

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 373-4147

IN THE MATTER OF:

Docket No. 2014-34430 HHR

██████████

██████████

Appellant,

_____ /

DECISION AND ORDER

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

After due notice, a hearing was held on ██████████. Appellant appeared and testified on her own behalf. ██████████ Appeals Review Officer, appeared and testified on behalf of the Michigan Department of Community Health. ██████████ Adult Services Worker for ██████████ County Department of Human Services, and ██████████ Financial Manager, Medicaid Collections Unit for the Department of Community Health, appeared as witnesses for the Department.

ISSUE

Did the Department properly pursue recoupment against the Appellant for Home Help Services payments totaling ██████████

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 provided Home Help Services (HHS) to her mother a Medicaid beneficiary from ██████████ through ██████████ ██████████, when the beneficiary went into the hospital and then subsequently died on ██████████ (Exhibit A, pp. 2, 5-8, 21, 24, 26 and testimony).
2. On ██████████, the total HHS care cost for the beneficiary's care was ██████████ (Exhibit A, p. 24 and testimony).
3. The beneficiary went into the hospital and/or a nursing facility on several occasions during ██████████ including: ██████████ through ██████████ through ██████████ through ██████████, and finally on ██████████ through her death on ██████████. Department was not informed at the time that the

beneficiary was in the hospital or a nursing facility during these periods of time. (Exhibit A, pp. 5-8, 9-12 and testimony).

4. Accordingly, the Department issued payment to the Appellant for HHS for the whole months of ██████████ and ██████████ (Exhibit A, pp. 9-11, 26 and testimony).
5. Appellant cashed the checks for the months of ██████████ and ██████████ (Exhibit A, p. 26 and testimony).
6. On ██████████, the total HHS care cost for the beneficiary's care was increased to ██████████ (Exhibit A, p. 24 and testimony).
7. On ██████████, ASW ██████████ issued ██████████ letters to Appellant indicating that overpayments had occurred in the Home Help case in which Appellant was a provider for the time periods of ██████████ through ██████████, ██████████ through ██████████ and ██████████ through ██████████. The overpayments were ██████████, and ██████████ respectively, for a total overpayment of ██████████. (Exhibit A, pp. 9-11, 13, 14 and testimony).
8. On ██████████ the total HHS care cost for the beneficiary's care was increased to ██████████. (Exhibit A, p. 23 and testimony).
9. On ██████████ issued an Initial Collection Notification to Appellant indicating that, as Appellant was previously informed, she owed the Adult Services Program ██████████. The letter informed Appellant of her right to contest that debt and request a hearing. (Exhibit A, p. 13).
10. On ██████████ the Michigan Administrative Hearing System (MAHS) received a letter request for hearing filed by Appellant; however it was erroneously rejected by intake.
11. On ██████████ ASW ██████████ issued an Advance Negative Action notice to Appellant advising that due to the beneficiary's hospitalization from ██████████ ██████████ and again on ██████████ through her death on ██████████ the Appellant's HHS check for the month of ██████████ would be reduced to ██████████. (Exhibit A, pp. 5-8 and testimony).
12. On ██████████ ██████████ issued a Final Collection Notification to Appellant indicating that, as Appellant was previously informed, she owed the Adult Services Program ██████████ (Exhibit A, p. 9).
13. On ██████████, the Michigan Administrative Hearing System (MAHS) received another request for hearing filed by Appellant. (Exhibit A, p. 4).

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.

Adult Services Manual 101 (12-1-2013), page 1 of 5, addresses payment for home help services. It state in part:

Payment Services Home Help

Home help services are non-specialized personal care service activities provided under the independent living services program to persons who meet eligibility requirements.

Home help services are provided to enable individuals with functional limitation(s), resulting from a medical or physical disability or cognitive impairment to live independently and receive care in the least restrictive, preferred settings.

Home help services are defined as those tasks which the department is paying for through Title XIX (Medicaid) funds. These services are furnished to individuals who are **not** currently residing in a hospital, nursing facility, licensed foster care home/home for the aged, intermediate care facility (ICF) for persons with developmental disabilities or institution for mental illness. [Emphasis added].

Adult Services Manual 135 (12-1-2013), pages 2 & 3 of 9, addresses the responsibilities of a home help provider:

PROVIDER INTERVIEW

An initial face-to-face interview must be completed with the home help provider. A face-to-face or phone contact must be made with the provider at the six month review or redetermination to verify services are being furnished.

Explain the following points to the client and the provider during the initial interview:

- The provider is employed by the client **not** the State of Michigan.
- As the employer, the client has the right to hire and fire the provider.
- A provider who receives public assistance **must** report all income received as a home help provider to their family independence specialist or eligibility specialist.
- The client and provider are responsible for notifying the adult services specialist within **10 business days** of any change in providers or hours of care.
- The provider and/or client is responsible for notifying the adult services specialist within **10 business days** if the client is hospitalized.
- **Note:** Home help services **cannot** be paid the day a client is admitted into the hospital but **can** be paid the day of discharge.
- The provider **must** keep a log of the services provided on the DHS-721, Personal Care Services Provider Log and submit it on a quarterly basis. The log must be signed by both the provider and client or the client's representative. [Emphasis added].

Adult Services Manual 165 (5-1-2013), pages 1 & 3 of 7, addresses the issue of recoupment:

GENERAL POLICY

The department is responsible for correctly determining accurate payment for services. When payments are made in an amount greater than allowed under department policy, an overpayment occurs.

When an overpayment is discovered, corrective actions must be taken to prevent further overpayment and to recoup the overpayment amount. The normal ten business day notice period must be provided for any negative action to a client's services payment. An entry must be made in the case narrative documenting:

- The overpayment.
- The cause of the overpayment.
- Action(s) taken to prevent further overpayment.
- Action(s) taken to initiate the recoupment of the overpayment.

FACTORS FOR OVERPAYMENTS

Four factors may generate overpayments:

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

Appropriate action must be taken when any of these factors occur.

* * *

PROVIDER ERRORS

Service providers are responsible for correct billing procedures. Providers must only bill for services that have been authorized by the adult services specialist **and** that the provider has already delivered to the client.

Note: Applicable for home help agency providers and cases with multiple individual providers where hours may vary from month to month.

Providers are responsible for refunding overpayments resulting from an inaccurate submission of hours. Failure to bill correctly or refund an overpayment is a provider error. [Emphasis added].

The issue in the present case is an overpayment based on a provider error. The Department's witnesses established that the Appellant/provider's beneficiary went into the hospital and/or a nursing facility on several occasions during [REDACTED], including: [REDACTED] through [REDACTED], [REDACTED] through [REDACTED] through [REDACTED], and finally on [REDACTED] through her death on [REDACTED]. Department was not informed at the time that the beneficiary was in the hospital or a nursing facility during these periods of time. Accordingly, the Department issued payment to the Appellant for HHS for the whole months of [REDACTED] [REDACTED] and [REDACTED] and the Appellant cashed the checks for those monthly payments. After learning about the overpayment, the Department properly sent collection notices to Appellant, while also notifying her of her right to contest the debt and request an administrative hearing.

Appellant filed a request for hearing, claiming that she was under paid as caregiver for her mother. Appellant testified at the hearing that she felt the previous ASW had not properly assessed the amount of work and it resulted in her receiving less pay than she should have the entire time she served as the beneficiary's caregiver. Appellant did not dispute the dates that her mother the beneficiary was in the hospital or a nursing home as indicated in the [REDACTED] overpayment letters sent out by the ASW. Appellant simply says she was underpaid all along and should not have to repay the Medicaid dollars paid to her that correspond to the days the beneficiary was in the hospital or a nursing facility.

Appellant's argument is without merit. There was never an appeal by the beneficiary challenging the amount of HHS services previously authorized by the beneficiary's prior ASW. Furthermore, policy is clear that the beneficiary and provider are both responsible for reporting changes in care, including times when the beneficiary is out of the home and in the hospital or a nursing facility. The failure to notify DHS in this case of the beneficiary's absence in this case is provider error which means the Appellant is responsible for repaying the overpayments.

With respect to the subject of this hearing, this Administrative Law Judge finds that, based on the above findings of fact and conclusions of law, the Department properly sought recoupment 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.

IT IS THEREFORE ORDERED that:

The Department's decision in seeking recoupment is **AFFIRMED**. The overpayment amount is [REDACTED].

William D Bond

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [REDACTED]

Date Mailed: [REDACTED]

WDB/db

cc: [REDACTED]

***** NOTICE *****

The Michigan Administrative Hearing System 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. Michigan Administrative Hearing System 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.