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. 15-010560 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]. The Appellant appeared on her own behalf and offered testimony. [redacted] Appeals Review Officer, represented the Department. [redacted], Adult Services Worker (ASW), [redacted] Adult Services Manager (ASM), and [redacted], Finance Manager, MDHHS Medicaid Collection Unit appeared as witnesses for the Department.

ISSUE

Did the Department properly pursue recoupment against the Appellant for Home Help Services (HHS) for payments issued covering the time period of [redacted] through [redacted] and [redacted] through [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. At some point in time, the Appellant signed and returned a DHS 4676 Statement of Employment. The DHS 4676 informed the Appellant that all changes must be reported to DHS within [redacted] days and that if the Provider is paid for services they did not perform, it must be paid back to the Department. (Testimony)

2. From approximate [redacted] through [redacted] HHS services were provided to the Appellant. (Exhibit A, pp 11, 17)

3. From [redacted] through [redacted], the Appellant was in the hospital. (Testimony)

4. On [redacted], the Appellant was issued a warrant check in the net amount of [redacted] for HHS rendered from [redacted] through [redacted]. (Exhibit A, p 25; Testimony)

5. From [redacted] through [redacted] the Appellant was in the hospital. (Testimony)

6. On [redacted], the Appellant was issued a warrant check in the net amount of [redacted] for HHS rendered from [redacted] through [redacted]. (Exhibit A, p 25; Testimony)

7. At some point in time in [redacted], the ASW was notified of the Appellant's prior authorizations. Around this time, the ASW followed up by reviewing hospitalization records and calling the hospital to verify dates of hospitalization. (Testimony)

8. At no point in time prior to [redacted], did the Appellant notify the Department of the hospitalizations. (Testimony)

9. On or around [redacted], the Department determined the Appellant was overpaid for HHS during the month of [redacted] due to a hospitalization. The Department determined the amount of the overpayment by taking the monthly net amount dividing that by the number of days in the month and multiplying that amount by the number of days hospitalized. (Testimony)

10. On [redacted], the Department sent the Appellant an overpayment letter. The letter indicated the reason for overpayment was HHS were not provided due to the Appellant being hospitalized from [redacted] through [redacted]. (Exhibit A, pp 5-7; Testimony)

11. On or around [redacted], the Department determined the Appellant was overpaid for HHS during the month of [redacted] due to a hospitalization. The Department determined the amount of the overpayment by taking the monthly net amount dividing that by the number of days in the month and multiplying that amount by the number of days hospitalized. (Testimony)

12. On [redacted], the Department sent the Appellant an overpayment letter. The letter indicated the reason for overpayment was HHS were not provided due to the Appellant being hospitalized from [redacted] through [redacted]. (Exhibit A, pp 8-10; Testimony)

13. On [redacted], the Department of Community Health sent a letter to the Appellant requesting repayment of [redacted] to the Home Help Program. (Exhibit A, pp 14, 15; Testimony)

14. On [redacted], Appellant's hearing request was received by the Michigan Administrative Hearing System. (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 (ASM) 101, 12-1-2013, addresses HHS available to a client. This policy provides in part:

> 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. [ASM 101, p. 1 of 4, emphasis added].

ASM 135, 12-1-2013, addresses Home Help Providers and their responsibilities under the HHS program. This policy states in part:

- 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. [ASM 135, p. 3 of 9].

ASM 125 12-1-2013 covers the MI-Choice Waiver Program:

> The MI Choice waiver program provides home and community-based services for individuals:
>
> - Aged (65 and over) and disabled persons who meet the MA nursing facility level of care.
> - Who require at least one MI Choice service on a continual basis.
> - Meet Medicaid financial eligibility criteria; see BEM 106.
>
> The Michigan Department of Community Health, Home and Com-munity Based Services Section, administers the waiver through contracts with organized health care delivery systems, commonly referred to as waiver agencies. For a list of the waiver agencies see **Exhibit I in BEM 106.**
>
> MI Choice participants **cannot** receive services from both the **home help program** and the **waiver** as this is a duplication of Medicaid services. The level of care (LOC) code for the MI-Choice waiver is **22.**

ASM 165, 5-1-2013, 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.

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Client Errors

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

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 physical and mentally capable of performing their responsibilities.
- The client cannot provide a justifiable explanation for withholding or omitting pertinent information.

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.

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.

Example: Provider error occurs when the provider bills for, and receives payment for services that were not authorized by the specialist or for services which were never provided to the client. [ASM 165 5-1-2013, pp. 1, 3].

The ASW testified the Appellant received the payment for services that she did not receive covering the time period of [redacted] through [redacted] and [redacted] through [redacted]. The Appellant however argued that there was a missed payment but could not specifically recall when it was from and furthermore could not specifically recall whether she received the warrant checks in question or not.

The ASW in this matter testified that the Appellant was made aware of his responsibilities to report the client's changes in circumstances as well as his responsibility to repay moneys received when she did not receive the actual service when she signed the DHS 4676. For this reason, I find that the Appellant was made aware of his responsibilities and therefore had a responsibility to notify the Department when she stopped receiving services and also was notified of her responsibility to repay money received for services she did not receive.
The above cited policy specifically addresses recoupment of payment for services that were not provided. As such, the Department was proper in seeking recoupment as during the time periods in question, the Appellant was hospitalized and not receiving HHS.

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 the payment for Home Help Services from [redacted] through [redacted] and [redacted] through [redacted] totaling [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 was [redacted]. The Appellant is responsible to the Department for an overpayment in the amount o [redacted].

Corey Arendt
Administrative Law Judge
for Director, Nick Lyon
Michigan Department of Health and Human Services

Date Mailed: [redacted]

Date Mailed: [redacted]

CAA/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.