STATE OF MIC HIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
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IN THE MATTER OF:

[redacted]

Docket No. 15-012746 HHR
Case No. [redacted]

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 telephone conference hearing was held on [redacted] Appellant personally appeared and testified. Mr. Sylvester Gavin appeared as a witness on behalf of Appellant.

[redacted], Appeals Review Officer, represented the Department of Community Health (DCH or Department). [redacted], Adult Services Worker (ASW), [redacted], Adult Services Supervisor (ASS), and [redacted], Finance Manager, appeared as witnesses for the Department.

ISSUE

Did the Department properly propose recoupment against Appellant for an Home Help Services (HHS) payment for the period between [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 all relevant times, Appellant has been a beneficiary of the Department's HHS program with the Michigan Department of Health and Human Services (Department or DHHS).

2. On [redacted] the Department issued a "Warrant information/Overpayment period(s) below…" letter (DHS-566) to Appellant for [redacted] for the period of time from [redacted] for the following reason: "Client Cashed check and did not pay provider." (Exhibit A.5). The [redacted] notice of case action lacks the law or regulations applicable that support the proposed action. (Exhibit A.5).

3. On [redacted] the Department issued an Initial Collection Notification" letter to Appellant stating in part: "Our records indicate that you owe the Adult Services Program $[redacted] You were previously notified of this debt by the Department of Human Services." (Exhibit A.6). The [redacted] does not

contain any authority/law or policy applicable to purported action. (Exhibit A.6).

4. On [redacted] the Medicaid Collections Unit issued a Final Collection Notification letter to Appellant making reference to the Department of Human Services. (Exhibit A.7) The [redacted] letter does not contain any authority/law, policy or regulations as required by federal and state law. (Exhibit A.7).

5. Unrefuted evidence is that the provider did provide HHS services for Appellant in December, 2014.

6. The Department based the recoupment action on a [redacted] telephone conversation that the ASW had with Appellant's provider, which the ASW documented as follows: "Spoke with previous provider ...states that she did not complete/sign last quarter logs or receive check issued on [redacted]. Adv [sic] that check would be recouped from client… ." (Exhibit A.11).

7. The provider who made the statements and representations to the Department that she did not receive or sign the [redacted] warrant was not present at the administrative hearing for testimony and/or cross-examination. The Department did not request a subpoena, or submit an affidavit on from the provider.

8. A copy of the [redacted] warrant for [redacted] provided by the issuing bank shows that both Appellant and the provider signed the warrant. (Exhibit B.1).

9. Appellant made numerous attempts to obtain information and explanations regarding the proposed action but did not receive the requested explanation and evidence. (Exhibit A.4; Testimony).

10. On [redacted] Appellant filed a hearing request, stating in part that the provider statements were not true. (Exhibit A.4).

11. Evidence indicates that the Department did not recoup for any of the months that the logs were not signed except for [redacted].

12. During the administrative hearing, the Department's witness (ASW) made an unannounced departure during direct examination; when the witness did not answer a question, her supervisor (ASS) stated that "she left to plug her meter." (Testimony of ASS).

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 physician and may be provided by individuals or by private or public agencies.

Adult Services Manual 165 (5-1-2013) (hereinafter "ASM 165') addresses the overpayment and recoupment process for HHS:

> **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.
>
> **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 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 Overpayment

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.

Administrative Errors

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 over-payment. 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.

RECOUPMENT METHODS

Adult Services Programs

The Michigan Department of Community Health (MDCH) has the appropriations for the home help and adult community placement programs and is responsible for recoupment of overpayments. The adult services specialist is responsible for notifying the client or provider of the overpayment.

Note: The adult services specialist **must not** attempt to collect overpayments by withholding a percentage of the overpayment amount from future authorizations or reducing the full amount from a subsequent month.

When an overpayment occurs in the home help program, the adult services specialist must complete the DHS-566, Recoupment Letter for Home Help.

Recoupment Letter for Home Help (DHS-566)

Instructions

The DHS-566 must: Reflect the time period in which the overpayment occurred. Include the amount that is being recouped

- Reflect the time period in which the overpayment occurred.

- Include the amount that is being recouped

  Note: The overpayment amount is the net amount (after FICA and union dues deduction), not the cost of care (gross) amount.

- If the overpayment occurred over multiple months, the DHS-566 must reflect the entire amount to be recouped.

  Note: A separate DHS-566 is not required to reflect an overpayment for multiple months for the same client.

- Two party warrants issued in the home help program are viewed as client payments. Any overpayment involving a two party warrant must be treated as a client overpayment.

Exception: If the client was deceased or hospitalized and did not endorse the warrant, recoupment must be from the provider.

- Overpayments must be recouped from the provider for single party warrants.

- When there is a fraud referral, **do not** send a DHS-566 to the client/provider. Send a copy to the MDCH Medicaid Collections unit with a copy of the DHS-834, Fraud Investigation Request.

Note: Warrants that have not been cashed are not considered overpayments. These warrants must be returned to Treasury and canceled.

The DHS-566 must be completed in its entirety and signed by the specialist. If information is missing from the letter, the specialist will receive a memo from the MDCH Medicaid Collections unit requesting the required information.

ASM 165, pages 1-5 of 7

Also applicable to the case here are the federal notice requirements and corresponding due process/evidentiary issues found at 42 CFR. These regulations state in part:

NOTICE

§431.210 Content of notice.

A notice required under §431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain—

(a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;

(b) The reasons for the intended action;

(c) The specific regulations that support, or the change in Federal or State law that requires, the action;

(d) An explanation of—

(1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or

(2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

(e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992]

§431.211 Advance notice.

The State or local agency must send a notice at least 10 days before the date of action, except as permitted under §§431.213 and 431.214.

[78 FR 42301, July 15, 2013]

Also applicable to the case here are the federal regulations regarding procedural rights of the applicant or beneficiary:

§431.242 Procedural rights of the applicant or beneficiary.

The applicant or beneficiary, or his representative, must be given an opportunity to—

(a) Examine at a reasonable time before the date of the hearing and during the hearing:

(1) The content of the applicant's or beneficiary's case file; and

> (2) All documents and records to be used by the State or local agency or the skilled nursing facility or nursing facility at the hearing;
>
> (b) Bring witnesses;
>
> (c) Establish all pertinent facts and circumstances;
>
> (d) Present an argument without undue interference; and
>
> (e) Question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.
>
> [44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56506, Nov. 30, 1992]

First, it should be noted that in this case, both sides agree that services were in fact provided by the provider for the month of [redacted]. Thus, there is no issue here that an overpayment resulted because services were never provided. Services were provided.

Here, the Department's argument here that an overpayment occurred allegedly due to "Client Cashed check and did not pay provider." (Exhibit A.5). As noted in the Findings of Fact, the Department ASW based this decision based on a statement made by the provider to the ASW that she did not sign the last quarter logs, and, did not receive the check issued on [redacted]. (Exhibit A.11).

Appellant essentially argues that the provider's statements are not true. Appellant made numerous attempts to speak with someone at the DHS regarding the alleged debt, (Exhibit A.4), to no avail. Appellant also argues that she was not given copies of the check despite having requested the same, and did not understand why the Department was attempting to recoup. Appellant argues that the provider received all monies she was owed. (Exhibit A.4; Testimony).

After a careful review of the substantial and credible evidence of the whole record, this Administrative Law Judge finds that the Department has failed to bring forth credible and substantial evidence to support the proposed action for the reasons set forth below.

First and foremost, the Department's documentary evidence that the provider did not sign the warrant was not shown. The Department failed to include a copy of the warrant in the evidentiary packet, and, failed to give Appellant an opportunity to examine the document prior to the administrative hearing despite her numerous requests. Upon request by the ALJ at the hearing, the warrant was then and only then made part of the evidentiary record. The [redacted] warrant contains both the Appellant's and the provider's signatures. (Exhibit B.1).

Second, the provider's statement that she did not sign the warrant could not be challenged as the provider was not present at the administrative hearing for testimony and/or cross-examination. Appellant questioned the veracity of the statement. The Department did not have its witness to the administrative hearing, did not obtain a written statement, did not obtain an affidavit, and no subpoena was requested. The inability of Appellant to prepare for the hearing, and to confront and cross-examine an adverse witness violated 42 CFR 431.242 as well as numerous other federal and state requirements discussed below. It is hearsay, not credible, and violates due process rights. Such a statement cannot be given any credible weight by this forum, as explained below.

A Medicaid agency must issue a written notice whenever the agency takes any action affecting a recipient's claim for services. 42 CFR 431.206 Adequate notice is a fundamental component of due process. In *Mathews v. Eldridg*e, 424 US 319, 348-349 (1976), the Supreme Court noted that "[t]he essence of due process is the requirement that 'a person in jeopardy of serious loss (be given) notice of the case against him and opportunity to meet it.'" (quoting *Joint Anti-Fascist Comm. v. McGrath*, 341 US 123, 171-172. (Frankfurter, J., concurring)). The court in *Kapps* noted that, "[i]n order to be constitutionally adequate, notice of benefits determinations must provide claimants with enough information to understand the reasons for the agency's action." (404 F.3d at 123) The agency must make the reasons for its decision plain so that "the opposing party can evaluate and challenge them." *Gaines v. Hadi*, Not Reported in F.Supp.2d, 2006 WL 6035742 at 12 (S.D.Fla. 2006). "Claimants cannot know whether a challenge to an agency's action is warranted, much less formulate an effective challenge, if they are not provided with sufficient information to understand the basis for the agency's action." *Kapps*, 404 F.3d at 124.

In *Ortiz v. Eichler*, 794 F.2d 889 (3d Cir. 1985), the District Court had directed the agency to issue notices that comply with the federal regulations and principals of due process. The order noted, "[a]t a minimum, these notices shall...3) provide a detailed individualized explanation of the reason(s) for the action being taken which includes, in terms comprehensible to the claimant, an explanation of why the action is being taken and, if the action is being taken because of the claimant's failure to perform an act required by a regulation, an explanation of what the claimant was required by the regulation to do and why his or her actions failed to meet this standard ...." 794 F.2d at 892 (quoting the District Court order). The Third Circuit approved this directive, holding that it tracked the notice requirements set forth in federal regulations. (National AT Advocacy Project; Neighborhood Legal Services, Inc; Sheldon & Straube; February, 2011).

These legal tenets are part of basic evidentiary requirements in American jurisprudence and documented in numerous state law, policy and rules. In the Department of Licensing and Regulatory Affairs, MAHS, Administrative Hearing Rules, Rule 106 requires the ALJ to examine witnesses necessary to complete a record. Rule 106(1)(l), and under R 792.10128, Rule 128(d) opposing parties shall be entitled to cross-examine witnesses. The inability to examine all witnesses also violates the due process rights under the Rights of parties section R 792.11008 wherein it states that a claimant

has the right to "question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses." Rule 792.11008(i).

In addition, Department of Licensing and Regulatory Affairs, MAHS, Administrative Rules, and as applicable the provisions of Chapter 4 of the Michigan Administrative Procedures Action of 1969, 1969 PA 306, MCL 24.271 to 24.287 apply. MAPA specifically indicates in 24.272 that "A party may cross-examine a witness, including the author of a document prepared by, on behalf of, or for the use of the agency and offered into evidence. The party may submit rebuttal evidence." MAPA, 24.272(4).

BAM 600 also states:

> Both the local office and the client or AHR must have adequate opportunity to present the case, bring witnesses, establish all pertinent facts, argue the case, refute any evidence, cross-examine adverse witnesses, and cross-examine the author of a document offered in evidence. P 36.

The federal requirements found at 42.CFR cited above, as well as those cited above in the state laws, policies and rules, are not extra verbiage. They are specifically intended to protect and ensure that the individual has a right to understand the action the state intends to take, the reasons, and the specific regulations that support the action, and to ensure that the hearing process is fair and allows both sides to prepare and understand the evidence brought forth. 42 CFR 431.210, 211, 213; MAC R 792.11003; BAM 600; ASM 165; and DCH Administrative Hearing Pamphlet.

Here, Appellant was denied the opportunity to adequately prepare as she was not given notice of the evidence and the laws and regulations. Nor was the evidence submitted for the first time at the administrative hearing credible or substantial evidence of an overpayment as defined under Department policy and procedure. For these reasons and for the reasons stated above, the Department's proposed recoupment is not based on credible and substantial evidence and thus, the Department's proposed action must be reversed.

It is noted that the provider represented to the Department was that the provider did not sing the last quarter logs. If credible, policy would require recoupment as the HHS logs do not comply with policy requirements; however here, there was no evidence presented here that the Department is recouping an overpayment against Appellant or the provider for the months of October, 2014 and November, 2014.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly proposed recoupment against the Appellant for the time period from [redacted]

IT IS THEREFORE ORDERED THAT:

The Department's recoupment action is **REVERSED.**

The Department is ordered to remove the debt totaling [redacted] for the time period from [redacted] against Appellant from its collections data base.

Janice Spodarek
Administrative Law Judge
for Nick Lyon, Director
Michigan Department of Health and Human Services

Date Signed: [redacted]

Date Mailed: [redacted]

[redacted]

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. The 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.