STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Appellant
_____/

Docket No. 2010-47790 HHR
[redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. The Appellant appeared without representation. She had no witnesses. [redacted], appeals review officer, represented the Department.

ISSUE

Did the Department properly pursue recoupment against the Appellant?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1) The Appellant is a spend down Medicaid beneficiary who received Home Help Services (HHS).

2) The Appellant is afflicted with HIV and blindness.

3) The Appellant was not eligible for Medicaid during the months of [redacted]r [redacted]. (Department's Exhibit A, p. 8)

4) The Appellant was notified by certified mail on [redacted] that she owed the HHS program [redacted] for having received HHS payments during periods of Medicaid ineligibility. (Department's Exhibit A, p. 11)

5) The certified mail receipt was executed by [redacted]. (Department's Exhibit A p. 11)

6) The Appellant said that '[redacted] came to her home with an attitude and took two checks from her mother."

7) The instant appeal was received by the State Office of Administrative Hearings and Rules on [redacted]. (Appellant's Exhibit #1)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Home Help Services (HHS) are provided to enable functionally limited individuals to live independently and receive care in the least restrictive, preferred settings. These activities must be certified by a health professional and may be provided by individuals or by private or public agencies.

A threshold requirement, however, is Medicaid eligibility for the HHS recipient as clearly explained in the Adult Service Manual:

> **Home Help Services (HHS)**
>
> **Payment** related independent living services are available if the client meets HHS eligibility requirements. Clients who may have a need for HHS should be assisted in applying for Medicaid (MA). Refer the client to an eligibility specialist. Cases pending MA determination may be opened to program 9 (ILS). HHS eligibility requirements include all of the following:
>
> • The client must be eligible for Medicaid.
> • Have a scope of coverage of:
> •• 1F or 2F,
> •• 1D or 1K, (Freedom to Work), **or**
> •• 1T (Healthy Kids Expansion).
>
> ****
>
> .
>
> (Emphasis supplied) ASM, 362, 12-1-07, at page 2

Services Requirements Manual (SRM 181, 6-1-07), addresses the issue of recoupment:

GENERAL POLICY

The department is responsible for correctly determining eligibility of payment of service program needs, and the amounts of those payments. In the event of payments in an amount greater than allowed under department policy, an overpayment occurs.

When an overpayment is discovered, corrective action must be taken to prevent further overpayment and the overpayment is to be recouped. The normal suspense period must be allowed for any client negative actions. An entry is to be made in the case record to document the overpayment, the cause of the overpayment and the action taken to prevent further overpayment and to recover the overpayment.

INSTANCES OF OVERPAYMENT
Four instances may generate overpayments:

- Client errors.
- Provider errors.
- Administrative errors.
- Department upheld at an administrative hearing.

APPROPRIATE RECOUPMENT ACTION

Appropriate action in these instances is to be based on the following:

1. Information given to the department by a client is incorrect or incomplete.

    a. Willful client overpayment occurs when:

        - A client reports inaccurate or incomplete information or fails to report information necessary to make a correct eligibility or grant determination; and
        - The client had been clearly instructed regarding the client's reporting responsibilities, (a signed DHS-390 or DHS-3062 is evidence of being clearly instructed); and
        - The client was physically and mentally capable of performing the client's reporting responsibilities; and
        - The client cannot provide a justifiable excuse for withholding information.

b. Non-willful client errors: Are overpayments received by clients who are unable to understand and perform their reporting responsibilities due to physical or mental impairment or who have a justifiable excuse for not giving correct information.

2. Provider caused overpayment: Service providers are responsible for correctly billing for services which were authorized and actually delivered and for refunding overpayments resulting from a negative billing process (payment is issued as a result of a specialist generated payment document). Failure to bill correctly or refund overpayments is a provider error.

SRM 181 6-1-2007, Pages 1-2 of 4.

The Department witness testified that during her in home face to face assessment in [redacted], she learned from the Appellant that she had received "a spend down letter" – which led to the recoupment action by the department. The witness identified the months of no Medicaid coverage as 2C for the months of [redacted] – although the Department opted to not recoup for the month of [redacted]. The Department witness testified that the Appellant has ongoing services as of this hearing and that the Department opted to not pursue recoupment for the month of [redacted] because the Appellant said she was not aware that she was then ineligible. The witness referred the matter to the MDCH central office – which dispatched two notices of recoupment to the Appellant.

The Appellant testified that she is blind and HIV positive and that she does not understand how this operation works. "I did nothing… I don't understand it… I have been in the system since [redacted] said. The Appellant testified that she has not pursued an appeal with DHS about her eligibility status.[1] The Appellant said that her income has been static for the last (3) three years.

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly sought recoupment from the Appellant of [redacted].

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly pursued recoupment against the Appellant.

[1] The Appellant was instructed by the Appeal Review Officer to investigate an appeal with DHS regarding her Medicaid status if she believes there is an error. This State Office of Administrative Hearings and Rules does not have jurisdiction to decide those issues.

[redacted]
Docket No. 2010-47790
Hearing Decision & Order

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED. The overpayment amount is [redacted]

Dale Malewska
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 11/12/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.