X	X	
MCO denial of request to obtain services outside network for enrollees in rural areas with only 1 MCO	X	X	
Enrollee dissatisfaction about quality of care or services provided			X
Provider or MCO employee failure to respect enrollee rights			X
MCO denial of enrollee request for expedited appeal			X
Other matters about which enrollee is dissatisfied that are not subject to MCO appeal			X

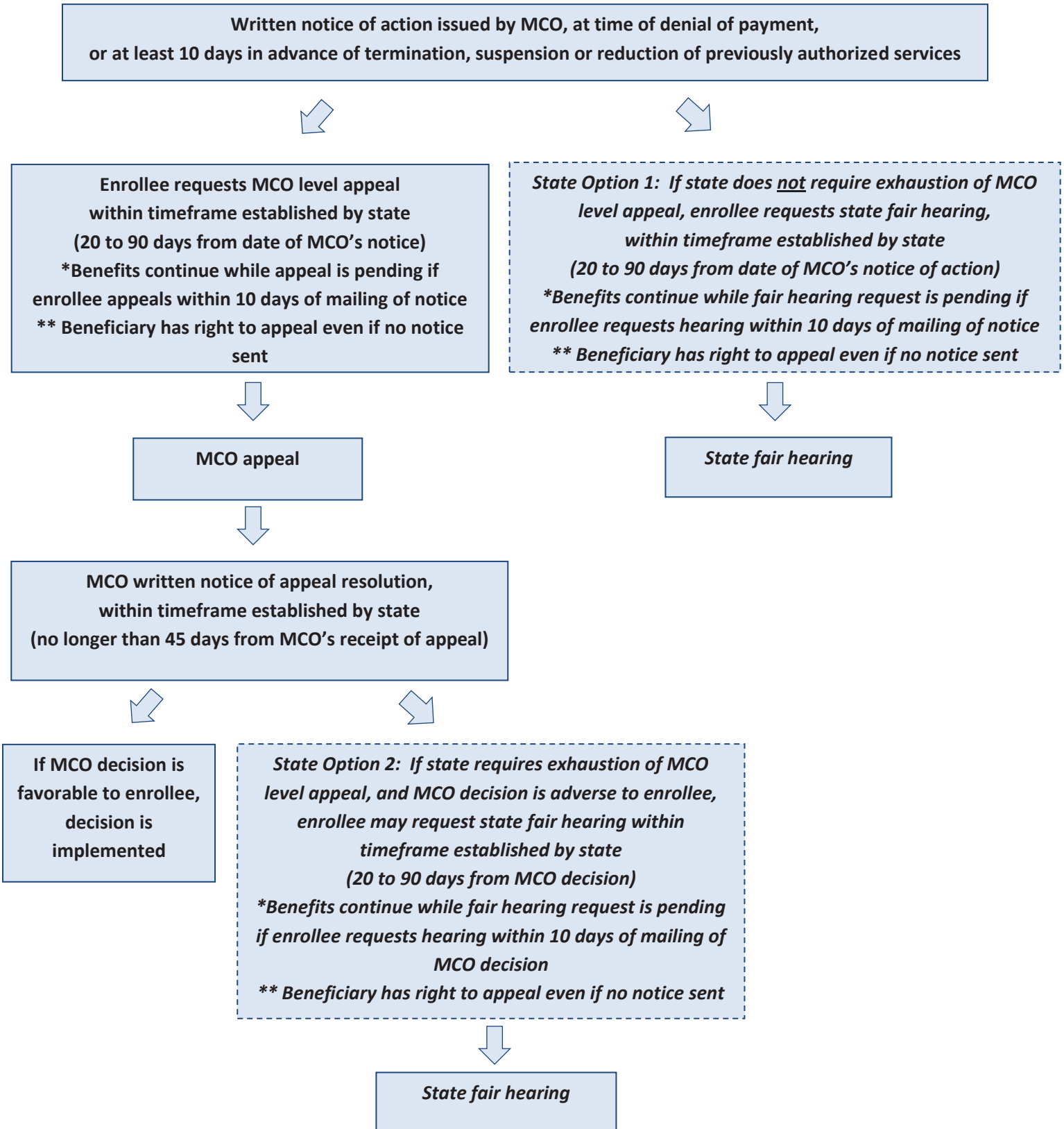
#### *MCO Notices of Action*

The MCO appeals process begins with a written notice of action (Figure 3, p. 17). MCO notices must use easily understood language and formats, must be available in the prevalent non-English languages spoken by enrollees in the MCO service area, as determined by the state, and must be available in alternative formats, such as those appropriate for people with visual limitations or with limited reading proficiency. An MCO notice must explain the action the MCO has taken or intends to take, the reasons for the action, the enrollee or provider's right to file an appeal, the enrollee's right to request a state fair hearing if the state does not require exhaustion of MCO appeals first, the procedures for exercising MCO appeal rights, the circumstances under which expedited resolution is available and how to request it, and the enrollee's right to continued benefits pending appeal, how to request continued benefits, and the circumstances under which enrollees may be required to pay the costs of continued benefits. The required contents of MCO notices of action are summarized in Text Box 6. As in the state fair hearing context, notice is not a prerequisite for an individual to appeal, and individuals can ask for a hearing without waiting to receive a notice.

**Text Box 6:**  
**Required Contents of MCO Notices of Action**

- Explanation of the action
- Reasons for the action
- Right to file MCO appeal
- Right to request state fair hearing (if exhaustion of MCO appeal process not required first)
- Procedures for exercising MCO appeal rights
- When expedited resolution is available and how to request it
- Right to continue services pending appeal, how to request it, and when enrollee liable to repay

Figure 3:  
Managed Care Appeals Process





Different timeframes apply to the mailing of MCO notices, depending upon the type of decision. Notices of decisions to terminate, suspend or reduce previously authorized services generally must be mailed at least 10 days before the date of the action, except in limited circumstances.<sup>15</sup> Notices of denial of payment must be mailed at the time of any action affecting the beneficiary's claim. Notices regarding decisions to deny or limit services in response to standard service authorization requests must be mailed as expeditiously as the enrollee's health condition requires and within state-established timeframes that may not exceed 14 calendar days of receipt of the service request. However, decisions on service authorization requests must be expedited if a provider indicates, or the MCO determines, that the standard decision timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. In such cases, notice of the MCO's decision must be provided as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the service request. Both the standard and expedited service request timeframes may be extended by 14 additional calendar days if requested by the enrollee or provider or if the MCO justifies (to the state agency upon its request) a need for additional information and how the extension is in the enrollee's interest. If the MCO extends the decision timeframe, it must provide written notice to the enrollee and inform the enrollee of her right to file a grievance about its decision to extend the timeframe. Service authorization decisions that are not made within the required timeframes are treated as denials. The timeframes required for mailing notices of various types of MCO decisions are illustrated in Figure 4 (p. 19).

#### *MCO Appeal Requests and Continued Benefits Pending Appeal*

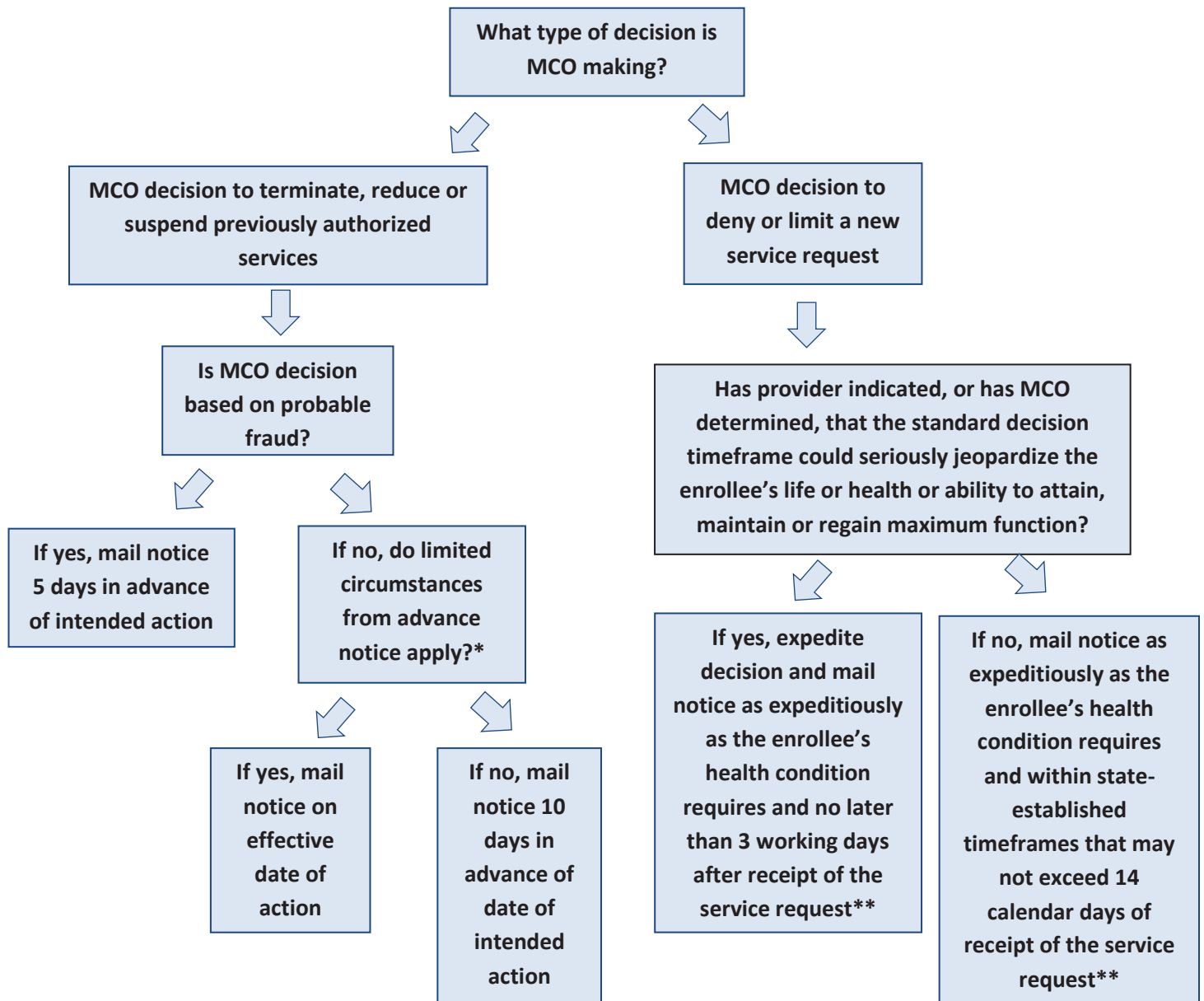
An MCO enrollee, or a provider acting on her behalf and with her written consent, may file an MCO appeal (Figure 3, p. 17). A case example of an MCO service termination appeal is described in Text Boxes 7, 8, and 9. Providers also may file grievances or state fair hearing requests on behalf of enrollees, if the state agency permits the provider to do so. MCOs must ensure that punitive action is not taken against providers who support an enrollee's appeal or who request expedited resolution of appeals. MCO appeals may be filed orally or in writing. Oral inquiries seeking to appeal an action must be treated as appeals to establish the earliest possible filing date. Oral appeals must be followed with a written signed appeal, unless the enrollee requests expedited resolution of the appeal (described below). MCO appeals must be filed within a reasonable timeframe established by the state agency, within 20 to 90 days from the date of the MCO's notice of action. MCOs must give enrollees any reasonable assistance with completing appeal forms and taking other procedural steps, such as providing interpreter services and toll-free numbers with adequate TTY and interpreter capability, and must acknowledge receipt of appeals.

#### **Text Box 7:**

##### **Example of an MCO Service Termination Appeal - John's Story, Part 1 - Notice**

John is a 15-year-old boy with cerebral palsy and cognitive limitations. He receives Medicaid benefits through an MCO. John's primary care doctor prescribed physical therapy services twice a week to help improve John's mobility and ability to assist in transferring from his wheelchair. John has received physical therapy for several years. Recently, John's Medicaid MCO sent a notice that says John's physical therapy services are no longer considered medically necessary and will be discontinued.

**Figure 4:**  
**Timeframes for Mailing MCO Notices of Action**



\*Limited circumstances from advance notice include the agency's receipt of factual information confirming a beneficiary's death, a beneficiary's clear written statement declining services, a beneficiary's admission to an institution where she is no longer eligible for services, returned mail with no forwarding address, the beneficiary's acceptance for services by another jurisdiction, a change in the level of care prescribed by beneficiary's physician, and an adverse preadmission screening determination.

\*\* Time period may be extended by 14 additional calendar days if requested by the enrollee or provider or if the MCO justifies (to the state agency upon its request) a need for additional information and how the extension is in the enrollee's interest; if MCO extends time period, it must provide written notice to the enrollee and inform the enrollee of her right to file a grievance about the decision to extend the decision timeframe.

The MCO must continue the enrollee's benefits while an appeal is pending in cases involving the termination, suspension or reduction of a previously authorized course of treatment ordered by an authorized provider, if the period covered by the original authorization has not expired and if the enrollee or provider files an appeal within 10 days of the mailing of the notice of action, or by the effective date of a proposed action, and requests that services continue. In these cases, benefits must continue until the enrollee withdraws the appeal; 10 days after the mailing of the MCO notice of appeal resolution, unless the enrollee timely requests that services continue while a state fair hearing request is pending; the issuance of a state fair hearing decision adverse to the enrollee; or the expiration of the time period or service limits of a previously authorized service. If the final resolution of the MCO appeal upholds the MCO's initial decision, the MCO may recover the cost of services furnished to the enrollee while the appeal was pending.

#### *MCO Appeals Process and Decisions*

MCOs have flexibility in designing their internal appeals process, provided that enrollees have a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. The MCO must afford the enrollee and her representative the opportunity before and during the appeals process to examine the enrollee's case file, including medical records, and any other documents and records considered during the MCO appeals process. Individuals who decide MCO appeals must not have been involved in any previous review and must be health care professionals with appropriate clinical expertise in treating the enrollee's condition, as determined by the state, in appeals of denials based on lack of medical necessity, grievances regarding denials of expedited appeal resolution, and cases that involve clinical issues. The state agency must require MCOs to maintain records of grievances and appeals and must review that information as part of the state quality strategy. The MCO must resolve each appeal as expeditiously as the enrollee's health situation requires and within state-established timeframes no longer than 45 days after the MCO receives the appeal in standard appeals and no longer than 3 working days after the MCO receives the appeal in expedited appeals. These timeframes may be extended by the MCO by up to 14 calendar days at the enrollee's request or if the MCO shows (to the state agency's satisfaction upon its request) the need for additional information and how the delay is in the enrollee's interest. The MCO must provide written notice to the enrollee of the reason for any extensions. The MCO must maintain an expedited appeals review process for cases

#### **Text Box 8:**

##### **John's Story, Part 2 – MCO Internal Hearing**

John's parents decide to appeal the MCO's denial. Their state requires exhaustion of the MCO appeals process before a state fair hearing. John's parents file a written request for an MCO appeal. Because John's parents ask for the appeal within 10 days of the date of the termination notice, they also are able to ask for John's benefits to continue while the appeal is pending. John's parents receive a letter with a date for them to meet with the MCO. John's parents attend the appeal meeting, which is run by one of the MCO's medical directors who was not involved in the initial decision. The MCO's nurse case manager also is there to explain why the MCO wants to discontinue physical therapy. John's parents have the chance to explain why they think therapy should continue. A few days later, John's parents receive a letter saying that the MCO has upheld its decision to discontinue services.

where the MCO determines from an enrollee's request, or the provider indicates, that the standard appeal resolution timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. If the MCO denies a request for expedited resolution, it must resolve the appeal within the standard timeframe, make reasonable efforts to provide the enrollee with prompt oral notice of the denial of expedited review and follow up with written notice of the denial of expedited review within 2 calendar days. The timeframes within which MCOs must take final action on appeals are illustrated in Figures 5 and 6 (pp. 22 and 23).

The MCO must provide written notice of the disposition of all appeals and must make reasonable efforts to also provide oral notice of decisions in expedited appeals. The written notice of appeal resolution must contain the MCO's decision and the date the appeals process was completed, and for appeals not resolved wholly in the enrollee's favor, must advise the enrollee about the right to request a state fair hearing and how to do so, the right to request that benefits continue while the fair hearing is pending and how to do so, and that the enrollee may be held liable for the cost of continued benefits if the state agency ultimately upholds the MCO's decision. If the MCO or a state fair hearing officer reverses an MCO decision to deny, limit or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires. If the MCO or a state fair hearing officer reverses an MCO decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the state must pay for those services in accordance with state policy and regulations.

#### *State Fair Hearing Requests by MCO Enrollees*

The state agency may permit MCO enrollees to request state fair hearings directly in response to MCO notices of action, or the state agency may require MCO enrollees to first exhaust the internal MCO appeal process before requesting a state fair hearing (Figure 3, p. 17). Figures 5 and 6 (pp. 22 and 23) compare the timelines for each option. State fair hearing requests must be filed within a reasonable time specified by the state within 20 to 90 days from the date of the MCO's notice of appeal resolution if the state requires exhaustion of the MCO appeal procedures, or within 20 to 90 days from the date of the MCO's notice of action if the state permits direct access to a fair hearing.

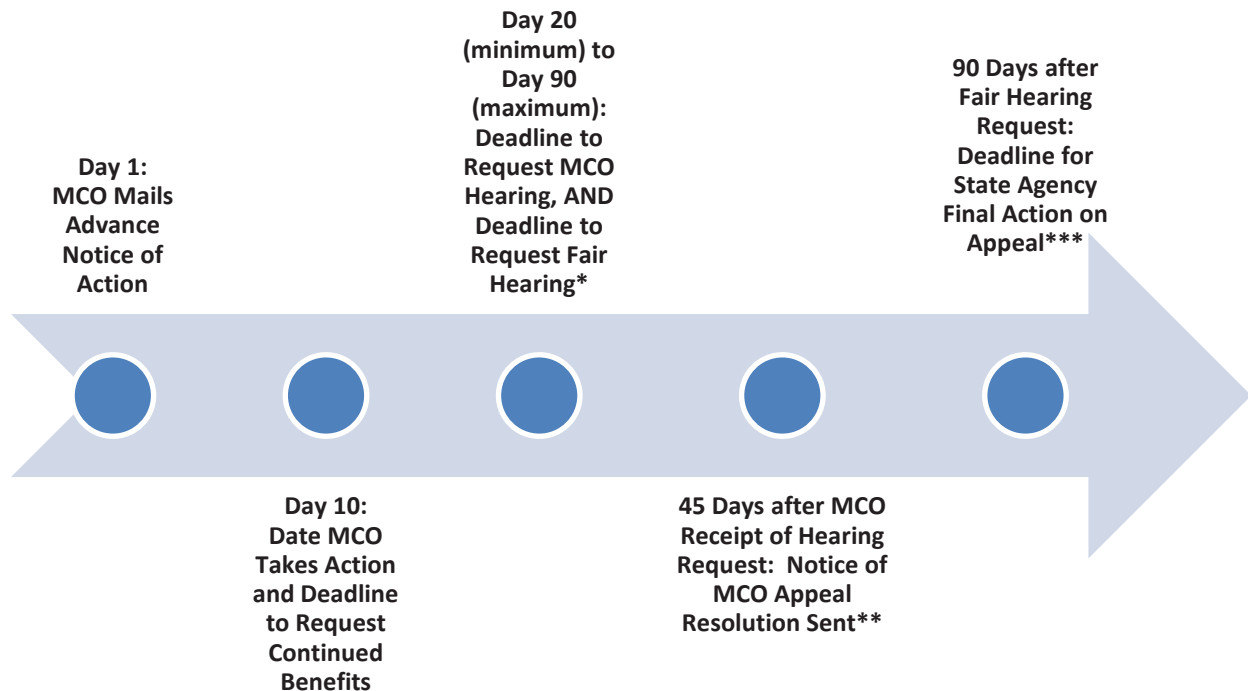
#### **Text Box 9:**

##### **John's Story, Part 3 – State Fair Hearing**

John's parents decide to ask for a state fair hearing. Again, they appeal in time to request that John's benefits continue. They also call the local legal aid office, and an attorney there agrees to take their case and represent John at the hearing. At the fair hearing, the MCO is represented by a lawyer, too. The MCO medical director and nurse case manager testify about why the MCO decided to terminate physical therapy, and John's parents also testify about why John needs services to continue. In addition, John's doctor and physical therapist provide testimony about why they believe physical therapy continues to be medically necessary for John. All witnesses are cross-examined by the opposing lawyers, and the hearing officer also asks questions. The hearing officer takes a couple of months to issue a written decision. The decision finds that the MCO has to continue to authorize physical therapy for John under Medicaid's Early and Periodic Screening Diagnosis and Treatment benefit. Because John's benefits continued while the appeal was pending, his services have not been disrupted during the appeal.



**Figure 5:  
Timeline for Managed Care Appeal Process with  
State Option for *Simultaneous* Fair Hearing**

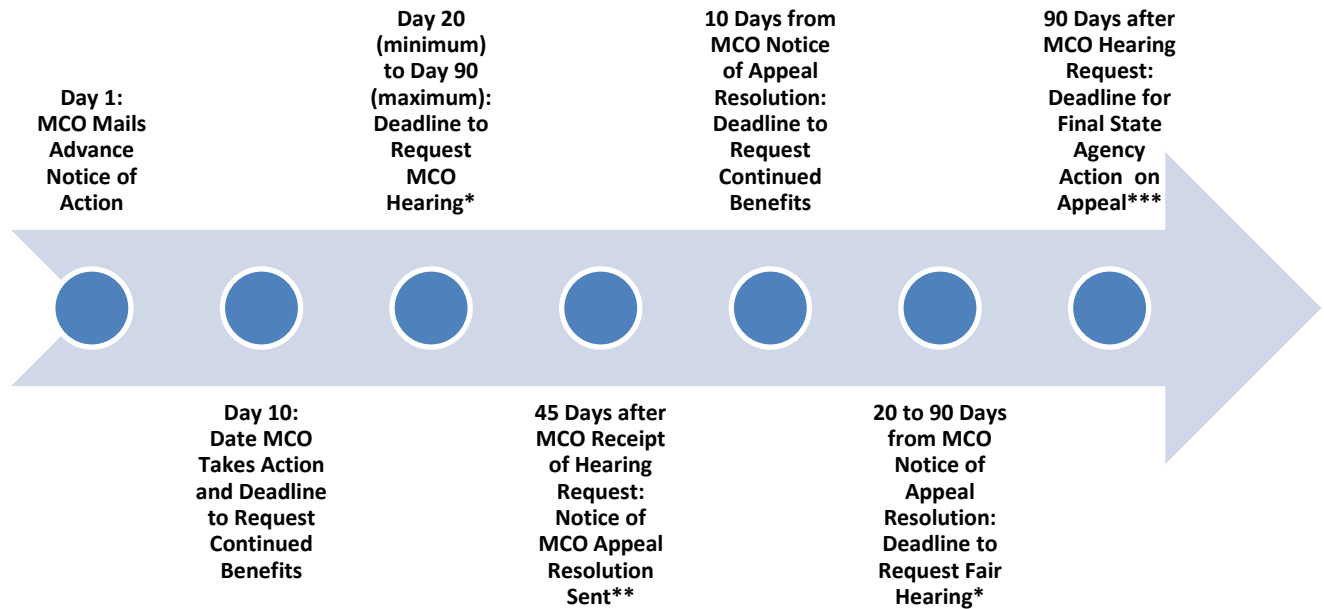


\*Established by state within federal limits

\*\*Except that expedited appeals must be resolved within state-established timeframe no later than 3 working days of MCO's receipt of appeal. Timeframes may be extended by the MCO by up to 14 calendar days if the enrollee requests or if the MCO shows (to the state agency's satisfaction upon its request) the need for additional information and how the delay is in the enrollee's interest, with written notice to the enrollee of the reason for any extensions. If the MCO denies a request for expedited resolution, it must resolve the appeal within the standard timeframe, make reasonable efforts to provide the enrollee with prompt oral notice of the denial of expedited review and follow up with written notice of the denial of expedited review within 2 calendar days.

\*\*\* Except that expedited appeals must be resolved within 3 working days after state agency receives case file and information from MCO that expedited criteria are met, but appeal was not resolved within that timeframe or was resolved within that timeframe but wholly or partially adverse to enrollee. Criteria for expedited resolution are if resolution in standard timeframe could seriously jeopardize enrollee's life or health or ability to attain, maintain or regain maximum function.

**Figure 6:**  
**Timeline for Managed Care Appeal Process with**  
**State Option for *Subsequent* Fair Hearing**



\*Established by state within federal limits

\*\* Except that expedited appeals must be resolved within state-established timeframe no later than 3 working days of MCO's receipt of appeal. Timeframes may be extended by the MCO by up to 14 calendar days if the enrollee requests or if the MCO shows (to the state agency's satisfaction upon its request) the need for additional information and how the delay is in the enrollee's interest, with written notice to the enrollee of the reason for any extensions. If the MCO denies a request for expedited resolution, it must resolve the appeal within the standard timeframe, make reasonable efforts to provide the enrollee with prompt oral notice of the denial of expedited review and follow up with written notice of the denial of expedited review within 2 calendar days.

\*\*\*Not including number of days enrollee subsequently took to request fair hearing. Expedited appeals must be resolved within 3 working days after state agency receives case file and information from MCO that expedited criteria are met, but appeal was not resolved within that timeframe or was resolved within that timeframe but wholly or partially adverse to enrollee. Criteria for expedited resolution are if resolution in standard timeframe could seriously jeopardize enrollee's life or health or ability to attain, maintain or regain maximum function.

If an MCO enrollee requests a state fair hearing, the state agency must take final administrative action within 90 days of the date the enrollee requested an MCO appeal, not including the number of days the enrollee took to subsequently request a state fair hearing, or within 90 days of the date the enrollee filed for direct access to a state fair hearing if the state does not require exhaustion of MCO appeals. In expedited appeals, the state agency must take final administrative action as expeditiously as the enrollee's health condition requires and no later than 3 working days after the agency receives from the MCO the case file and information about any appeal of a service denial that, as indicated by the MCO, meets the criteria for expedited resolution (i.e., resolution in standard timeframe could seriously jeopardize enrollee's life or health or ability to attain, maintain or regain maximum function) but was not resolved within that timeframe or was resolved within that timeframe but wholly or partially adverse to the enrollee. If the state agency permits direct access to state fair hearings, the state agency must take final administrative action as expeditiously as the enrollee's health condition requires but no later than 3 working days after the agency receives directly from an MCO enrollee a fair hearing request on a decision to deny services that the state agency determines could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function if resolved within the standard timeframe. The timeframes for final administrative action by the state Medicaid agency in fair hearings for MCO enrollees are illustrated in Figures 5 and 6 (pp. 22 and 23), and MCO enrollees' appeal rights are summarized in Text Box 10 below.

**Text Box 10:**  
**MCO Enrollee Appeal Rights**

- To request an MCO appeal, within applicable time limits
- To request a state fair hearing, within applicable time limits
- To file an MCO grievance
- To receive adequate timely written notice of MCO decisions
- To have oral inquiries about appeals treated as appeals
- To receive reasonable assistance from the MCO in completing appeal forms and other procedural steps
- To request that services continue until an appeal decision, within applicable time limits
- To request expedited review of appeals
- To have a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing
- To have the opportunity before and during the appeals process to examine the enrollee's case file, including medical records, and any other documents and records considered during the MCO appeals process
- To have MCO appeal decided by individual who was not involved in any previous review and in certain circumstances, who is a health care professional with appropriate clinical expertise
- To receive written notice of the MCO appeal decision
- To have services authorized or provided promptly and as expeditiously as the enrollee's health condition requires, and to have services received while the appeal was pending paid, if the enrollee wins her appeal

## Looking Ahead

The Medicaid appeals process provides important protections for individual applicants and beneficiaries seeking eligibility for the program and coverage of prescribed services. Monitoring of appeals at a systemic level also can provide useful management insights into program performance and opportunities for quality improvement. At the same time, the appeals process is multi-layered and can be complex to navigate. While Medicaid state agency and managed care employees become familiar with the process as repeat players and typically have access to lawyers through the state attorney general's office or private law firms, relatively few applicants and beneficiaries are represented by legal counsel in Medicaid appeals. A report issued by the Legal Services Corporation found that "[o]nly a small fraction of the legal problems experienced by low-income people (less than one in five) are addressed with the assistance of either a private attorney (pro bono or paid) or a legal aid lawyer."<sup>16</sup> Similarly, the National Center for Medical-Legal Partnership estimates that "every low-income family has an average of three unmet legal needs" and that "publicly funded legal aid agencies turn away three out of every five applicants for assistance."<sup>17</sup>

The features of the Medicaid appeals system are increasingly significant as health reform is implemented. The Medicaid appeals process is different from the appeals processes available through the Medicare program and private health insurance. Recent health reform initiatives encourage the integration of Medicare and Medicaid benefits for people who are eligible for both programs, raising questions about how appeals in integrated systems must be handled to ensure conformity with constitutional due process requirements. In addition, as of January, 2014, new health insurance affordability programs, such as premium tax credits through insurance exchanges and basic health plans provided at state option, will be available. The health reform law requires a single streamlined application for Medicaid, CHIP and benefits available through the exchanges that must assess every applicant's Medicaid eligibility before considering eligibility for other programs. Unless an individual is approved for Medicaid, every application or redetermination of an individual's eligibility for a state health subsidy will therefore trigger notice and a right, if requested, to a fair hearing. The appeals system for benefits available through the exchanges is still being developed. In addition, disputes about covered services will inevitably arise when the estimated 16 million childless adults obtain new coverage through the Medicaid expansion, many of whom will enroll at state option in Medicaid managed care organizations. Consequently, the Medicaid appeals process will continue to play an important role in ensuring that applicants and beneficiaries receive the services to which they are entitled.

This background paper was prepared by MaryBeth Musumeci of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

## Endnotes:

<sup>1</sup> This paper is based largely on the applicable federal Medicaid regulations; significant judicial precedent governing Medicaid appeals is beyond its scope. It also does not address applicants' and beneficiaries' right to sue to enforce the Medicaid Act in federal court, which may be appropriate in circumstances where beneficiaries seek a determination that state action violates federal law and/or injunctive relief, neither of which are available in the fair hearing context.

<sup>2</sup> The Fifth Amendment to the U.S. Constitution, applicable to the federal government, in pertinent part provides "No person shall. . . be deprived of life, liberty, or property, without due process of law." The Fourteenth Amendment to the U.S. Constitution in pertinent part provides ". . . nor shall any State deprive any person of life, liberty, or property, without due process of law. . . ."

<sup>3</sup> *Goldberg v. Kelly*, 397 U.S. 254, 261 (1970) (quoting *Kelly v. Wyman*, 294 F. Supp. 893, 899, 900 (S.D.N.Y. 1968)).

<sup>4</sup> *Id.*, 397 U.S. at 266 (quoting *Kelly v. Wyman*, 294 F. Supp. at 904-05).

<sup>5</sup> See also National Health Law Program, *The Advocate's Guide to the Medicaid Program*, 2.23-2.25 (May 2011). The CMS State Medicaid Manual is available at

<http://www.cms.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927&intNumPerPage=10>.

<sup>6</sup> See 42 U.S.C. § 12131 *et seq.*; 28 C.F.R. Part 35.

<sup>7</sup> CMS State Medicaid Manual, § 2900.3, available at

<https://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>.

<sup>8</sup> *Id.*, § 2900.4, available at <https://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>.

<sup>9</sup> Exceptions to the 10 day advance notice requirement include the agency's receipt of factual information confirming a beneficiary's death, a beneficiary's clear written statement declining services, a beneficiary's admission to an institution where she is no longer eligible for services, returned mail with no forwarding address, the beneficiary's acceptance for services by another jurisdiction, a change in the level of care prescribed by beneficiary's physician, and an adverse preadmission screening determination. Cases of probable fraud require 5 days advance notice.

<sup>10</sup> CMS State Medicaid Manual, § 2902.6, available at

<https://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>.

<sup>11</sup> *Id.*, § 2902.8, available at <https://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>.

<sup>12</sup> *Id.*, § 2902.9, available at <https://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>.

<sup>13</sup> *Id.*, available at <https://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>.

<sup>14</sup> *Id.*, § 2904.1, available at <https://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927>.

<sup>15</sup> The same exceptions as listed in note 9 above apply here.

<sup>16</sup> Legal Services Corporation, "Documenting the Justice Gap in America: The Current Unmet Civil Legal Needs of Low-Income Americans" (2009), available at

[http://www.lsc.gov/pdfs/documenting\\_the\\_justice\\_gap\\_in\\_america\\_2009.pdf](http://www.lsc.gov/pdfs/documenting_the_justice_gap_in_america_2009.pdf).

<sup>17</sup> Ellen Lawton *et al.*, "Disparities in Health, Disparities in Law: The Global Potential of Individual Advocacy," in *Health Capital and Sustainable Socioeconomic Development* (Patricia A. Cholewka & Mitra M. Motlagh eds., 2008).



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# Guarding Due Process: The Federal Protections of Medicaid Appeals

By Eric J. Einhart, Esq.

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Medicaid appeals are a lifeline for beneficiaries facing the loss or denial of vital health care coverage. Rooted in federal law and constitutional due process, these protections have long served as a critical check on state action. Yet over time, states have tested the boundaries and attempted to dilute these rights. With shifting politics and the fallout from *Loper Bright v. Raimondo*, elder law and special needs attorneys must be ready to defend the foundations of Medicaid appeals.

## I. The Federal and Constitutional Foundations of Medicaid Appeals

The right to appeal adverse Medicaid determinations arises from both federal statute and the Due Process Clause of the Fourteenth Amendment. The cornerstone decision, *Goldberg v. Kelly*,<sup>1</sup> held that public assistance benefits are statutory entitlements, and that recipients must be afforded a pre-termination hearing that includes: (1) timely notice; (2) the right to be heard; (3) the opportunity to present evidence; and (4) an impartial decisionmaker. These procedural protections became embedded in Medicaid law and regulation.

Under federal law and regulations, state Medicaid programs must provide a fair hearing to any individual whose claim for assistance is denied or not acted upon with reasonable promptness.<sup>2</sup> These rights apply across eligibility, service authorization, and managed care determinations. Additional requirements govern appeals in managed care settings.<sup>3</sup>

## II. The Structure of the Medicaid Appeals Process

The Medicaid appeals framework generally consists of two levels:

### 1. Internal Managed Care Appeals

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<sup>1</sup> *Goldberg v. Kelly*, 397 U.S. 254, 90 S.Ct. 1011, (1970)

<sup>2</sup> 42 U.S.C. § 1396a(a)(3) and 42 CFR §§ 431.200–431.250

<sup>3</sup> 42 CFR §§ 438.400–438.424

For Medicaid beneficiaries enrolled in Managed Care Organizations (MCOs), the first appeal is often to the MCO itself. Beneficiaries may request an appeal within 60 days of receiving an adverse benefit determination. The MCO must resolve the appeal within 30 days (or 72 hours if expedited).<sup>4</sup>

Beneficiaries may request continuation of services during the appeal if the request is made within 10 days of the notice and the service was previously authorized.<sup>5</sup>

## 2. State Fair Hearings

Whether the denial comes through fee-for-service or managed care, every Medicaid beneficiary has a right to a state fair hearing.<sup>6</sup> This hearing must be held before an impartial decision-maker and be accessible to persons with disabilities and limited English proficiency.<sup>7</sup>

Hearings must be requested within 90 days of the adverse notice,<sup>8</sup> and decisions must be made within 90 days of the request.<sup>9</sup> If expedited, a decision is due within 3 working days.

Importantly, if the appeal is filed timely, benefits must generally continue during the appeal process.<sup>10</sup>

After a Medicaid fair hearing, if the beneficiary disagrees with the decision, they may seek further review by filing an appeal in state court—typically through an administrative or judicial review process. In some cases, if federal rights are at issue, the matter may be brought in federal court.<sup>11</sup> These appeals are usually limited to the administrative record and must be filed within strict timeframes, with courts applying a deferential standard of review to the agency’s decision.

## III. Core Legal Authorities for Practitioners

Understanding and asserting the following legal sources is critical for Medicaid appeals:

Title XIX of the Social Security Act<sup>12</sup>

Regulations for fair hearings and managed care appeals<sup>13</sup>

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<sup>4</sup> 42 CFR § 438.408

<sup>5</sup> 42 CFR § 438.420

<sup>6</sup> 42 CFR § 431.220

<sup>7</sup> 42 CFR §§ 431.240, 431.205

<sup>8</sup> 42 CFR § 431.221

<sup>9</sup> 42 CFR § 431.244

<sup>10</sup> 42 CFR § 431.230

<sup>11</sup> 42 U.S.C. § 1983

<sup>12</sup> 42 U.S.C. § 1396

<sup>13</sup> 42 CFR Parts 431 and 438; 42 C.F.R. Part 431 (current through Apr. 30, 2025), available at <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-431?toc=1>; 42 C.F.R. Part 438

The State Medicaid Plan (SMP) – A binding agreement between each state and Centers for Medicare & Medicaid Services (CMS), which includes specific commitments to uphold federal rules<sup>14</sup>  
CMS State Medicaid Manual (SMM)<sup>15</sup> – Offers interpretations and implementation guidance. Courts have granted it Skidmore deference.<sup>16</sup>  
Transmittal 64 and DRA 2005 policy guidance<sup>17</sup>  
SSI Program Operations Manual System (POMS)<sup>18</sup>

#### IV. Efforts by States to Curtail Appeals Protections

Despite federal requirements to ensure due process, some states have adopted policies that effectively restrict Medicaid beneficiaries' rights to fair hearings and appeals. These practices often exploit procedural loopholes or create administrative barriers that hinder access to benefits. Notable examples include:

##### Tennessee: Unlawful Termination Without Due Process

In 2024, a federal court found that TennCare, Tennessee's Medicaid program, unlawfully terminated benefits for thousands since 2019. The court ruled that TennCare failed to provide proper notice or appeal rights during redeterminations, violating both Medicaid law and constitutional due process.<sup>19</sup>

##### Florida: Procedural Disenrollments and Inadequate Notices

Florida has come under fire for disenrolling large numbers of beneficiaries—especially children and medically fragile individuals—without sufficient notice. Many were dropped for procedural reasons, highlighting systemic flaws and raising serious concerns about fairness and transparency.<sup>20</sup>

##### North Carolina: Legislative Overrides Affecting Appeals

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(current through Apr. 30, 2025), available at <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438>

<sup>14</sup> 42 CFR § 430.10; and Medicaid.gov, *State Overviews*, <https://www.medicaid.gov/state-overviews> (current through Apr. 30, 2025).

<sup>15</sup> Centers for Medicare & Medicaid Services, *State Medicaid Manual*, <https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927> (current through Apr. 30, 2025)

<sup>16</sup> *Skidmore v. Swift & Co.*, 323 U.S. 134, 140, 65 S. Ct. 161, 164, 89 L. Ed. 124, 129 (1944); *Hughes v. McCarthy*, 734 F.3d 473, Med. & Med. Guide (CCH) ¶ 304,660 (6th Cir. 2013).

<sup>17</sup> Centers for Medicare & Medicaid Services, *CMS Manual System*, Pub. 100-00, *State Medicaid Manual*, Transmittal 64, <https://www.hhs.gov/guidance/document/cms-manual-system-transmittal-64> (current through Apr. 30, 2025)

<sup>18</sup> Social Security Administration, *Program Operations Manual System (POMS)*, <https://secure.ssa.gov/poms.nsf/home?readform> (current through Apr. 30, 2025)

<sup>19</sup> *A.M.C. v. Smith*, 620 F.Supp.3d 713 (M.D. Tenn., Nashville Div., 2022)

<sup>20</sup> *Weida v. Agency for Health Care Administration*, No. 3:23-cv-00985 (M.D. Fla. filed Aug. 15, 2023)



In 2011, North Carolina shifted final decision-making in Medicaid appeals from the state's health agency to administrative law judges.<sup>21</sup> While intended to increase independence, critics warned the move could conflict with federal requirements for centralized Medicaid oversight and jeopardize federal funding.<sup>22</sup>

### Trigger Laws – Medicaid Expansion at Risk

Nine states have enacted “trigger laws” to roll back Medicaid expansion if federal funding drops below a set threshold. While these laws have not taken effect, they create instability and could lead to sudden coverage losses, increased appeal volume, and confusion about eligibility. Importantly, even if a trigger law is activated, federal rules still require:

- Submission of a State Plan Amendment (SPA);<sup>23</sup>
- Public notice and comment;<sup>24</sup>
- Individual case assessment before termination;<sup>25</sup> and
- Proper notice and hearing rights.<sup>26</sup>

In addition, other states have employed various tactics to undermine or narrow Medicaid appeal rights such as inadequate notices,<sup>27</sup> delays and procedural barriers,<sup>28</sup> MCO interference,<sup>29</sup> and administrative inconsistencies.

Practitioners should be vigilant and use federal law as a shield against state policies or practices that are inconsistent with Medicaid's foundational due process protections.

## V. Federal Responses and Legal Remedies

CMS has responded to state-level issues through regulatory enforcement, including corrective action plans and conditioning funding to compliance with notice and appeals requirements.

Courts also play a vital—though limited—role in oversight. While judicial review is often deferential, successful challenges have reinforced that federal law prevails when states deviate from approved Medicaid plans or violate federal regulations.<sup>30</sup>

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<sup>21</sup> 2011 N.C. Sess. Laws 398

<sup>22</sup> *Piedmont Behavioral Healthcare v. Delia*, No. 5:12-CV-46 (E.D.N.C. filed Mar. 28, 2012).

<sup>23</sup> 42 CFR § 430.12

<sup>24</sup> 42 CFR § 431.408

<sup>25</sup> 42 CFR § 435.916

<sup>26</sup> 42 CFR §§ 431.200-431.250

<sup>27</sup> 42 CFR § 431.210

<sup>28</sup> 42 CFR § 431.244(f)

<sup>29</sup> 42 CFR § 438.402(b)

<sup>30</sup> *Health and Hospital Corporation of Marion County v. Talevski*, 143 S. Ct. 1444 (2023)

Practitioners should frame appeals around federal compliance, not just state rule interpretation. Citing CMS guidance, federal law, and case precedent can strengthen the argument and shift the legal analysis in your favor.

#### A. CMS Corrective Action Plans: Scope and Effectiveness

CMS uses Corrective Action Plans (CAPs) to address state noncompliance with federal Medicaid rules. Under federal law, when CMS identifies deficiencies states must submit a CAP detailing corrective steps. CMS must approve or reject the plan within 21 days, and implementation is required upon approval.<sup>31</sup>

States with high error rates following a Payment Error Rate Measurement (PERM) review must also submit separate CAPs for Medicaid and CHIP, targeting the root causes of improper payments.<sup>32</sup>

While some states implement CAPs successfully, others show ongoing deficiencies, prompting continued federal oversight and, in some cases, sanctions or funding adjustments.<sup>33</sup>

#### B. Judicial Review: The Role of Chevron Deference

Historically, courts applied the *Chevron* doctrine, deferring to federal agencies' reasonable interpretations of ambiguous statutes.<sup>34</sup> In Medicaid cases, this often meant courts upheld CMS's reading of complex regulations, limiting judicial review of state disputes.

That changed with the U.S. Supreme Court's 2024 decision in *Loper Bright Enterprises v. Raimondo*,<sup>35</sup> which overturned *Chevron*. Courts now have greater authority to interpret statutes independently, opening the door to increased judicial scrutiny of both federal and state Medicaid policies.

#### C. Notable Judicial Interventions Upholding Medicaid Protections

Despite the historically deferential stance, courts have occasionally played a pivotal role in reinforcing Medicaid protections in cases such as, *Arkansas Dep't of Human Services v. Ahlborn*,<sup>36</sup> *NFIB v. Sebelius*,<sup>37</sup> *Kadel v. Folwell* and *Fain v. Crouch*.<sup>38</sup>

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<sup>31</sup> 42 CFR § 430.49

<sup>32</sup> 42 CFR § 431.992

<sup>33</sup> 42 CFR § 431.992 and 42 CFR § 430.35

<sup>34</sup> *Chevron U.S.A., Inc. v. Natural Resources Defense Council*, 104 S. Ct. 2778 (1984),

<sup>35</sup> *Loper Bright Enterprises v. Raimondo*, 144 S. Ct. 2244 (2024)

<sup>36</sup> *Arkansas Dep't of Human Services v. Ahlborn*, 126 S. Ct. 1752 (2006)

<sup>37</sup> *NFIB v. Sebelius*, 132 S. Ct. 2566 (2012)

<sup>38</sup> *Kadel v. Folwell*, No. 22-1721, and *Anderson v. Crouch*, No. 22-1927 (4th Cir. Apr. 29, 2024)

These cases underscore the judiciary's capacity to uphold beneficiary rights and ensure state compliance with federal Medicaid standards.

#### D. Recommendations for Practitioners

Elder law and special needs planning attorneys are essential in protecting Medicaid beneficiaries' rights. As the legal landscape evolves, practitioners should:

1. Anchor arguments in federal statutes, emphasizing rights to fair hearings and timely care.
2. Cite key federal regulations outlining notice, hearing, and benefit continuation requirements.
3. Challenge state reliance on informal CMS guidance lacking the force of law.
4. Build a strong factual and legal record during administrative hearings to support potential judicial review.
5. Stay current with case law and be ready to litigate when state policies conflict with federal mandates.
6. Leverage the State Medicaid Plan to enforce binding federal obligations.

Applying these strategies helps ensure due process and improves outcomes in Medicaid appeals.

#### **Conclusion**

The Medicaid appeals process is a vital safeguard for vulnerable individuals. In the evolving legal landscape –especially post-*Loper Bright*– elder law and special needs planning attorneys must stay vigilant. Grounding arguments in statute, relying on binding regulations, and challenging unsupported agency actions will be key to protecting due process and ensuring fair treatment for beneficiaries.

About the Author:

*Eric J. Einhart, Esq., is a partner with the Russo Law Group, P.C., who practices elder law and special needs planning in the New York metro area. He is the incoming President of the 2025-2026 NAELA Board of Directors.*

## Elements of the Medicaid Appeals Process under Fee for Service—Iowa

**Notes:** Data are based on publicly available policy documentation identified between January and November of 2017.

Follow-up contact was made with state Medicaid employees to clarify policies that either could not be found or were unclear.

Every attempt was made to find the most recent data; however, not all recent data was publicly available. Many policies may have been developed years earlier and may not be in current practice.

Please contact MACPAC at 202-350-2000 to report errors or changes.

Source date reflects the effective date of the policies where available, otherwise it reflects the documentation date.

NF is none found; NA is not applicable; the Department refers to the Department of Human Services.

**Source:** Data collected by MACPAC staff

[Back to Summary](#)

Key elements	Summary data	Source language	Sources and websites	Source date	Date last searched
Prehearing					
Notice of action	Not less than 10 days before action to reduce, terminate, or suspend services	Whenever the Department proposes to terminate or reduce ongoing food assistance, financial assistance, Medicaid, or services, give timely and adequate notice of the pending action, except as listed under Dispensing With Timely Notice. "Timely" means that the notice is mailed at least ten calendar days before the date the action becomes effective. The timely notice period begins on the day after the notice is mailed.	Iowa Department of Human Services. Appeals and Hearings. <a href="https://dhs.iowa.gov/sites/default/files/1-E.pdf">https://dhs.iowa.gov/sites/default/files/1-E.pdf</a>	1/26/2007	2/6/2018
Filing an appeal	NF	NF	NF	NA	2/6/2018
Resolving the appeal	NF	NF	NF	NA	2/6/2018
Requesting/scheduling a hearing					
Requesting a fair hearing	Request must be received within 30 days from the date of the notice of action	A hearing will be held if the appeal is filed within 30 days after official notification of an action or before the effective date of the action.  When the appeal is filed more than 30 days, but less than 90 days after notification, the director will determine whether a hearing will be held.	Iowa Department of Human Services. Appeals and Hearings. <a href="https://dhs.iowa.gov/sites/default/files/1-E.pdf">https://dhs.iowa.gov/sites/default/files/1-E.pdf</a>	4/12/2013	2/6/2018
Scheduling a fair hearing	Upon receipt of fair hearing request a written notice of hearing will be sent by mail containing necessary information regarding the hearing. The hearing will take place by phone. No timeline specified for notice	If you are eligible for a hearing, the Appeals Section will send your appeal file to the Department of Inspections and Appeals-Division of Administrative Hearings. They will schedule a telephone hearing and send you a written notice of the date and time.	Iowa Department of Human Services. After Appeal Filed. <a href="https://dhs.iowa.gov/appeals/after-appeal-filed">https://dhs.iowa.gov/appeals/after-appeal-filed</a>	2017	2/6/2018
Post-hearing					
Receipt of decision	Action to carry out the decision will be taken within 90 days from the date of the appeal request.	Once the Administrative Law Judge has made a decision on your appeal, a Proposed Decision will be issued. It will explain the issue of the appeal, a brief summary of the testimony given during the hearing, and the judge's decision.  Prompt, definite and final administrative action to carry out the decision rendered shall be taken within 90 days from the date of the appeal.	(A) Iowa Department of Human Services. Appeals Decision: <a href="https://dhs.iowa.gov/appeals/decision">https://dhs.iowa.gov/appeals/decision</a>  (B) Iowa Department of Human Services. Appeals and Hearings. <a href="https://dhs.iowa.gov/sites/default/files/1-E.pdf">https://dhs.iowa.gov/sites/default/files/1-E.pdf</a>	(A) 2018 (B) 4/12/2013	2/6/2018
Optional level for rehearing or reconsideration	Reconsideration is available for the proposed decision if filed within 10 calendar days. Further, rehearing may be requested within 20 days after the date of the final decision.	If you disagree with the Proposed Decision, you may request a review. Your attorney, representative or yourself may request a review. The Department also may request a review if they disagree with the Administrative Law Judge's decision. Write a letter stating that you want to request a review and send or fax it to the Appeals Section at the address below. It must be postmarked, faxed or emailed within 10 calendar days of the date on the Proposed Decision.  Additionally, the appellant may request a rehearing within 20 days after the date of the final decision. The DHS director determines if the rehearing is to be held.	(A) Iowa Department of Human Services. Appeals Decision: <a href="https://dhs.iowa.gov/appeals/decision">https://dhs.iowa.gov/appeals/decision</a>  (B) Iowa Department of Human Services. Appeals and Hearings. <a href="https://dhs.iowa.gov/sites/default/files/1-E.pdf">https://dhs.iowa.gov/sites/default/files/1-E.pdf</a>	(A) 2018 (B) 5/1/2015	2/6/2018
Adverse decision	To petition the final decision in district court you must file within 30 days of the date on the final decision.	When the appellant is dissatisfied with the final decision, the appellant may file for judicial review in their county of residence or Polk County. A request for judicial review must be filed in the district court within 30 days of the date of the final decision.	Iowa Department of Human Services. Appeals and Hearings. <a href="https://dhs.iowa.gov/sites/default/files/1-E.pdf">https://dhs.iowa.gov/sites/default/files/1-E.pdf</a>	5/1/2015	2/6/2018
Continuation of benefits	Benefits may be continued if an appeal is filed within 10 days of the notice of action	Assistance shall not be reduced, restricted, discontinued, or terminated, nor shall a license or registration be revoked, or other proposed adverse action be taken pending a final decision on an appeal when: ♦ The appellant files an appeal within the timely notice period. ♦ The appellant files an appeal within 10 days from the date adequate notice is issued for termination, reduction, or suspension of services, Food Assistance, Family Investment Program or Medicaid based on the completed monthly report. If adequate notice is required, benefits may be continued if the appeal is filed within ten days of the date of the notice. When timely and adequate notice is required, benefits may be continued if the appeal is filed before the effective date of the notice.	Iowa Department of Human Services. Appeals and Hearings. <a href="https://dhs.iowa.gov/sites/default/files/1-E.pdf">https://dhs.iowa.gov/sites/default/files/1-E.pdf</a>	2/13/2009	2/6/2018



# Federal Protections for Medicaid Appeals

Vincent J. Russo, Esq. and Eric J. Einhart, Esq.





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# We Will Cover...



- Legal Foundations
- State Actions to limit Appeals
- Federal Remedies
- Practical Considerations of a Fair Hearing



# Federal and Constitutional Foundations

- Due Process Clause of 14<sup>th</sup> Amendment
- Goldberg v. Kelly
  - Timely notice
  - Right to be heard
  - Opportunity to present evidence
  - Impartial decision maker
- Federal statute and regulations



# Structure of Medicaid Appeals Process

- Internal Managed Care Appeals
- State Fair Hearings
- Appeals in State Court





# Core Legal Authorities

- Title XIX of Social Security Act
- Regulations for fair hearings and managed care appeals
- State Medicaid Plan (SMP)
- CMS State Medicaid Manual (SMM)
- Transmittal 64 and DRA 2005 policy guidelines
- SSI POMS



# Efforts by States to Limit Appeals Protections

- Tennessee
  - unlawful termination without due process
- Florida
  - procedural disenrollment and inadequate notices
- North Carolina
  - legislative overrides affecting appeals
- Trigger laws



# Federal Responses and Legal Remedies

- CMS - Corrective action plans
- Judicial review
- Notable judicial interventions



# Recommendations for Practitioners

- Anchor arguments in federal statutes
- Cite key federal regulations
- Challenge informal guidance
- Build strong factual/legal record
- Monitor relevant case law
- Litigate state-federal policy conflicts
- Leverage SMP to enforce federal obligations



# Right to a Fair Hearing

- Medicaid Applicant/Recipient's Right to Challenge Local Medicaid Agency:
  - Determination
  - Action
  - Failure to Act





# Notice Requirements

- Adequate Notice
- Contents of Notice
- Timely Notice
- Exceptions to Timely Notice



# Agency Conference “Reconsideration”

- Informal Meeting
- Reserve Right to a Fair Hearing



# Requesting Fair Hearing

- Procedures for a Request
- Time to Request a Fair Hearing
- Withdrawing / Abandonment



# Aid Continuing

- Right to Aid Continuing
- Timing
- Exceptions
- Right to Return Home and Receive Care



# Scheduling a Fair Hearing / Location

- Notification
- Where Held - Location
- Priority
- Adjourning





# Notice of a Fair Hearing

- Content
- Rights
- Timing



# Burden of Proof / Evidence

- Appellant has Burden of Proof
- Substantial Evidence
- Consolidation



# Who May be Present

- Parties and their Representatives
- Media Presence



# Responsibilities of Local Medicaid Agency

- Documentary Evidence
- Appearance
- Authority to Make Binding Decision



# Hearing Officer

- Employed by the State
- Removal





# Hearing Record

- Electronic Recording (transcript)
- Request for Record



# The Decision

- Must be in Writing
- Content
- Decision without a Hearing



# Adverse Decision: Reopening a Decision

- Corrective Decision
- Request to Reopen



# Fair Hearing: Precedents

- Not subject to Judicial Stare Decisis



# Judicial Review

- Court Review
- Timing to Request Review
- Appeal of an Adverse Decision

# QUESTIONS?







# Federal Protections for Medicaid Appeals

## Have a Great Day!

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*Center for Elder Justice*

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# **2025 Fundamentals of Special Needs Trusts Administration Webinar**

**Friday, May 30, 2025**

**2:30-3:20 pm**

## **Protecting Beneficiaries from Financial Mismanagement**

**Presenter: Peter Wall and Bradley Frigon**

- PowerPoint



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2025 Fundamentals of Special Needs Trust Administration

# Protecting Beneficiaries from Financial Mismanagement

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True Link Financial Advisors, LLC is an SEC -registered investment advisor and wholly owned subsidiary of True Link Financial Inc. Financial Advisors, LLC provides the investment advisory services, True Link Financial, Inc. provides the prepaid Visa cards well as the trust administration software and recordkeeping portal software ("True Link Platform"). The companies shall be referred to herein collectively as "True Link". When providing investment management services to special needs trust clients, the client is the Trust, not the individual trust beneficiaries.





**Bradley J. Frigon**

Law Offices of Bradley J. Frigon, LLC

## Presenter's Bio

- 43 years practicing attorney
- Focus in the elder law arena
- Extensive experience across estate planning, estate and probate litigation, special needs planning, guardianship and conservatorship matters, Medicaid, and taxation
- Nationally recognized expert in special needs planning and tax issues
- Master of Laws in Taxation
- Licensed to Practice Law in Colorado, Wyoming and Kansas
- Co-Author Fundamentals of Special Needs Trusts

### Associations:

- Past-President of the National Academy of Elder Law Attorneys (NAELA)
- NAELA fellow
- Appointed member of the Special Needs Alliance for Colorado and Wyoming
- Counsel for the Colorado Fund for People with Disabilities
- Fellow of the American College of Trust and Estate Counsel (ACTEC)
- Certified Elder Law Attorney (CELA)
- Colorado, Wyoming and Kansas Bar Associations



**Peter J. Wall**

Director of Fiduciary Services  
True Link Financial Advisors, LLC

# Presenter's Bio

20 years of professional trust administration - Focus in Elder Law & SNT Planning

## Prior to joining True Link Financial Advisors, LLC:

- Developed and helped lead an Elder Law and SNT division of an \$80 billion nationally chartered trust bank
- Past President of the Centennial Estate Planning Council
- Member of the Board of Directors for Easter Seals
- Past President of VSA Access Gallery
- Member of the Academy of Special Needs Planners

## Special needs trusts, estate planning, taxation, and trust administration faculty member and presentations include:

- 2016, 2018-2025 Stetson National Conference on Special Needs Planning and Special Needs Trusts
- CBA 2012, 2014, 2015, 2017 & 2022 CBA Elder Law Retreat
- 2013 National Down Syndrome Congress
- 2015 46th Annual Autism Society National Conference
- 2022 Schwab IMPACT®
- 2017, 2021, 2023 National Conference for National Guardianship Association
- 2019, 2020, 2024 Special Needs Alliance
- 2019, 2020, 2021 & 2025 National NAELA Conference
- 2024 Federal Financial Institutions Examination Council (FFIEC) Annual Conference, Washington, DC
- 2020, 2021, 2022 & 2023 PFAC Annual Conference



## Attorney Calvin Curtis, Salt Lake City - \$12,779,496

- SALT LAKE CITY — Attorney Calvin Curtis of Salt Lake City, was sentenced to serve 97 months in federal prison by a U.S. District Court Judge today. Curtis was ordered to pay **\$12,779,496 in restitution to the 26 victims of his crimes and sentenced to an additional three years of supervised release upon his release from federal prison.**
- Curtis previously **pleaded guilty in November of 2021, to embezzling millions of dollars from clients of his estate planning law firm based in Salt Lake City**, known as Calvin Curtis Attorney at Law PLLC, and [Curtiselderlaw.com](http://Curtiselderlaw.com). By the time of his sentencing, it had been discovered that **Curtis had embezzled over \$12 million dollars from his former clients who prosecutors say are elderly, incapacitated, or disabled individuals.**
- In the plea agreement, Curtis admitted that he is an attorney who specialized in special needs trusts and that beginning in January 2008, he began a fraudulent scheme to defraud a client known as "G.M." out of money. **Curtis admitted that due to his role, he had access to millions of dollars in two different trust accounts belonging to victim G.M., and that he transferred at least \$9,500,000 intended for the care of G.M. into his own accounts, and then used this money for his own personal use.** Curtis admitted that he also created fake financial statements and submitted these to the court ordered conservator of G.M. to conceal the fraud.
- Assistant United States Attorneys prosecuted the cases against Curtis and Special Agents from the IRS Criminal Investigation and FBI conducted the investigation.

## Attorney General Bonta Announces Arrest of a Licensed Fiduciary for Stealing \$2.5 Million from Clients

- LOS ANGELES — California Attorney General Rob Bonta, together with Los Angeles Police Department (LAPD), today announced the arrest of and charges against a licensed **Professional Fiduciary who stole over \$2.5 million dollars from 12 clients in assets she was hired to protect and manage. The suspect managed many special need trusts, conservatorships and power of attorney involving adult dependents or elderly clients that relied on her to provide fiduciary services. The suspect allegedly transferred money from a special needs or conservator account into her own personal account for personal use.**
- “Bad actors who prey on the most vulnerable in our state will be brought to justice,” said Attorney General Bonta. “Our elders deserve to be treated with dignity, not as puppets to further the agendas of selfish individuals. The California Department of Justice is committed to defending the rights of our most vulnerable and holding their abusers accountable.”
- The investigation conducted by LAPD and DOJ's White Collar Investigation Team (WCIT) found that the suspect managed many Special Need Trusts and Conservatorships involving adult dependents or elder clients that rely on her to provide fiduciary services. **Evidence showed that the suspect transferred money from a Special Needs /Conservator Account and into her own personal account for personal use. This resulted in a collective loss to 12 victims in the amount of 2.5 million dollars.**





# The Center for Special Needs Trust Administration (The Center)

- Innocent until proven guilty
- For purposes of this presentation, we will examine the complaint. *The following slides contain allegations only*

## Case Management Items:

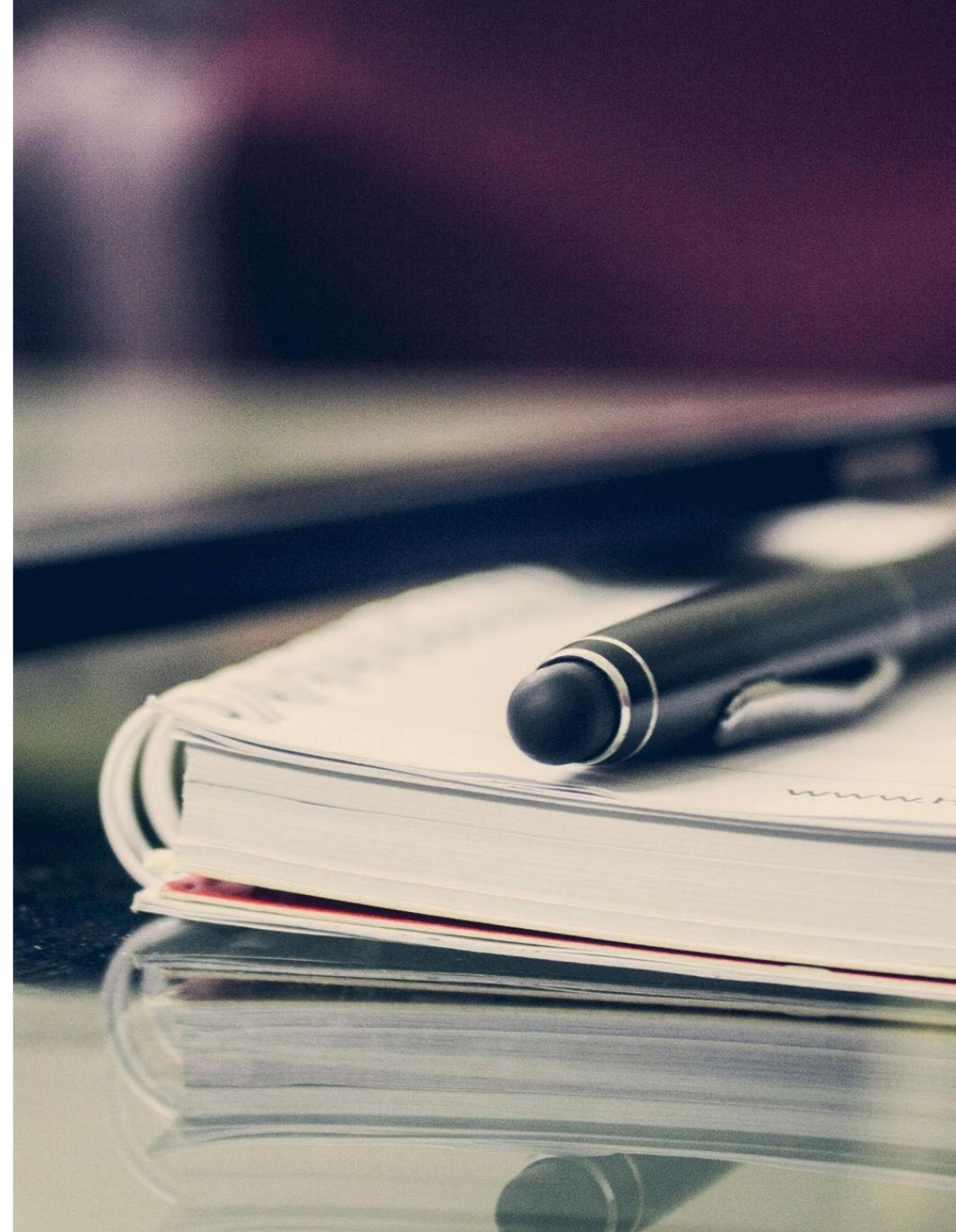
- The Center is a 501(c)(3) non-profit corporation in FL which administers pooled and non-pooled SNTs
- The Center administers over 2,000 SNTs with assets under management
- The Center filed for Chapter 11 bankruptcy on October 12, 2024
- The Center's leadership discovered \$100 million of funds under its control was paid out as a loan - taken from over 1,000 beneficiaries and The Center itself



# The Center

## Case Management Items (alleged):

- \$100 million loan in question was made to the Boston Finance Group (BFG), a company controlled by The Center's Founder, Leo Govoni
- BFG and Govoni allegedly undertook a multi-year effort to access Center's funds while ensuring beneficiaries did not receive proper disclosure, and made no meaningful attempts to repay the loan
- Center filed Chapter 11 bankruptcy to:
  - Provide beneficiary notice
  - Allow Center to pursue recovery
  - Facilitate ongoing investigation and administration of trusts
  - Preserve value of current assets and restructure the organization
- Note and Credit Agreement matured Jan 1, 2017. BFG failed to pay the Note on maturity date.
  - Periodic interest payments and an alleged small principal reduction payment were made to The Center
  - BFG continued to receive advances from The Center and its SNTs until late 2020
- Govoni and John Staunton were directors of The Center through early- to mid-2009





# The Center

## Control/Oversight

### Case Management Items (alleged):

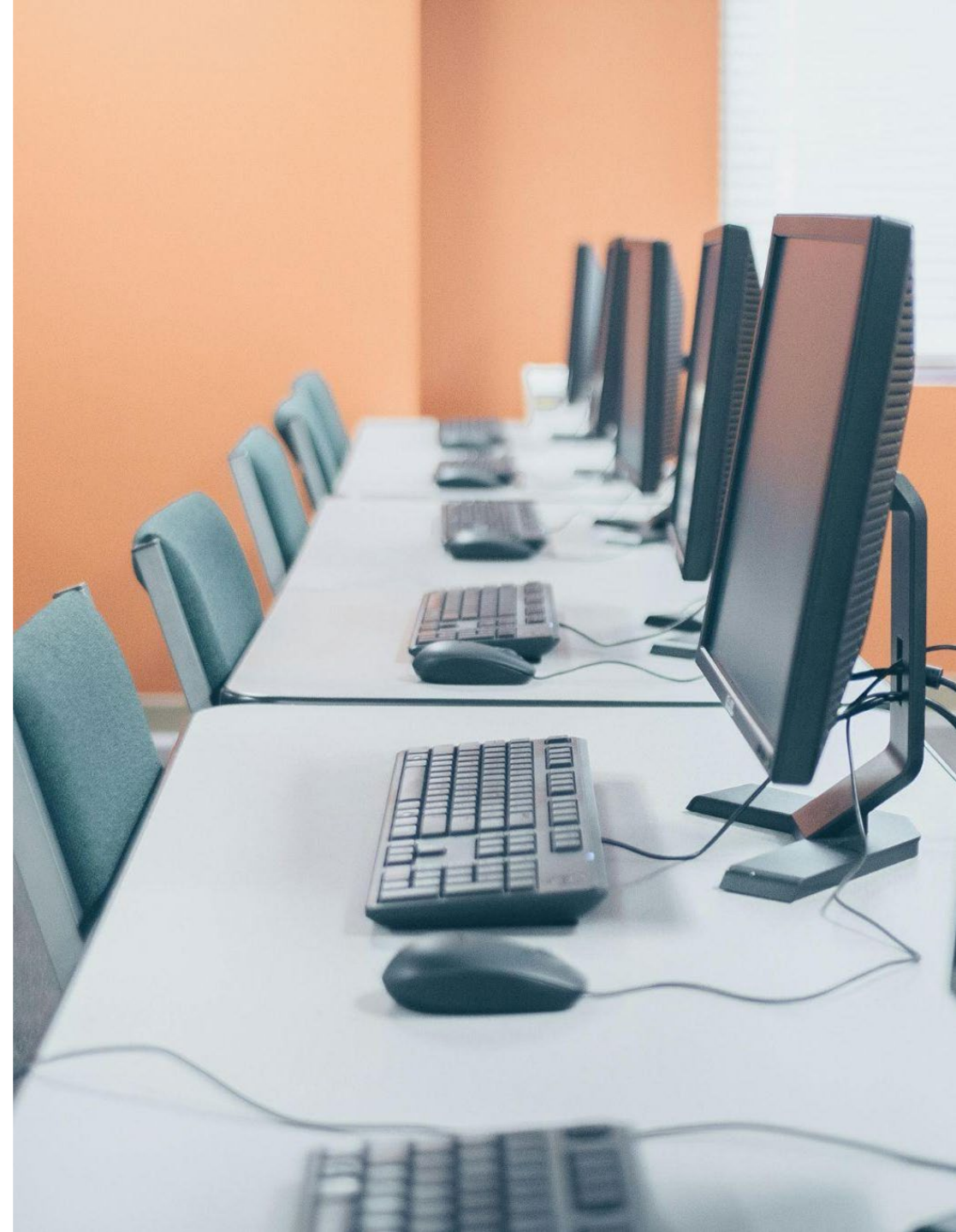
- Govoni's control over The Center's finances:
  - Center employees would knowingly or unknowingly assist Govoni in transferring funds to BFG
  - Control of outside entities in charge of operations and financial reporting
- Employee Tracy Gregory
  - Employed by Boston Settlement Group (owned by Govoni) and The Center (2008 - 2020)
  - Had full access to The Center's bank accounts and financial records in her position as accounting manager
  - Allowed the purported \$100M to be transferred
- Financial Disclosures/Accountings
  - Required at least annually
  - The Center retained accounting firm Fiduciary Tax & Accounting Services, LLC (FTAS)
    - Purportedly owned by John Witeck
    - Actually formed by Govoni, Golden was listed as registered agent of FTAS per FL Secretary of State, Govoni currently hold majority interest in FTAS
    - FTAS has prepared trust accountings for The Center since FTAS' founding, and 95% of FTAS' work comes from The Center - billing approximately \$650,000 annually to The Center

# The Center

## Technology

### Case Management Items (alleged):

- The Center hired Austin Colby Co. for its IT and HR needs
  - Austin Colby is owned and operated by Govoni
  - Austin Colby only services entities affiliated with Govoni
  - Austin Colby controlled The Center's electronics, computer network, and records
    - Including employee access to any electronic systems and records
- In re: HR, Austin Colby's services were comprehensive
  - Employees of The Center were at times employees of Austin Colby's
  - Allowed Govoni to control hiring and firing of The Center's employees, including his daughter, Caitlin Janicki (former head of case management and Vice President of The Center)





# The Center

## Discovery/Resolution

### Case Management Items (alleged):

- Govoni's daughter Caitlin Janicki resigned in April, 2022
  - Left behind an unsigned letter dated November 11, 2021, from BFG to The Center's Board of Directors seeking to modify the terms of the Note by extending the maturity date and reducing its interest payments (well after initial maturity)
- After Janicki's resignation, Govoni approached The Center's Board and attempted to take control of The Center. The Board rejected this proposal.
- Then, Govoni suggested a "Third Party Agreement" to the Board for The Center to be run and managed by Global Litigation Services, LLC (controlled by Govoni). The Board rejected this proposal.
- Finally, Govoni proposed that Jonathan Golden (BFG partner, FTAS agent) run The Center with a significant salary. The Board rejected this proposal.
- The Board terminated Austin Colby's services during this time period.
  - Austin Colby subsequently prevented The Center from accessing their electronic books and records
  - It is believed that due to Austin Colby's conduct, The Center has lost access to many critical records and documents

# The Center

## Discovery/Resolution

### Case Management Items:

- Leo Govoni found liable for \$122 million in missing funds by Middle District of Florida
  - Judgment allows bankruptcy trustee to leverage Govoni's assets to recoup funds
  - Issues a restraining order barring Govoni from selling assets tied to 100+ companies he owns
  - Requires BFG to pay all "reasonable attorney's fees and costs incurred in collecting under the promissory note"
- Edward Peterson III, attorney with Johnson Pope Bokor Ruppel & Burns, counsel for Leo Govoni filed a motion to withdraw citing "irreconcilable differences"
  - Motion asks that "all current deadlines and hearings be continued" for 60 days





# How to Select a Pooled Trust

1. Review Form 990
2. Organizational structure
  - a. Independent Board of Directors
3. Has the Pooled Trust adopted a Best Practices Procedure?
4. External Audit Firm
5. Independent Investment Advisor
6. Published Fee Schedule
7. Types of Insurance in Place





# Overview

- Beneficiary competence/oversight
  - Statement comprehension/financial literacy
  - Communication from trustee
  - Other fiduciaries (e.g., guardian, conservator, agent under POA, etc.)
  - Support network
- Attorney Trustees
- Trust Protectors
- Trust Advisory Committees
- Supported Decision-Makers
- Delegated vs. Directed Investment Management
- Fiduciary Exception to Privilege
- Regulatory Issues



# Beneficiary:

## Beneficiary Social / Emotional Health:

- Emotional wellness
- Community connections
- History with prior trustee (as applicable)
- Meeting: in-person or virtual
- Family dynamics
- Other fiduciaries
  - Guardian, conservator, agent under POA, etc.
- Financial Literacy
  - Statement frequency/comprehension
- Undue Influence







# Multidisciplinary Issues

Elder Law inherently involves multidisciplinary focus across social work, finance, criminal justice, psychology, fiduciary administration, public benefits, etc., to include consultations with:

- Social workers
- Geriatric care managers
- Case managers
- Discharge planners
- Financial advisors
- CPAs
- Agents under POA
- Doctors
- Family members
- Supported Decision -Makers

## ABA Model Rule 1.6

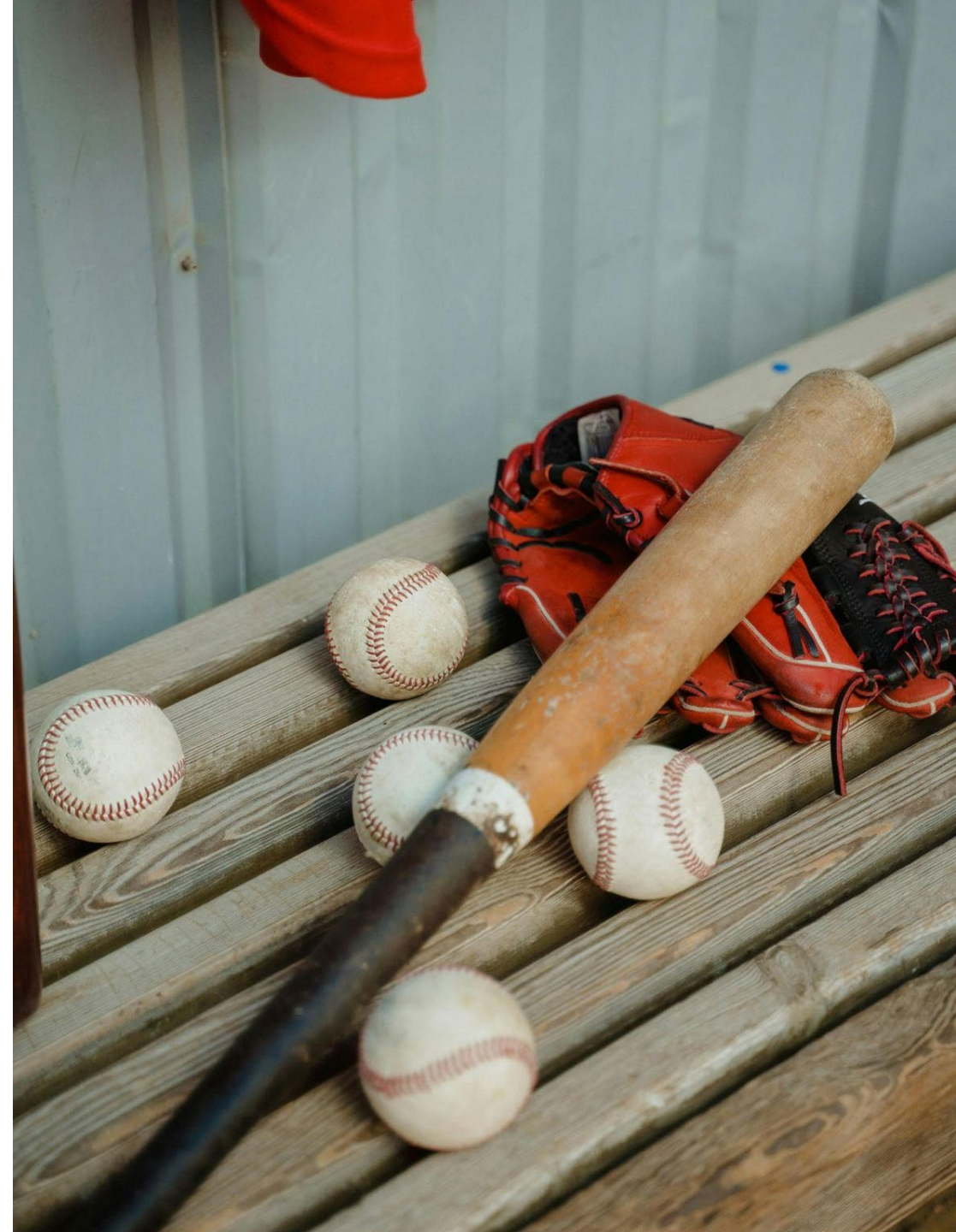
- a) "A lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent."
- b) Lawyers may "reveal information relating to the the representation of a client to the extent the lawyer reasonably believes necessary":
  - To prevent reasonably certain death or substantial bodily harm
  - To prevent the client from committing a crime or fraud
  - To secure legal advice for the lawyer in terms of compliance with the Model Rules
  - To comply with other law or court order



# Multidisciplinary Issues

## Who's On First?

- *Trustee*: assets titled in the trust
  - *Guardian*: protected person's living situation, health care decisions, well-being
  - *Conservator*: assets not titled in trust
  - *Agent under Power of Attorney* : assets not titled in trust if no conservator
  - *Co-Trustee*
  - *Supported Decision -Maker*: none







# Attorney Trustee

## May serve per ABA Model Rules of Conduct (Model Rules)

- Rule 5.7 (b)(9) - Services performed by attorneys such as “title insurance, financial planning, accounting, [and] trust **services...** ” [emphasis added] are “law-related services.”
  - Not the practice of law
  - Immediate appointment, testamentary, co-trustee, successor trustee

## Requires full disclosure in writing

- Materially limited representation (Rule 1.7)
- *TIP: Document and disclose client capacity and undue influence particulars.*

## Inherent conflict of interest:

### Rule 1.7

“A lawyer shall not represent a client if the representation involves a concurrent conflict of interest.”

- Representation of one client is directly adverse to another client
- Materially limited representation by the attorney’s responsibilities to another client, third person, or personal interest of the attorney

### Rule 1.7(b)

Notwithstanding the conflict-of-interest provisions “the lawyer may represent a client if”:

- they provide competent and diligent representation to each affected client
- not prohibited by law
- free of claims in the same litigation or proceeding
- informed consent confirmed in writing



# Trust Protector

- Promotes settlor intent and beneficiary involvement
- May remove trustee
- May amend trust document for changes in law, public benefits, etc.
- May weigh in on discretionary distributions
- Supporters/Family Members may act Trust Protector
  - Best Practice: identify any conflicts of interest (e.g., remainderperson, housemate, etc.)
- Note: inherent conflict of interest
- **TIP:** avoid Materially Limited Representation

## From Bradley J. Frigon, JD, LL.M (tax), CELA, CAP:

“The Trust Protector may amend any provision of this Agreement, as it applies to any Trust for which the Trust Protector is serving, pursuant to [subsequent restrictions]. Notwithstanding the foregoing, the Trust Protector may not amend this Agreement in any manner that would make Trust corpus or income available to the Beneficiary for Medicaid eligibility. Further, the Trust Protector may not limit or alter the rights of the Beneficiary in any Trust assets held by the Trust before the amendment, nor may the Trust Protector remove or add any individual or entity as a beneficiary of any Trust asset.”



# Trust Protector

- Other common powers:
  - Removal or replacement of trustee (with or without cause)
  - Trust amendment
  - Mediating agent between trustees and beneficiaries
  - Amend distribution provisions
  - Add beneficiaries in the event of additional descendants
  - Receive/review statements
  - Direct and delegate investment decisions
  - Hiring and dismissing agents of the trust
  - Authority over business decisions for companies owned by the trust

**TIP:** Consider provisions to allow Trust Protector to add co-trustee
- Advisory capacity
  - Rights vs. duties
  - Indemnify for acts or omissions to act on the part of trustee
- Not a general power of appointment - IRC § 2041, 2514

**TIP:** Review liability, E&O, malpractice insurance!





# Trust Protector

- Duties
  - Remain current on public benefits regulations
  - Remain current on tax law
  - Review and assess unique assets
    - Beneficiary-occupied residence, commercial real estate, promissory notes, mineral interests, closely held business, etc.
  - Assess beneficiary diminished capacity/undue influence
    - Guardianship/conservatorship
  - Review financial statements
    - Tax returns
    - Statements
    - Discretionary distributions
    - Trust longevity
  - Address beneficiary support system
  - Meet with other fiduciaries (guardians, conservators, etc.)
  - Review trust no less than annually with trustee
    - To include reporting requirements to applicable agencies





# Trust Protector

## Should the drafting attorney appoint himself/herself as Trust Protector?

- Conflict waiver
- Fee for serving as TP
- Dual Role as Attorney and TP
- Can you draft away your liability
- Adverse with Trustee-Beneficiary
- What is your escape plan?

“Serving in the capacity of Trust Protector shall not prevent our Trust Protector from also providing legal, investment or accounting services on behalf of the trust or the trust beneficiaries. If our Trust Protector is providing professional services, our Trust Protector is entitled to charge its normal and customary fees for legal services rendered or to be rendered and in addition is entitled to be compensated for its services as Trust Protector.”

- *Wealth Counsel*



“The authority of our Trust Protector is conferred in a nonfiduciary capacity; and, our Trust Protector shall not be liable for any action taken in good faith. Our Trust Protector shall not be liable for any act or omission to act and shall be reimbursed promptly for any costs incurred in defending or settling any claim brought against it in its capacity as Trust Protector unless it is conclusively established that the act or omission to act was motivated by an actual intent to harm the beneficiaries of the trust or was an act of self-dealing for personal pecuniary benefit.”

- *Wealth Counsel*



# Removing a Trustee

“Our Trust Protector shall have the authority to remove any Trustee of a trust created under this agreement. Whenever the office of Trustee of a trust is vacant and no successor Trustee is effectively named, our Trust Protector shall appoint an **Independent Trustee** to serve as Trustee.” – Corporate Fiduciary or Public Charity-  
( *Wealth Counsel* )

“A Trust Protector may not appoint itself as a Trustee and a Trust Protector may not simultaneously serve as both Trust Protector and Trustee. This is in keeping with the intent and purpose that the Trust Protector’s only interest will be to protect the financial resources governed by this agreement and our intent that the assets of this trust agreement not be considered income or resources for all entitlement benefits from any government agency, such as Social Security Disability payments, Medicare, Medicaid, Supplemental Security Income (SSI), In-Home Support Service (IHSS) and any other special purpose benefits.”  
- *Wealth Counsel*

# Appointment of Successor Trust Protector

## No designated Trust Protector - Default Appointment

1. Grantors
2. Acting or successor Trust Protector
3. Appointment by acting Trustee
4. Trust Document designates an individual or Trust Advisory Committee to appoint
5. Court on petition by beneficiary/trustee
6. Office of Trust Protector remains vacant

“Any Trust Protector (including successors) shall have the right to appoint a successor Trust Protector in writing, such appointment to take effect upon the death, resignation or incapacity of the appointing Trust Protector. If ( the grantors) have named a successor Trust Protector, the appointment of a successor Trust Protector under this subsection shall take effect only if and when all Trust Protectors that we have named fail to qualify or cease to act. In no event shall [name] serve as Trust Protector.”

- *Wealth Counsel*

# Other Trust Protector Considerations

- Conflict between Trust Protector and Trustee - who wins?
- Can a Trustee remove a Trust Protector?
- Unreasonable Fee charged by Trust Protector
- No response from a Trust Protector
- Trust Protector is overly involved in Trust Administration



# Conflict of Interest

## Rule 1.7

“A lawyer shall not represent a client if the representation involves a concurrent conflict of interest.”

- Representation of one client is directly adverse to another client
- Materially limited representation by the attorney’s responsibilities to another client, third person, or personal interest of the attorney

## Rule 1.7(b)

Notwithstanding the conflict-of-interest provisions “the lawyer may represent a client if”:

- they provide competent and diligent representation to each affected client
- not prohibited by law
- free of claims in the same litigation or proceeding
- informed consent confirmed in writing

## Referral Implications:

- Negligent vs. Proper Referrals
- Due Diligence
  - Fiduciary Duties
  - Agent Delegation
  - Statement Frequency
  - Board of Directors/Owners
    - Corporate Transparency Act
  - Policies and Procedures
- Ethical Considerations
  - Liability / Disclosures
  - Conflict of Interest

# Trust Protector

## Insurance Coverage

- Many malpractice insurance policies exclude fiduciary services
- Customized fiduciary insurance may be necessary

## Conflict of Interest

- “Lifetime annuity stream of income”
  - **Mitigation: provide for removal of trustee**
- Full disclosure
  - Potential current and future conflicts of interest
  - “Materially limited” representation
  - Fees

## Multidisciplinary Law Firms

- May have non-attorney employees (financial planners, CPAs, etc.)
  - Unauthorized practice of law concerns
- Disclose “double-dipping”
  - Legal services vs. trust administration

## Fees

- Must be “reasonable and appropriate”
  - Commensurate with other local trustees
  - State statute
  - Court approval/regulation



# Attorney Trustee/Trust Protector

- Third-party discretionary trust for the benefit of young man on the autism spectrum living in a group home
- Neither co-trustee (corporate co-trustee and attorney co-trustee) had visited beneficiary in five years.
- Court determined that Mark lacked any type of advocacy for his ongoing needs, save \$3,525 expended from the trust for a care manager. The vast majority of the distributions from Mark's trust were fees for the trustee and their counsel.
- Trustee's "excuse for inaction was its lack of institutional capacity to ascertain or meet the needs of this severely disabled...young man."
- Trustee's "failure to fulfill their obligations should result in denial or reduction of their commissions for the period of inaction."
- Highly publicized in The Village Voice
- Materially limited representation



In the Matter of the Accounting of J.P. Morgan Chase Bank, N.A., and H.J.P. as Co -Trustees of the Mark C.H. Discretionary Trust of 1995 v. Marie H., 956 N.Y.S.2d 856 (N.Y. Surr. Ct., 2012).

Trustee's affirmative duty to be proactive in researching, documenting and providing for SNT beneficiary's needs.

**Applicable to trust protectors, too?**



# Trust Advisory Committee

- Promotes settlor intent and beneficiary involvement
- May weigh in on discretionary distributions
- May be tasked with development of distribution plan
- Supporters/family members/etc. may act as part of Committee
  - **BEST PRACTICE TIP:** identify any conflicts of interest (e.g., remainderperson, housemate, etc.)

## From Wealth Counsel:

“The Trust Advisory Committee shall consist of a minimum of 3 members, but no more than 5 members to be determined by the chairperson(s) then serving. If any member of the Trust Advisory Committee is unwilling or unable, for any reason, to act or continue to act as a committee member, the chairperson(s) then serving may decide whether or not to fill the vacancy. However, there shall be at least three (3) members serving at all times. If there are fewer than 3 members serving and the chairperson(s) then serving are unable or unwilling to appoint a successor committee member, the Trustee may appoint the successors.”

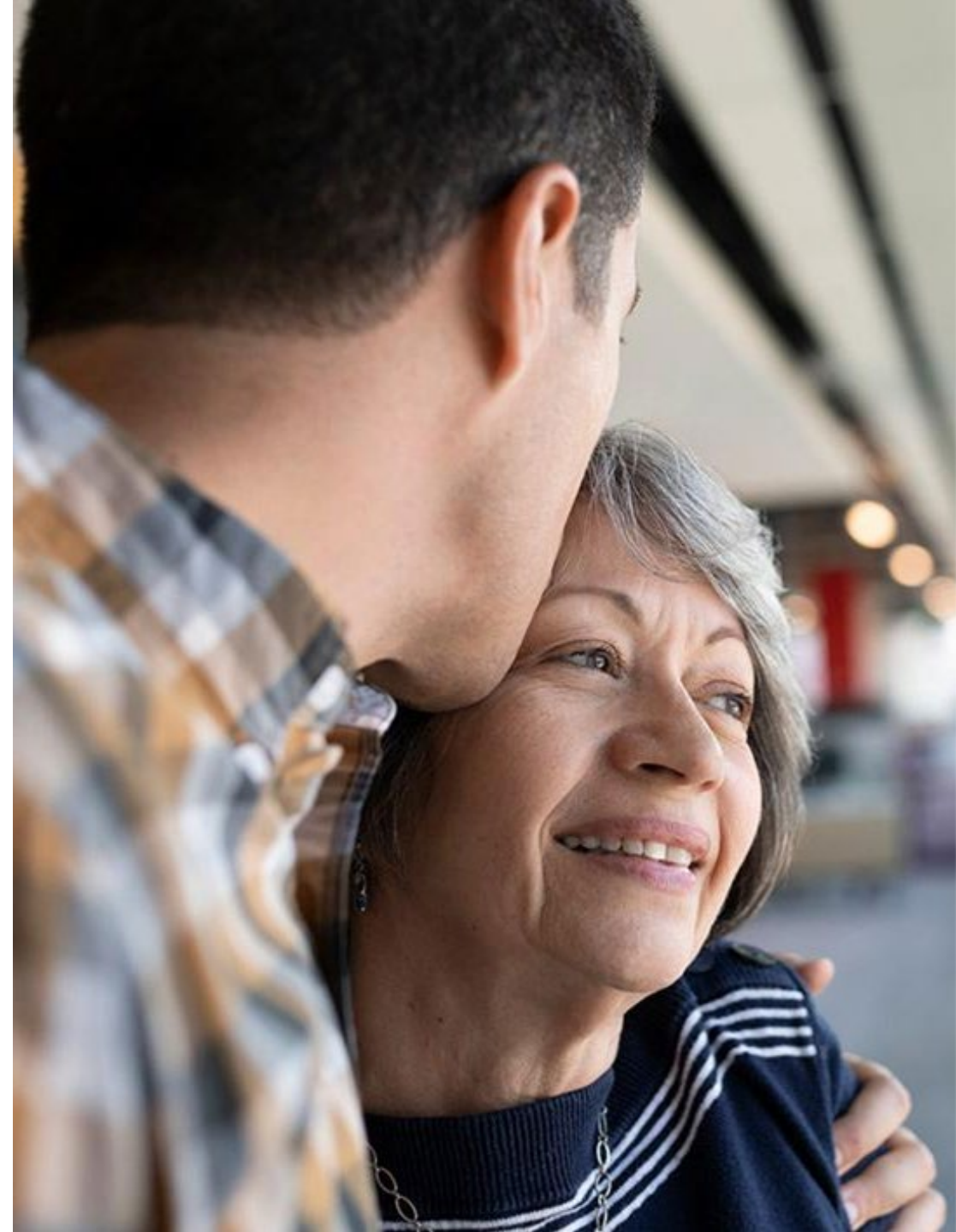
## Potential Duties:

- Distribution plan
- Communication with beneficiary
- Regular meetings



# Supported Decision-Makers:

- Empowerment of person making the decision (Decider) / beneficiary
  - “least restrictive alternative”
  - assessment of all facets of a decision
  - less costly
  - more person-centered planning opportunities
- Limit guardianship/conservatorship appointments
  - “most restrictive”
  - more costly
  - O'Connor v. Donaldson, 422 U.S. 563 (1975): “a State cannot constitutionally confine, without more, a non dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends...”
- Selected by Decider
- Put in a position of trust (friend, family member, professional)
- Tasked with information gathering and communication with Decider not surrogate decision-maker
- May assist beneficiary with understanding trust statement, potentially identifying mismanagement





# Investments

## Delegated Investment Management

### UPIA § 9

- “a trustee may delegate investment and management functions”
- “trustee shall exercise reasonable care, skill and caution in selecting an agent”
- Relies on duties of loyalty and impartiality as well as audit and judicial oversight



### BEST PRACTICE TIP

Trust Protectors, etc. should perform a thorough review of investment advisor before delegation.

## Review criteria in advisor selection process

- ☐ Past or pending legal issues
- ☐ Investment Policy Statement (“IPS”)
- ☐ Fee schedule
- ☐ Investment management agreement
- ☐ Staff experience
- ☐ SEC/state registration
- ☐ Conflict of interest
- ☐ Historical performance
- ☐ Soft - dollar arrangements
- ☐ Proprietary investment products
- ☐ Insurance coverage
- ☐ Data security
- ☐ SNT-specific knowledge
- ☐ OCC Bulletin 2013 -29: “Third -Party Relationships: Risk Management Guidance”



# Investments

## Delegated Investment Management

### UPIA § 9(a)(3)

Trustee has an ongoing duty to “periodically [review] the agent’s actions in order to monitor the agent’s performance and compliance...”



### BEST PRACTICE TIP

Trust Protector, etc. should perform an annual review of delegated investment advisor.

## Ongoing Review Criteria

- ☐ SEC or state annual qualifications/registration
- ☐ Adverse regulatory or legal actions
- ☐ Firm control person review
- ☐ Disaster Recovery Program
- ☐ ADV Parts 1, 2 & 3
- ☐ ADV/FINRA brochures
- ☐ Compliance with IPS





# Investments

## Directed Investment Management

- Uniform Directed Trust Act – 2017
- “Trust protector”, “trust advisor”, “trust director”
- Directed trustee’s authority to act in re: investments is reduced, therefore the trustee’s liability is potentially reduced
- Trustee must monitor actions for gross negligence, willful misconduct or imprudence
- Uniform Trust Code § 808 – directed trustee provisions do not bifurcate investment function as trustee will always be liable if advisor’s actions constitute a breach of trust



Rollins v. Branch Banking & Trust Co. of Va., 2001 WL 34037931  
(Va. Cir. Ct. April 30, 2001)

- Trustee directed to hold individual security
- Individual security was large portion of portfolio (overconcentration)
- Security value declined significantly, suit brought claiming failure to diversify

Court found:

- Trustee not liable for failure to diversify because of directed language
- Trustee was liable for breach of trust by failing to warn beneficiaries of impending security decline



### BEST PRACTICE TIP

Trust protector, etc. should perform an annual review of directed investment advisor.

# Fiduciary Exception to Privilege

*Hammerman v. Northern Trust* (235 Ariz 153 (Ariz App 2014))

## Fiduciary Exception to Privilege

- “We adopt the fiduciary exception to the attorney-client privilege and hold that disclosure to the beneficiary and successor trustee of otherwise privileged communications is required insofar as the trustee seeks legal advice in its fiduciary capacity on matters of trust administration. We further hold that the attorney-client privilege extends to legal advice sought in the trustee's personal capacity on matters not of trust administration.”
- Potentially any communication between the trustee and counsel that is paid for from the trust/beneficiary's funds is part of file to be turned over to successor trustee/beneficiary

# Fiduciary Exception to Privilege

## Privilege only vests in the office of the trustee

- Successor trustee/trust protector may obtain any confidential communication between a previous trustee and their attorney.

## Fiduciary exception to privilege

- Prevents any fiduciary from asserting attorney-client privilege against beneficiaries seeking to obtain communications between the trustee and their counsel as it relates to trust administration advice.
- Varies state -to-state (i.e., fiduciary exception to privilege not applicable in all states)



*Jicarilla Apache Nation v United States*, 112  
Fed.Cl. 274 (2013)

- No definitive conclusion
- Discusses conflicting decisions of lower courts



*IN RE: The Kipnis Section 3.4 Trust* ,  
No. 1 CA-CV 13-0260112, AZ App. (2014)

- Adopts fiduciary exception to privilege
- Required disclosure of privileged communications



# Regulation

## Trustee regulatory oversight

Fiduciary Type	Examples of Oversight Agency
Private Professional Fiduciaries	<ul style="list-style-type: none"><li>• Sometimes State Department of Regulatory Agencies or via state statute</li></ul>
National or State-chartered Trust Companies	<ul style="list-style-type: none"><li>• Office of the Comptroller of the Currency (OCC)</li><li>• State-specific trust/bank regulatory agency</li></ul>
Pooled Special Needs Trusts (PSNT)	<ul style="list-style-type: none"><li>• Some aspects - SSA, Medicaid and IRS, etc.</li></ul>
Financial Advisors	<ul style="list-style-type: none"><li>• SEC, state regulatory agencies</li><li>• Investment Advisers Act of 1940 (15 U.S.C. § 80b-1, et. al.)</li></ul>
Accountants	<ul style="list-style-type: none"><li>• American Institute of CPAs (AICPA)</li><li>• FINRA</li><li>• NASBA</li></ul>
Life Insurance Agents	<ul style="list-style-type: none"><li>• NAIC</li><li>• FINRA</li><li>• State-specific insurance regulatory agency</li></ul>
Public Administrators/ Public Guardians	<ul style="list-style-type: none"><li>• State-specific statute or audits</li></ul>
Attorneys	<ul style="list-style-type: none"><li>• ABA, local Bar Association</li><li>• Model Rules of Professional Conduct</li></ul>



# PSNT Regulation: Sen. Rick Scott/SSA

*Muller, B. (May 27, 2024). SSA responds to Sen. Rick Scott following an 8 On Your Side investigation into special needs trusts. WFLA.*

## SSA Response:

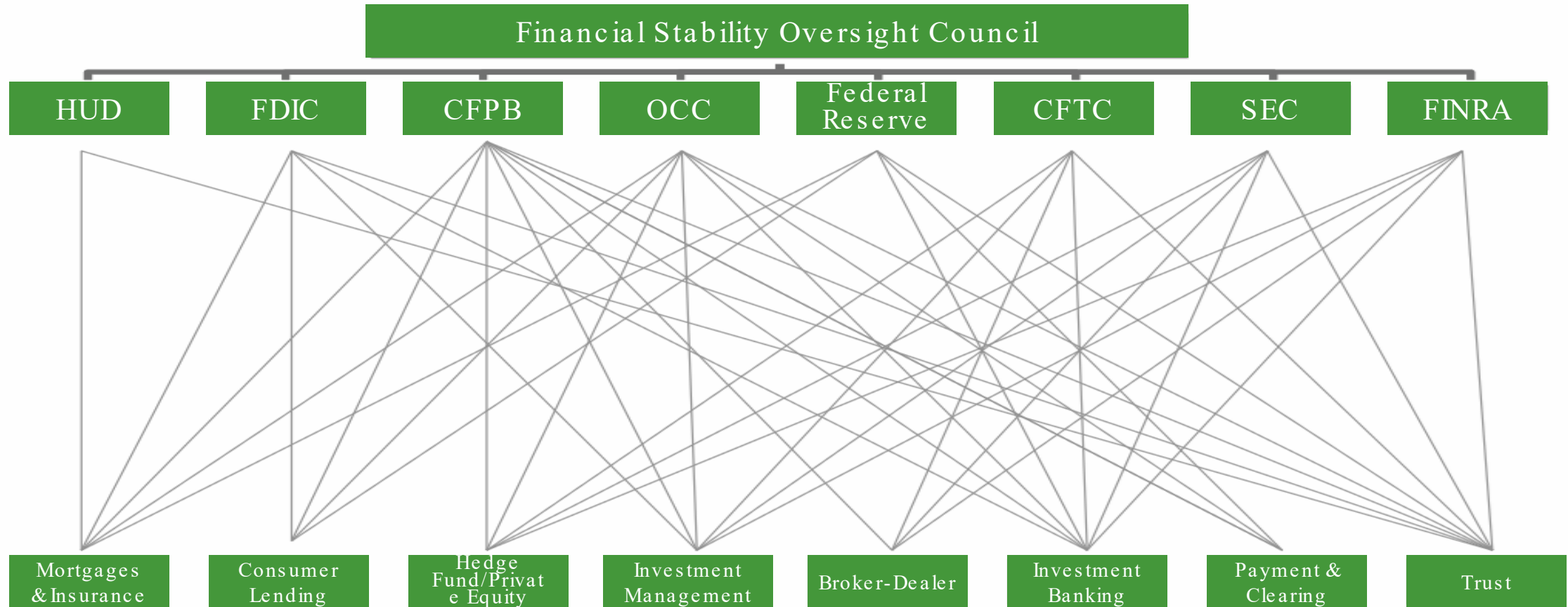
- Letter from SSA Commissioner Martin O'Malley - May 7, 2024
- SSA “does not provide oversight to SNTs, adding a trust is a legal arrangement generally regulated by state law.”
- “[O'Malley] wrote, ”The Social Security Act provides the agency with limited authority regarding financial trusts.””
- “SSA said it does not investigate trusts, unless [they're] investigating the misuse of someone's benefit and that it remains focused on how the trust is treated for social security income.”





# PSNT Regulation: Federal Oversight

## FINANCIAL REGULATORY STRUCTURE





2025 Fundamentals of Special Needs Trust Administration

# Thank You!

## Protecting Beneficiaries from Financial Mismanagement

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*Center for Elder Justice*

Access and Justice For All®

# **2025 Fundamentals of Special Needs Trusts Administration Webinar**

**Friday, May 30, 2025**

**3:20-3:55 pm**

**AI: From Hype to Hope—Harnessing  
The Tools**

**Presenter: Jeremy Sapriel**

- PowerPoint



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2025 Fundamentals of Special Needs Trust Administration

# AI: From Hype to Hope - Harnessing the Tools

**Jeremy Sapriel**

True Link Financial, Inc.

True Link Financial Advisors, LLC is an SEC-registered investment advisor and wholly owned subsidiary of True Link Financial Inc., Whereas True Link Financial Advisors, LLC provides the investment advisory services, True Link Financial, Inc. provides the prepaid Visa cards and accompanying software, as well as the trust administration software and recordkeeping portal software ("True Link Platform"). The companies shall be referred to herein collectively as "True Link". When providing investment management services to special needs trust clients, the client is the Trust, not the individual trust beneficiaries.



# What is AI



# What is AI and How Does it Work?

Artificial intelligence (AI) is a type of technology that enables computers to perform tasks that usually require human intelligence, such as learning, problem-solving, and decision-making. Unlike traditional deterministic software, AI is probabilistic - it makes predictions based on patterns learned from data.

1

## **Train**

AI models analyze vast amounts of data, identifying patterns and assigning weights to concepts. These weights represent the relationships between concepts and create context.

2

## **Generate**

Using these learned patterns, AI systems produce original, contextually relevant content and actions - such as text, images, audio, code, or steps - in response to user input or tasks. When a question or input goes in, the strongest connections are used to produce its response.

3

## **Iterative Refinement**

AI continuously enhances its effectiveness and accuracy by incorporating feedback from new data and user interactions.

## AI Terms

Definition, description,  
usage, classification,  
examples, applications.

Overview and core concepts  
of artificial intelligence.

Understanding the current  
state of AI research and  
development.

# AI Terms

## Core Concepts

- Agentic: AI that can take independent actions
- Frontier Model: Cutting-edge AI systems
- Logic Model: Structure for reasoning

## Technical Terms

- GPU: Hardware that powers AI
- GPT: Generative Pre-trained Transformer
- Prompt: Instructions given to AI

## Process Terms

- Inference: AI generating outputs
- Training: Teaching AI with data
- Deep Research: Advanced AI investigation



# Deciding how and where to use AI Tools

1

## High Toil Tasks

Focus on repetitive, time-consuming work that AI can do instead.

2

## Low-Risk Applications

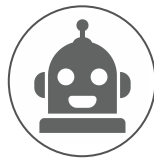
Choose scenarios where perfection isn't critical for getting perfect.

3

## Question Types

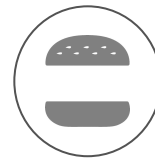
Decide if you need general information (higher accuracy) or precise answers (specialized).

# AI's Impact: Arguments for a Juicy Future vs Nothingburger



## Juicy Futuristic

- "Hiring" an agent for an open role
- Pace of change unprecedented
- Robots
- Extraordinary capabilities (AGI)
- Examples of computers overtaking human capabilities in games such as chess and go
- Potential to cure diseases
- Use cases today very real ways



## Nothingburger

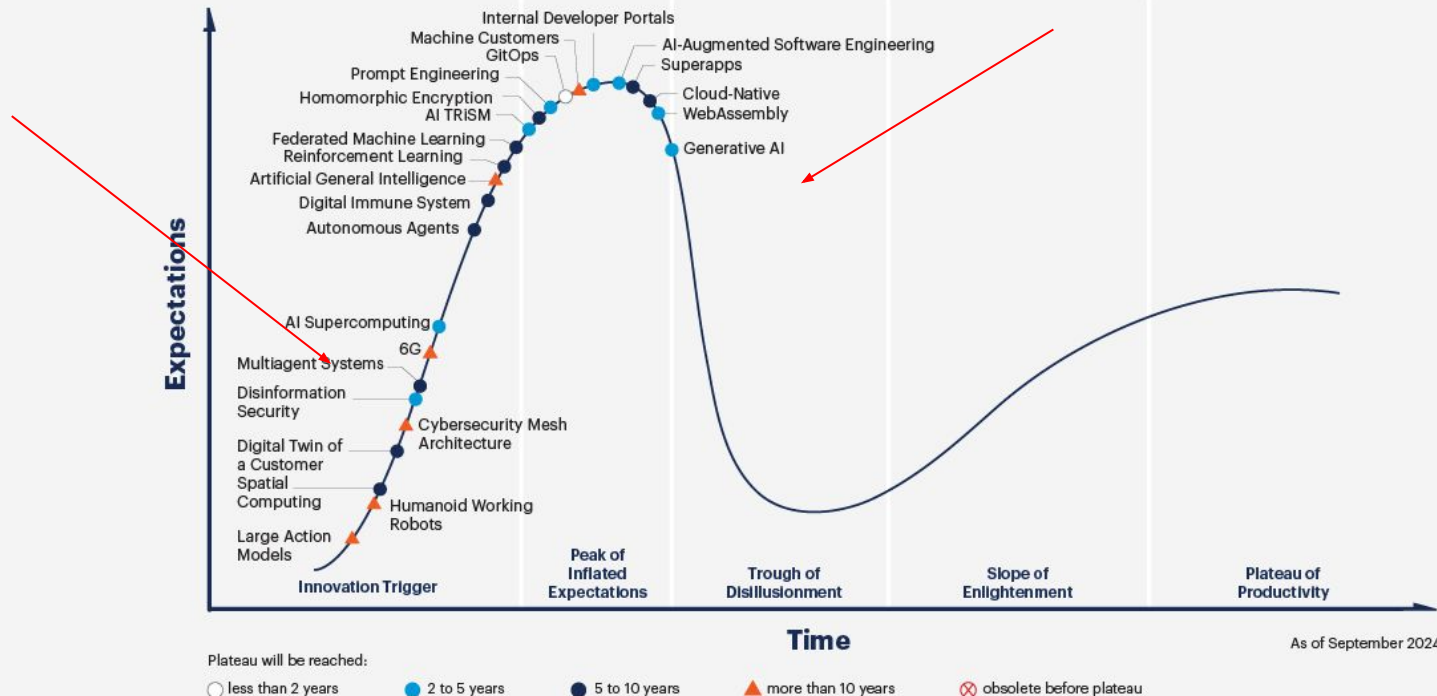
- Makes mistakes (so do humans)
- Can't do groundbreaking physics (yet)
- My day-to-day remains unchanged
- Techies said the same thing about Crypto & I won't get burned by believing the talking heads again



# So many headlines!

AI and the Gartner Hype Cycle - what's the hype cycle and what stage are we in?

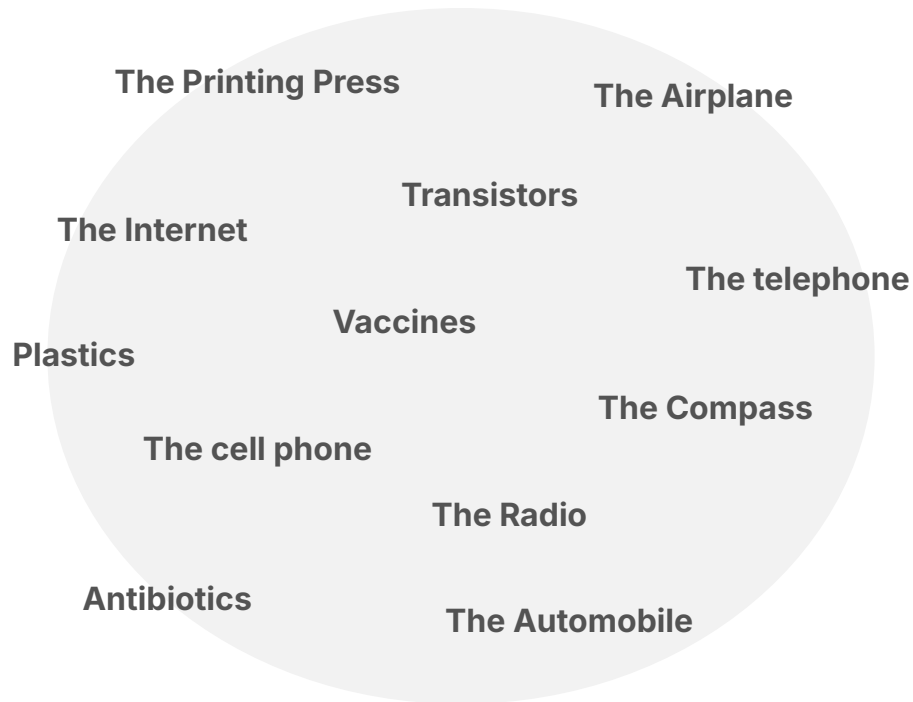
## Hype Cycle for Emerging Technologies, 2024



# What size Innovation do you think this is?

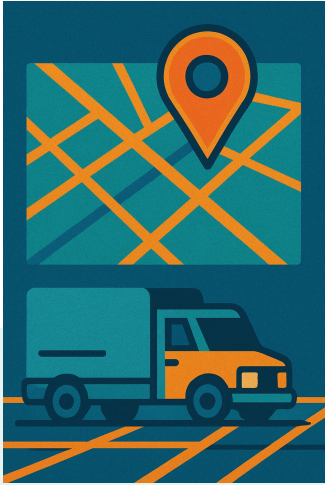
Even with the Hype - AI will probably land somewhere in that word cloud of upper tier inventions.

It's an Event Horizon - That is, we'll think of this technology in terms of the pre-invention and post-invention periods where the world is forever shaped by this tool



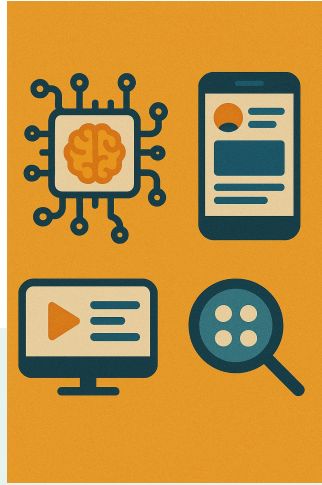
# Examples and Use Cases

# Examples of AI already influencing your world...



## **Logistics**

Google Maps & Waze  
Amazon Delivery (AI  
optimized supply chains)



## **Algorithms**

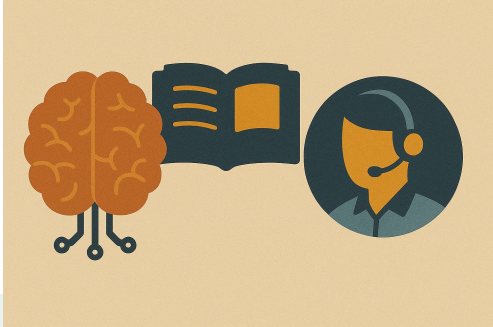
Facebook Feed  
Netflix Recommendations  
Google Search



## **Finance**

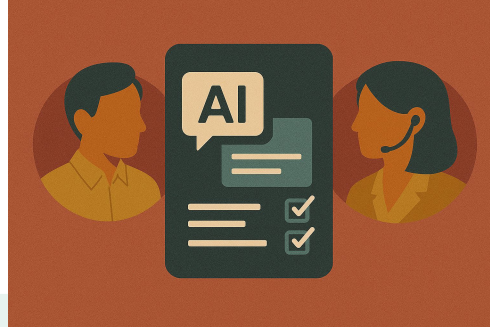
AI trading stocks and  
Fraud detection

# Consider Adding AI to Your Flow for: Communication



## **Knowledge Center**

Customer service, Internal staff queries, FAQs on website



## **Language Translation**

Live translation with slang and nuance



## **Meeting Summaries**

Zoom AI  
Copilot for Teams



# Consider Adding AI to Your Flow for: Idea Generation & Refining



## **Step 1: Brainstorming Concepts**

Blogs - Reports - Posts - emails



## **Step 2: Refine Ideas**

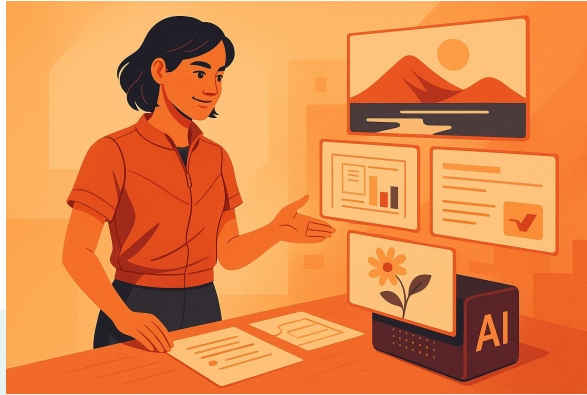
Build these ideas out further, what might they need, now that we've done and decided X, can you help me do Y?

# Consider Adding AI to Your Flow for: Multimedia



## **Audio**

Read articles and books in human voice or take multiple articles or papers and turn them into an engaging podcast



## **Image Generation**

Create photos, graphics, and layouts because a picture is worth 1000 words



## **Video Generation**

Video generation from prompts are getting more and more sophisticated too

# Consider Adding AI to Your Flow for: Productivity



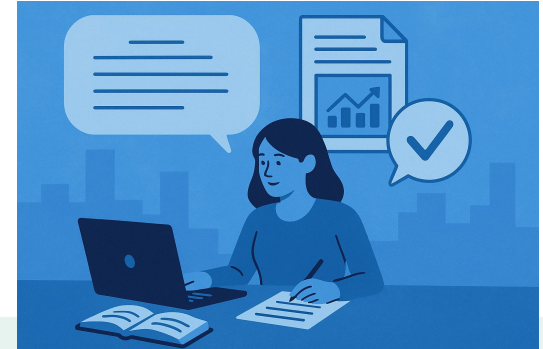
## **HR**

Use AI to help with Resume Screening and Candidate Ranking along with helping to write, review, and summarize performance evals or create a talk track for hard conversations



## **Finance & Reporting**

Build report queries and have AI help with data interpretation, Risk Assessment, and fraud detection



## **General Best Practice and Report Writing**

Have AI research best practices and how you might apply them to your particular practice or problem

# Risks and Safety



## Three principles for our discussion of risk and safety

- 1) Our world without AI is not riskless
- 2) A "7th grade health class" approach
- 3) More capability requires more safeguard





# 1) Our world without AI is not riskless

- Instead of using AI tools, we take actions that carry some amount of risk:
  - Googling
  - Multi-tasking
  - Doing manual tasks
  - Guessing
- An example: Anthropic tests whether their new models make dangerous behavior (e.g., constructing a weapon) easier as compared to accessing Google or textbooks
- How might we assess risk versus our practices today?

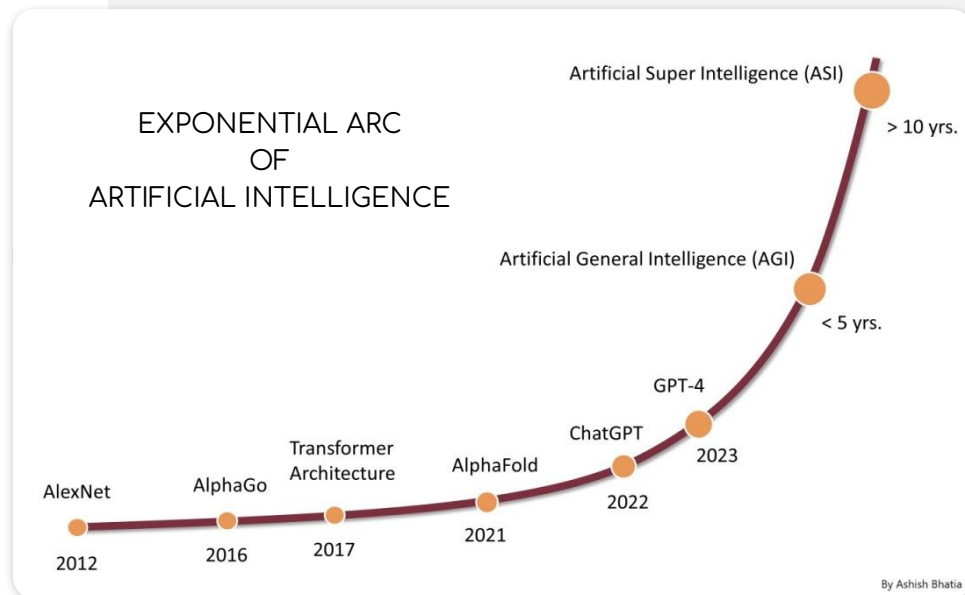


## 2) Pragmatic and practical guidance

- AI is everywhere and will only become more commonplace
- Members of our teams are already using these tools!
- What would it look like to avoid prohibitions in favor of pragmatic and practical guidance?

### 3) More capability requires more safeguard

- Higher capability requires higher safeguards (e.g., nuclear codes)
- PCs and internet: linear increase in capability
- AI: exponential increase in capability
- How might we ensure our approach to risk and safety evolves as capabilities change?



# Big risks

- **Misuse** – AI for biological/chemical warfare, cyberattacks, deepfakes for political manipulation
- **AI Autonomy** – Agent hacking, AI-powered fraud, military/law enforcement
- **Algorithm Bias & Manipulation** – Unfair outcomes due to biased training data, misinformation amplification, adversarial attacks on AI models
- **Job Displacement** – Automation replacing jobs faster than economies can adapt
- **Existential Risks** – Loss of human control over highly advanced AI, misaligned superintelligence

# Day-to-day risks

- **Data privacy** – sharing sensitive information with an AI tool
- **Misinformation** – trusting and acting on incorrect or misleading information
- **Bias** – models are built on data from our biased world and can replicate the bias they were trained on



# What might this mean for all of us?

- **Set practical AI use policies for your organization** – Discuss responsible AI use with your team
- **Use AI as an assistant, not a decision-maker** – Check AI output and trust your own experience and expertise
- **Keep using your 21st century tech common sense** – If you wouldn't type it into Google, don't type it into an AI chatbot
- **Select AI providers that have strong privacy and security policies** – e.g., allow for opt-out from data retention (see our upcoming list)
- **Revisit your approach and keep learning** – as AI use evolves and capabilities change, so too should our approach to risk mitigation

# Interactive demo: POMS Bot

# Demo Part 1: “POMS Manual Bot and Revocable Trusts”



What are 3 questions I should use to demo an SSA POMS manual bot to a conference?

If you're demoing an **SSA POMS manual bot** at a conference, you want questions that showcase its ability to efficiently retrieve complex policy information, interpret nuanced SSA rules, and provide clear, actionable answers. Here are three strong demo questions:

### 1. Eligibility Determination Question

*"A Supplemental Security Income (SSI) applicant has a revocable trust. How does SSA treat this for resource eligibility?"*

- This tests the bot's ability to navigate **POMS SI 01120.200** (Trusts Established on or After January 1, 2000) and provide an explanation on whether the trust counts as a resource.

### 2. Payment Rules Question

*"If an SSI recipient enters a nursing home, how does that affect their benefits?"*

- This requires the bot to reference **POMS SI 00520.001** (Temporary Institutionalization) and explain how Medicaid-covered care affects SSI payments.

### 3. Appeals & Overpayments Question

*"An SSDI recipient was overpaid due to unreported work. What options do they have to appeal or request a waiver?"*

- This showcases the bot's ability to pull details from **POMS GN 02250.000** (Waiver of Recovery) and **GN 03102.000** (Reconsideration Procedures), summarizing the appeals and waiver process.

Would you like a question tailored for a specific audience (e.g., caseworkers, attorneys, SSA employees)?



Ask anything



Search



Deep research



Demo Part 2: “Who is Pete Wall’s favorite football team?”



I need to explain this to a beneficiary. Can you please write me an email to Dave that concisely explains this?

Here's a concise and clear email you can send to Dave:

**Subject:** Important Information About Your Revocable Trust and SSI

Hi Dave,

I wanted to reach out regarding how your **revocable trust** affects your **Supplemental Security Income (SSI) eligibility**.

Since a revocable trust allows you to access or control the funds, **SSA considers the assets in the trust as a countable resource**. This means the trust could affect your SSI eligibility because SSI has strict resource limits.

If you're looking to maintain SSI benefits, you may need to explore options like an **irrevocable trust** or a **special needs trust** that meets SSA's exceptions. However, making changes to your trust could have other financial implications, so it's important to proceed carefully.

Let me know if you'd like to discuss this further. I'm happy to help clarify anything!

Best,

[Your Name]

[Your Contact Information]

This keeps it simple while still providing the key points. Let me know if you'd like any tweaks!



Ask anything





# Key takeaways from the demo

## Saves You Time

Used well, it can save you hours of work and time

## Data Quality Matters

Good data in produces good results. AI reflects the information it's given. So, always double check anything that is critical to get fully right.


## It Won't Bite!

You can't break it, give it a whirl if you haven't already.

SSA POMS Manual

Live · ? Anyone with a link

CreateConfigure



**Name**

SSA POMS Manual

**Description**

Expert SSA POMS guidance with a witty yet approachable tone, specializing in special needs trusts & rep payees.


**Instructions**


This GPT is designed to go to the SSA website to read, interpret, and provide advice based on the SSA Program Operations Manual System (POMS). It also offers general Social Security guidance and industry best practices where relevant. It should always reference the POMS manual using the SSA's POMS website for authoritative answers while supplementing responses with additional insights when necessary.  
It ensures clarity in explanations, provides citations when appropriate, and avoids offering legal or financial advice beyond general

**Conversation starters**

**Knowledge**

If you upload files under Knowledge, conversations with your GPT may include file contents. Files can be downloaded when Code Interpreter is enabled

 Social Security POMS M... PDF

 Pete Loves the Eagles.pdf PDF

Upload files

**Capabilities**

☒ Web Search

☒ Canvas

☒ DALL·E Image Generation

☐ Code Interpreter & Data Analysis

**Actions**

Create new action

# What are a few tools I should try today?

## **All-Purpose Chatbots:**

- OpenAI ChatGPT
- Anthropic Claude
- Google Gemini
- xAI Grok
- Perplexity (cross model)

## **Productivity:**

- Copilot - MS Office
- Gamma - slides
- Cursor - build software

## **Media**

### **Image & Video:**

- DALLE
- Midjourney
- Sora

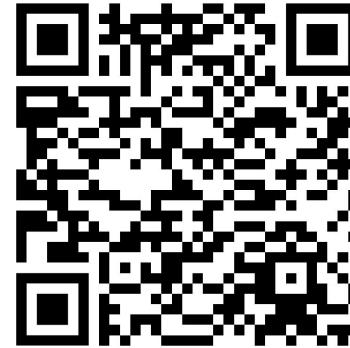
### **Audio:**

- Google Notebook LLM  
(text to podcast)
- ElevenLabs

# Questions, Contact info, & POMS Bot QR Code Link

② Questions ②

Jeremy Sapriel: [Jeremy.Sapriel@truelinkfinacial.com](mailto:Jeremy.Sapriel@truelinkfinacial.com)



POMS Bot

# True Link POMS Bot Disclaimer

True Link Financial, Inc. ("True Link") created this tool using OpenAI's Custom GPT feature, which allows us to tailor AI-generated responses to better address user queries related to the SSA Program Operations Manual System. Please note that AI-generated results may not always be accurate, complete, or applicable to your situation. You should review source documents and consult an expert before making decisions based on the information provided. True Link does not monitor or control the responses generated by this tool and cannot guarantee their accuracy or relevance. True Link disclaims all liability for any results produced using this tool. By using this tool, you acknowledge that AI-generated responses may be imperfect and that you assume full responsibility for any decisions based on them.



**STETSON LAW**

*Center for Elder Justice*

Access and Justice For All®

# **2025 Fundamentals of Special Needs Trusts Administration Webinar**

**Friday, May 30, 2025**

**3:20-3:55 pm**

**Using AI. It's a tool, not a co-worker...**

**Presenter: Ashley Krenelka Chase**

- PowerPoint



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LAW**

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Elder Justice*

Access and Justice For All®

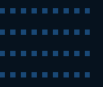


# Using AI: It's a Tool (Not a Coworker)



Ashley Krenelka Chase  
Stetson University College of Law  
akrenelk@law.Stetson.edu







# Unique considerations for special needs trusts:



Sensitivity of beneficiary information  
(disabilities, finances, government  
benefits)

Complexity of state/federal benefit  
coordination

Long-term fiduciary responsibilities



The background of the slide features three large, overlapping teal-colored circles arranged horizontally. They are set against a dark gray background. A white horizontal band cuts across the middle of the circles, containing the title text.

# **Ethical Framework for AI Use**

# Core Duties under Model Rules and State Opinions

- Confidentiality
- Candor to Tribunal
- Competence & Diligence
- Supervision
- Bias Mitigation
- Fee Transparency

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- +
  - **State-Specific Guidance**
-

# Jurisdiction Key Provisions

- **California** Strict input restrictions; mandatory cybersecurity reviews
- **Florida** "Self-learning" AI warnings; hallucination mitigation protocols
- **Texas** Client disclosure recommendations; access-to-justice focus
- **New York** Conflict checks for AI training data sources
- **ABA Model** Competence as ongoing duty to learn AI risks/benefits

# Special Needs Trusts Case Studies

- **Risk Scenario:** AI drafts trust with language jeopardizing SSI eligibility
  - Duty to spot benefit-related errors (Competence + Diligence)
- **Beneficiary Communication:** AI-generated updates containing HIPAA violations
  - Confidentiality safeguards for sensitive health data



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# Best Practices for Trusts Attorneys

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- **Tool Vetting Checklist:**
  - Data retention policies
  - Encryption standards
  - Third party audits
- Fee Structure Explanations
- Manual Review of government benefit cross-references

# Emerging Issues



STATE LEGISLATIVE TRENDS



ABA/NYDFS PROPOSALS FOR AI  
AUDIT TRAILS IN TRUST ACCOUNTING

# Resources

This presentation integrates guidance from California, Florida, Texas, New York, and the ABA, with practical examples tailored to trust administration.

- <https://www.calbar.ca.gov/Portals/0/documents/ethics/Generative-AI-Practical-Guidance.pdf>
- <https://www.proskauer.com/uploads/secured-sports-law-cle-program-3-presentation>
- <https://ediscverytoday.com/2024/01/26/generative-ai-ethics-opinion-issued-by-florida-bar-artificial-intelligence-trends/>
- [https://www.nycbar.org/wp-content/uploads/2024/08/20221329\\_GenerativeAILawPractice.pdf](https://www.nycbar.org/wp-content/uploads/2024/08/20221329_GenerativeAILawPractice.pdf)
- <https://www.floridabar.org/the-florida-bar-news/aba-issues-first-ethics-guidance-on-a-lawyers-use-of-ai-tools/>
- <https://www.lawnext.com/2025/02/a-compendium-of-legal-ethics-opinions-on-gen-ai-as-compiled-by-you-guessed-it-gen-ai.html>
- [https://www.americanbar.org/groups/business\\_law/resources/business-law-today/2024-october/aba-ethics-opinion-generative-ai-offers-useful-framework/](https://www.americanbar.org/groups/business_law/resources/business-law-today/2024-october/aba-ethics-opinion-generative-ai-offers-useful-framework/)
- <https://www.2civility.org/breaking-down-the-abas-guidance-on-using-generative-ai-in-legal-practice/>
- <https://library.law.unc.edu/2025/02/aba-formal-opinion-512-the-paradigm-for-generative-ai-in-legal-practice/>
- <https://brief.steno.com/legal-ai-rules-by-state>
- <https://www.nycbar.org/reports/formal-opinion-2024-5-generative-ai-in-the-practice-of-law/>