

ISSUE

Whether the Department acted properly when it issued an Order of Summary Suspension to Petitioners on November 22, 2021, effective November 24, 2021.

FINDINGS OF FACT

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

1. Petitioners were enrolled with the Department as Medicaid providers, providing Home Help services to Medicaid beneficiaries. (Exhibit A, pp 010; 014; Testimony).
2. REDACTED is the owner and operator of REDACTED, LLC. By signing the Medicaid Agreement, REDACTED agreed to comply with the provisions of 42 C.F.R. § 455.107, 42 C.F.R. § 455.104, 42 C.F.R. § 455.105, and The Social Welfare Act. (Exhibit A, pp 009-026; Testimony)
3. In 2019-2020, MDHHS OIG performed a post payment review of Petitioners' Home Help Agency and identified an overpayment in the amount of REDACTED. (Exhibit A, pp 003, 027-037; Testimony)
4. MDHHS OIG identified the overpayment because Petitioners were being paid at the agency rate for Home Help providers without meeting Medicaid policy's staffing requirements under ASM 136. (Exhibit A, pp 003, 027-037; Testimony)
5. On October 6, 2020, MDHHS OIG sent Petitioners a Notice of Preliminary Findings. The Notice provided Petitioners 30 days to provide any additional documentation to support the claims. (Exhibit A, pp 027-031; Testimony)
6. On November 9, 2020, after not receiving any additional documentation from Petitioners, MDHHS OIG sent Petitioners a Notice of Final Recovery. The final amount due was REDACTED (Exhibit A, pp 032-037; Testimony)
7. The Notice of Final Recovery allowed Petitioners 30 days to appeal the findings, either through an Internal Conference or an Administrative Hearing. (Exhibit A, pp 033-034; Testimony)
8. Petitioner did not appeal the Notice of Final Recovery. (Testimony)
9. On November 22, 2021, MDHHS issued an Order of Summary Suspension to Petitioners, suspending Petitioners from participation in the Michigan Medicaid Program, effective November 24, 2021, for failing to participate in

good faith repayment negotiations. (Exhibit A, pp 006-007; Testimony)

10. On December 6, 2021, the Department of Attorney General, acting as the Department's collection agency, sent Petitioners financial disclosure forms to complete and return within 30 days. As of the date of the hearing, Petitioners had not returned the forms. (Testimony)
11. As of the date of this Order, Petitioners have also failed to set up a repayment plan or make any payments towards the outstanding balance. (Testimony)
12. On November 24, 2021, Petitioners filed a request for hearing. (Exhibit 1)

CONCLUSIONS OF LAW

The Social Welfare Act of 1939, 1939 PA 280, (Act) as amended, provides for the summary suspension of Medicaid providers.

MCL 400.111f provides, in pertinent part:

(1) The director may issue an order incorporating a finding that emergency action is required to protect the state's interest, as the state's interest is described in this subsection by the statement of circumstances warranting emergency action, in any of the following: the public health, welfare, or safety; medically indigent individuals; or public funds of the program of medical assistance. Circumstances that warrant emergency action include, but are not limited to, any of the following:

(a) A reasonable belief, determined in accordance with professionally accepted standards, that rendered services for which a provider has submitted claims were medically unnecessary, inappropriate, or of inferior quality, and therefore that the continued participation in the program by the provider or payments to the provider for services constitutes a threat to the public health, safety, or welfare or to the health, safety, or welfare of recipient medically indigent individuals.

(b) A reasonable belief that the provider has violated the Medicaid false claims act, Act No. 72 of the Public Acts of 1977, being sections 400.601 to 400.613 of the Michigan Compiled Laws, the health care false claims act, Act No. 323 of the Public Acts of 1984, being sections 752.1001 to 752.1011 of the Michigan Compiled Laws, or a substantially similar statute of another state or the federal government.

(c) A reasonable belief that the overpayment sought to be recovered pursuant to this section, or pursuant to any other section of this act, is in jeopardy of not being recovered.

(d) A reasonable belief that 10% or \$10,000.00, whichever is less, for a noninstitutional provider, or 10% or \$50,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted at any time during the most recent 12-month period was unsubstantiated or was for services that were noncovered.

(e) A reasonable belief that 10% or \$10,000.00, whichever is less, for a noninstitutional provider, or 10% or \$50,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted at any time during the most recent 12-month period were medically unnecessary, inappropriate, or of inferior quality.

(f) A reasonable belief that 15% or \$15,000.00, whichever is less, for a noninstitutional provider, or 15% or \$75,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted at any time during a consecutive 12-month period, and that 5% or \$5,000.00, whichever is less, for a noninstitutional provider, or 5% or \$25,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted during the most recent 12-month period, was for services that were noncovered.

(g) A reasonable belief that 15% or \$15,000.00, whichever is less, for a noninstitutional provider, or 15% or \$75,000.00, whichever is less, for an institutional provider, of the provider's claims submitted at any time during a consecutive 12-month period, and that 5% or \$5,000.00, whichever is less, for a noninstitutional provider, or 5% or \$25,000.00, whichever is less, for an institutional provider, of the provider's total program dollar amount for claims submitted during the most recent 12-month period, was for services that were medically unnecessary, inappropriate, or of inferior quality.

(h) A reasonable belief that the provider is refusing to comply with section 111b(7), (19), or (25).

* * * *

(5) Upon a determination that circumstances described in subsection (1) exist, the director may issue an order for the

summary suspension of payments on pending or subsequent claims, in whole or in part, or for the summary suspension of a provider from participation in the program of medical assistance. The summary suspension shall be effective on the date specified in the order or on service of a certified copy of the order on the provider, whichever occurs later, and shall remain in effect during administrative or judicial proceedings on the suspension. Upon request of a provider, a contested case hearing pursuant to chapter 4 and chapter 6 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 and 24.301 to 24.306 of the Michigan Compiled Laws, shall be commenced not later than 15 days after the summary suspension. If a contested case hearing is requested by a provider relative to an emergency suspension under this section, a hearing shall be held to determine whether the emergency suspension is supported by competent, material, and substantial evidence on the whole record. Under appropriate circumstances, the state department may hold or institute a hearing under section 111c(1), or take an action under section 111d at the same time an action is taken under this section, while an action under this section is pending, or after a decision on an action is made. The presiding officer may consolidate the 2 hearings into a single proceeding in the interest of economy. However, the director shall not make a final decision in a contested case under section 111c(1) or 111d arising from or related to an emergency action or the circumstances upon which an emergency action was taken.

(MCL 400.111f(1)(a)-(h), (5), Emphasis added)

MCL 400.111b provides, in pertinent part:

(1) As a condition of participation, a provider shall meet all of the requirements specified in this section except as provided in subsections (25), (26), and (27).

(16) A provider promptly shall notify the director of a payment received by the provider to which the provider is not entitled or that exceeds the amount to which the provider is entitled. If the provider makes or should have made notification under this subsection or receives notification of overpayment under section 111a(17), the provider shall repay, return, restore, or reimburse, either directly or through adjustment of payments, the overpayment in the manner required by the director. Failure to repay, return, restore, or reimburse the overpayment or a

consistent pattern of failure to notify the director shall constitute a conversion of the money by the provider.

MCL 400.111d provides, in pertinent part:

(1) Participation as a provider in the program is subject to denial, suspension, termination, or probation on the grounds specified by section 111e. The director may take 1 or more of the following actions:

(a) Refuse to enroll an applicant.

(b) Suspend a provider indefinitely or for a term certain.

MCL 400.111e provides, in pertinent part:

(1) The grounds for action by the director under section 111d(1) and the actions to which they may be applied shall be as follows:

(5) In addition to or in place of the grounds specified in subsection (1), (2), or (3), the director may base an action provided for in section 111d(1)(a), (b), (c), (d), (e), or (f) on his or her judgment that the action is necessary to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program. (Emphasis added.)

The *Michigan Medicaid Provider Manual, General Information for Providers Section, Section 6 — Termination of Enrollment* October 1, 2021, pp. 12-13, governs termination of Medicaid Providers enrollments, including summary suspensions. It states as follows:

SECTION 6 - DENIAL OF ENROLLMENT, TERMINATION AND SUSPENSION

6.1 TERMINATION OR DENIAL OF ENROLLMENT

MDHHS may terminate or deny enrollment in the Michigan Medicaid program. Termination of enrollment means a provider's billing privileges have been revoked and all appeal rights have been exhausted or the timeline for appeal has expired. Denial of enrollment means the provider's application will not be approved for participation in the Medicaid program.

The basis for termination or denial of enrollment includes, but is not limited to:

- Failure to submit timely and accurate information;
- Failure to cooperate with MDHHS screening methods;
- Conviction of a criminal offense related to Medicare, Medicaid, or the Title XXI program in the last 10 years;
- Termination on or after January 1, 2011 under Medicare or the Medicaid program, or the Children's Health Insurance Program (CHIP) of any other state;
- Failure to submit sets of fingerprints as required within 30 days of a CMS or MDHHS request;
- Failure to permit access to provider locations for site visits;
- Falsification of information provided on the enrollment application; or
- Inability to verify a provider applicant's identity.
- Failure to comply with Medicaid policies regarding billing Medicaid beneficiaries.

Providers may appeal the decision to terminate or deny enrollment. Denial of enrollment due to a temporary enrollment moratorium is appealable, but the scope of review is limited to whether the temporary moratorium applies to the provider appealing the denial. The basis for imposing a temporary moratorium is not subject to review. After termination from the Medicaid program, the provider must contact MDHHS to request re-enrollment as a Medicaid provider and reinstatement of billing privileges. Providers whose enrollment has been denied are not prohibited from submitting a subsequent reenrollment application.

Summary suspension prevents further payment after a specified date, regardless of the date of service (DOS.).

If an indication of fraud or Medicaid misuse/abuse is discovered during any of the following, MDHHS considers it as a basis for summary suspension:

- An evaluation of billing practices.

- The prior authorization (PA) process.
- An on-site review of financial and medical records and a written report of this review is filed.
- The construction of a profile to evaluate patterns of utilization of Medicaid beneficiaries served by the provider.
- A peer review of services or practices.
- A hearing or conference between MDHHS and the provider (and counsel, if so requested).
- Indictment or bindover on charges under the Medicaid or Health Care False Claim Act or similar state/federal statute.

Any entity that offers, in writing or verbally, discounts on co-pay amounts, fax machines, computers, gift cards, store discounts and other free items, or discounts/waives the cost of medication orders if an entity uses their services:

- May violate the Medicaid False Claim Act and Medicaid/MDHHS policy, which may result in disenrollment from Medicaid/MDHHS programs.
- May violate the Michigan Public Health Code's prohibition against unethical business practices by a licensed health professional, which may subject a licensee to investigation and possible disciplinary action.

The record establishes that Petitioners are enrolled Medicaid Providers and executed an application agreement in which they agreed to adhere to all of the terms and conditions listed therein.

In this case, the Department argues that the evidence presented supports its summary suspension action because Petitioners did not appeal the Notice of Final Recovery dated November 9, 2020 and have since failed to set up a repayment plan or make any payments towards the outstanding balance. As such, the Department argues that summary suspension is appropriate because under MCL 400.111f (1)(c) there is, "A reasonable belief that the overpayment sought to be recovered pursuant to this section, or pursuant to any other section of this act, is in jeopardy of not being recovered." The Department also argues that suspension is necessary to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program.

Petitioner testified that she was audited in 2019 and has since fallen on great hardship. Petitioner indicated that the Department gave her as many extensions as they could but then she divorced in 2019 and things got worse. Petitioner testified that during the audit

she had difficulty with her tax preparer so she could not provide the proof the Department required to show she was entitled to the agency rate. Petitioner indicated that she was finally able to file her first quarter taxes in 2020, but then the pandemic hit, and her business was hurt even more. Petitioner noted that the Department then reduced her payment rate from the agency rate to the individual rate, which further hampered her ability to pay back the money. Petitioner testified that currently she has no income so she cannot repay the money. Petitioner did indicate that her business is still running, and she still has employees, although she did lose one client during the pandemic. Petitioner testified that she was seeking any leniency or relief the Department could offer. Petitioner noted that she has applied for some funding for her business and if that comes through, she will repay the money or set up a repayment plan.

In response, the Department's witness indicated that the Department would lift the summary suspension as soon as Petitioner either paid back the money or set up a repayment plan.

Having considered the parties' arguments in full, the Department has established by a preponderance of the evidence, that its summary suspension was proper.

First, it should be noted that since Petitioner failed to appeal the Final Notice of Recovery, the existence of the overpayment, and the amount of the overpayment, is not in dispute here. The only question is whether the Department's summary suspension was appropriate given Petitioner's failure to repay the overpayment or set up a payment plan.

As indicated above, MCL 400.111f(c) provides that summary suspension is appropriate where there is, "A reasonable belief that the overpayment sought to be recovered pursuant to this section, or pursuant to any other section of this act, is in jeopardy of not being recovered." The Legislature determined that the Department must only meet a reasonable belief standard of proof when taking emergency action under The Social Welfare Act. The rationale for this standard of proof is clear. A temporary suspension of Medicaid enrollment may be necessary under the listed circumstances to protect the public health, welfare, or safety of the medically indigent individuals, or public funds of the program of medical assistance until definitive proceedings are held on the merits. Given the lapse of time and Petitioners' failure to repay, return, restore, or reimburse, either directly or through adjustment of payments, the overpayment, there is more than a reasonable belief the overpayment sought to be recovered is in jeopardy of not being recovered. As indicated, Petitioners have made no payments and have not set up a repayment plan since the Notice of Final Recovery was issued on November 9, 2020.

Also, as a condition of participation, a provider shall repay, return, restore, or reimburse, either directly or through adjustment of payments, an overpayment in the manner required by the director. MCL 400.111b(1) & (16). Again, Petitioners have failed to repay, return, restore, or reimburse, either directly or through adjustment of payments, the overpayments as established following the audit. Petitioners have also failed to establish a repayment plan. Therefore, they are not in compliance with MCL 400.111b and are not in a condition to participate.

Furthermore, MCL 400.111d(1) states, in relevant part:

Participation as a provider in the program is subject to denial, suspension, termination, or probation on the grounds specified by section 111e. The director may take 1 or more of the following actions:

- (a) Refuse to enroll an applicant.
- (b) Suspend a provider indefinitely or for a term certain
- (c) Terminate the agreement with and the participation of a provider.

In turn, MCL 400.111e(5) provides one of those grounds—the Director may suspend a provider "on his or her judgment that the action is necessary to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program." Here, a summary suspension of Petitioners' enrollment is necessary to protect the state's interest in the public health, welfare, or safety; medically indigent individuals, or public funds of the program for medical assistance. A Medicaid provider who is having issues making any payments to the Department, or even setting up a payment plan, could be in such dire straights that the health, welfare or safety of Medicaid beneficiaries could be at risk. In addition, should the Department not take action to recover Medicaid overpayments, it could be placing future funding for the program at risk.

As such, the Department's Order of Summary Suspension is proper and should remain in place.

IT IS THEREFORE ORDERED that:

The Order of Summary Suspension issued by the Department on November 22, 2021, effective November 24, 2021, is UPHELD.