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

IN THE MATTER OF:

Docket No. 15-003032 HHR

[redacted],
Appellant,

[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 Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. Appellant appeared and testified on her own behalf. [redacted] Appeals Review Officer, represented the Respondent Department of Health and Human Services (MDHHS or the department). [redacted], Independent Living Specialist (ILS); [redacted], Adult Services Supervisor; and [redacted], Financial Manager Medicaid Collections Unit, appeared as witnesses for the Department of Health and Human Services (the Department or Respondent).

Respondent's Exhibit A pages 1-30 and Administrative Law Judge Exhibit 1-2 were admitted as evidence.

ISSUE

Did the Department properly pursue recoupment against the Appellant for an overpayment of Home Help Services (HHS) in the amount of [redacted]

FINDINGS OF FACT

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

1. Appellant was a Medicaid beneficiary.

2. In [redacted], the ILS conducted a home visit with Appellant.

3. As a result of the home visit, Appellant's Medical Assistance case closed and she was placed on a spend-down.

4. In [redacted] the ILS learned that the Appellant was using her Personal Care option to help meet her Medicaid spend-down, and, as such, was already paying the home help provider for the services the Department had authorized.

5. On [redacted], the ILS sent Appellant a Negative Action Notice letter stating that [redacted] was going to be recouped for the months of [redacted]r and [redacted] (after it was reported that Appellant was already paying for these services).

6. The payments for [redacted]r and [redacted] were only made due to the fact that a Negative Action had not been sent out to stop payments.

7. The recoupment is in response to a worker error and while there was no reason to believe that the services were delivered, the Appellant had already made payment to the provider for these services.

8. On [redacted], Appellant was notified again of the negative action.

9. On [redacted] the Department sent an Initial Collections Notice seeking to recoup payments for [redacted] and [redacted].

10. On [redacted], Appellant's hearing request was received by the Michigan Administrative Hearing System. (State's Exhibit 4).

11. On [redacted], the hearing was held.

12. At the hearing, Appellant waived the timeliness standard and requested to submit a letter from her provider indicating that she did not pay her provider out of pocket and did not use her HHS costs to meet her spend-down.

13. The record was left open until [redacted]

14. On [redacted], the department provided the Administrative Law Judge with the Michigan inspector General System Report. (Administrative Law Judge Exhibit 1-2)

15. On [redacted], no information had been received from Appellant and the was record closed.

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 (ASM) 165, 05-01-2013, 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.

ASM 165, page 1.

Client errors occur whenever information given to the department, by a client, is incorrect or incomplete. This error may be willful or non-willful.

Willful client overpayment occurs when all of the following apply:

- A client reports inaccurate or incomplete information or fails to report information needed to make an accurate assessment of need for services.

- The client was clearly instructed regarding their reporting responsibilities to the Department (a signed DHS-390 is evidence of being clearly instructed).

- The client was physically and mentally capable of performing their reporting responsibilities.

- The client cannot provide a justifiable explanation for withholding or omitting pertinent information.

When willful overpayments of $500.00 or more occur, a DHS-834, Fraud Investigation Request, is completed and sent to the Office of Inspector General; see BAM Items 700 - 720.

No recoupment action is taken on cases that are referred to OIG for investigation, while the investigation is being conducted. The specialist must:

- Complete the DHS-566, Recoupment Letter for Home Help.

- Select **Other** under the reason for overpayment. Note that a fraud referral was made to the Office of Inspector General.

- Send a copy of the DHS-566, with a copy of the DHS-834, Fraud Investigation Request to the Michigan Department of Community Health Medicaid Collections unit at:

  MDCH Bureau of Finance
  Medicaid Collections Unit
  Lewis Cass Building, 4th Floor
  320 S. Walnut
  Lansing, Michigan 48909

- **Do not** send a copy of the recoupment letter to the client or provider. MDCH will notify the client/provider after the fraud investigation is complete.

Note: When willful overpayments under $500 occur, initiate recoupment process.

Non-willful client overpayments occur when either:

- The client is unable to understand and perform their reporting responsibilities to the department due to physical or mental impairment.
- The client has a justifiable explanation for not giving correct or full information.

All instances of non-willful client error must be recouped. No fraud referral is necessary. ASM 165, pages 2-3

Computer or Mechanical Process Errors

A computer or mechanical process may fail to generate the correct payment amount to the client and/or provider resulting in an overpayment. The specialist must initiate recoupment of the overpayment from the provider or client, depending on who was overpaid (dual-party warrant or single-party warrant).

Specialist Errors

An adult services specialist error may lead to an authorization for more services than the client is entitled to receive. The provider delivers, in good faith, the services for which the client was not entitled to based on the specialist's error. When this occurs, no recoupment is necessary.

Note: If overpayment occurs and services were not provided, recoupment must occur. ASM 165, page 3

The Michigan Inspector General System (MIGS) report indicates that on [redacted] Appellant was a Medical Assistance (MA) and an ILS recipient. She had a spend-down of [redacted] Her current care amount was [redacted]. Appellant had been claiming, and the ES worker had been using, a personal care medical expense of [redacted] since [redacted] Appellant had also been receiving HHS payments for a care provider. This was a duplication of services at Appellant was already claiming to be paying her personal care services. The required criteria for Appellant to meet the spend-down using the personal care option and receive HHS payment has not been met. On [redacted] communication was made with the Adult Services Worker and the Eligibility Specialist. The ES worker e-mailed the Adult Services Worker on [redacted] stating that claimant is meeting her spend-down with the current care cost along with other receipts/bills the client is turning in. Therefore, client is not eligible for HHS payments as care costs does not exceed her spend-down. The HHS case should remain open as a support services case to assist in allowing the client to meet

her spend-down as an active HHS case is required for client to use the personal care option. If the care cost changes – either an increase or a decrease-that information must be reported to the ES worker for determination of eligibility. (Administrative Law Judge Exhibit 1)

Appellant testified on the record that she meets her spend-down with excess medical expenses every month without using the personal care expense. She did at one time [redacted]) pay her HHS out of pocket but since her health has changed, she now has sufficient medical expenses to meet the spend-down and qualify for HHS payments. Appellant did not provide evidence of her monthly medical expenses by the date of closure of the record.

Evidence on the record indicates that a Health Care Coverage Determination Notice dated [redacted] indicates that Appellant does have Medicaid Eligibility for the months of [redacted] through [redacted] and ongoing. (Respondent's Exhibit A, page 13) The notice also states that Appellant must pay the deductible amount to her personal care services provider. (Respondent's Exhibit A, page 14)

An [redacted] note from the ES worker indicates that she budgeted [redacted] and requested medical expenses. Appellant has provided ongoing medical expenses. With the [redacted] she is eligible for medical coverage. (Respondent's Exhibit A, page 20)

The Administrative Law Judge finds that the evidence on the record supports the Department contention that Appellant is using her HHS expense to meet her Medical Assistance spend-down and is receiving HHS payments which is a duplication of benefits.

DECISION AND ORDER

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

IT IS THEREFORE ORDERED that:

The Department's decision in seeking recoupment is **AFFIRMED**.

Landis Y. Lain
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]
Date Mailed: [redacted]

[redacted]
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LYL/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.