
**PAYMENT
OVERVIEW**

The Adult Services Authorized Payments (ASAP) is the payment system that processes adult services authorizations. The adult services worker enters the payment authorizations using the payments module in the ASCAP system.

- Warrants are delivered to the licensed provider each month after they submit a billing to the ASAP system for residents in their facility.
- Payments can be a full or partial month for reasons of temporary absence from the facility such as nursing home rehabilitation or hospital stay.
- The invoice must be entered in ASAP with the exact date of the authorization in ASCAP or the payment will not be processed.
- If at any time a warrant is not received or missing, there is a process to have the payment reissued.
- If the warrant was paid in error, the adult services worker must follow the recoupment process.

Funding Sources

The payments have two different funding sources depending on the needs of the residents.

1. Payments for residents who need personal care services provided in licensed Adult Foster Care (AFC), County Infirmaries (CI) and Home for the Aged (HA) are funded by Title XIX Medicaid funds.
2. Payments for residents who are not in need of personal care services but do need the supervision provided in licensed AFC, County Infirmaries and HA are funded by state dollars - General Fund/General Purpose (GF/GP).

Title XIX

The information on the assessment helps determine the funding source of the personal care supplement payment. If there is a limitation noted in at least one of the Activities of Daily Living (ADL) that is ranked a **level 2, 3, 4, or 5**, the adult services worker needs to have the client's physician complete a DHS-54A, Medical Needs

form. The physician certifies there is a need for personal care by checking "yes" on the form. The DHS-54A physician signature date must be entered into ASCAP to direct the personal care supplement payment dispersing out of Title XIX funds.

For Medicaid clients residing in a license facility, it is not necessary to delay entry of the initial authorization of payment while waiting for the DHS-54A to be obtained. The initial authorization may be put on the system for a short duration-90 days or less- when state funds are used for the payment.

Note: The adult services worker must remember to change the authorization once the DHS-54A is received by entering the date the physician signed and approved the need for personal care in the Medical tab in ASCAP. If state funds were the source, end date that authorization and enter the new 54A date. The ASAP payment system will switch payment to Title XIX funds to pay the licensee provider for services.

State Funded

State funds are used when the client is on Medicaid and has no ADL needs or medication requirements. The personal care supplement is paid using state funds. 54A form signed by the physician that states "no" means the 54A date is **not** entered in ASCAP.

Payment Authorizations

Licensed AFC homes, County Infirmaries and HA residents that have Medicaid are eligible for the personal care supplement payment from either GF/GP state funds prior to the obtaining of a DHS-54A, or from federal Title XIX funds after receipt of a DHS-54A stating the resident requires personal care.

Initial Authorization in ASCAP

The adult services worker will search in the payment module in ASCAP for the AFC provider. The provider is linked to the open ACP case client so the personal care supplement payment can be authorized. Authorizations will error out unless there is an active service case in the ACP program and an open Medicaid case with a scope of coverage of 1F, 2F, or 3G.

The pay start date and pay end date establish the duration of an authorization. Authorizations can be for one day, a partial month,

the current month, the future up to six months to the next review, retroactively or any combination of the above.

The pay begin date for an authorization will typically be the date of admission to the facility or the date the client became eligible for Medicaid after admission. Normally the pay end date is the last day of the month following the second six month review (annually).

Updates to Payment Authorizations

After the initial authorization, the adult services worker will often update the payment authorization at the review. If all information on the client and the provider remain the same, a new authorization is put on ASCAP.

If there is a change in provider, the client moves, or there is a break in services such as hospitalization, the authorization must be terminated with an end date. Each example is explained below:

- **Hospitalization.** When a client is hospitalized more than 24 hours, the adult services worker must stop payment. Medicaid pays the hospital from the date the client enters the hospital through the day prior to discharge. The AFC facility is then paid from the date of return to the home.

Example: The client enters the hospital on 5-18-2016. The AFC would be paid through 5-17-2016. The Adult services worker enters 5-17-2016 as the stop date of payment to the AFC. The hospital will bill Medicaid for the day the resident entered the hospital. When the client returns to the AFC from the hospital, the day of return to the AFC can be entered for the AFC to begin billing.

- **Temporary Absence Other Than Hospital.** Absences up to 104 days a year are permissible without an adverse effect on the AFC-HA personal care supplemental payment. This will eliminate a potential disincentive and encourage family visits, weekends or vacation time away from the facility. Providers will need to record the dates of absences in the facility resident record and adult service workers will monitor this at the time of the six month and annual redeterminations. Absences of more than 8 days a month, but less than 104 days a year must be approved by the Adult services worker and supervisor.

Reinstatement of Authorization

If a client returns to a facility within 90 days after the services case was closed and payment terminated, it is not necessary to have a

new **DHS-390 or DHS-54A Medical Needs** form. A new assessment is recommended. However, the worker is to re-open the case on ASCAP and reinstate the authorization for the personal care supplement payment.

Payments automatically stop

Personal care supplemental authorizations (code 0401) will automatically stop for the following reasons:

- Authorization end date is reached.
- Services case closes.
- Medicaid eligibility ends.
- Provider license ends.
- Level of Care (LOC) code error.
- Medicaid benefit program code is not eligible.

Payments on closed cases

An authorization can be completed on a closed case for a time period the case was open, Medicaid was active and the provider was assigned to the case. A Supervisor will need to approve this authorization.

Note: If the provider was not assigned prior to the case closure, contact the Adult Services Policy Unit for assistance via the policy email at: MDHHS-Adult-Services-Policy@michigan.gov. Please enter **ACP** in the subject line.

Adult Services Policy Unit payment exceptions

The following payment authorizations will be forwarded via ASCAP to the Adult Services Policy Unit for processing:

- Authorization period is more than six months prior to the current date. Payments within six months or future authorizations must be approved locally and cannot be approved as an exception. If the adult services worker happens to have a retroactive payment request that spans six months and beyond the current date (no more than 365 days prior to the current date), the request must be split into two different approval request.

Example: Today's date is July 24th and your licensed facility is requesting Title XIX personal care payments from the date the adult moved in, which was the month of July of the prior year. There would be two payments put in ASCAP, one being July through

December 31 (which would first be approved by your local supervisor and then pended to central office), and the second request from January 1 to the July 24th (which would be approved by your supervisor only).

- Authorizations that occur during the same time period as other adult services program (for example, Adult Protective Services payment and ACP payment). The authorization submitted to central office must only be for the time period the programs overlap.

Example: An APS payment was requested for living cost for a client who moved into an AFC facility November 1st through the 30th. An ACP case was opened also because the client qualifies for Medicaid, has personal care needs, and will remain at the facility permanently. The authorization to central office must reflect the overlap period of November 1 to the 30th on each request.

Whichever authorization is entered first is approved at the local office. The second authorization requires central office approval.

Example: An APS authorization was entered first will be approved by local office. The secondary ACP authorization will pend to central office for approval and vice versa.

- Cases that are closed in ASCAP but was open and active during the authorization period requested.
- The authorization is for a provider in a service period for which another provider has received an erroneous payment.
- Cases where an administrative error occurred. These exceptions must be approved by a local office director or designee in addition to the supervisor.

All payment exception requests sent to the supervisor and central office must have adequate justification explained in the rationale box in ASCAP with details as to why an exception is required.

If clear explanation is not provided with the exception, the payment request will be either delayed with central office asking for clarification or the request will be denied.

Payment authorizations approved by central office will contain the number "9" before the service code (9301, 9302, or 9401) on the payment line in ASCAP. When the payments are approved or denied, the Adult services worker will receive a confirmation E-mail.

**ASAP Licensee
Monthly Billings**

The licensee is required to enroll online at the State of Michigan Vendor Registration (MAIN) at [CPEXPRESS](#) or at this address: www.michigan.gov/cpexpress.

The licensee must enroll with the ASAP system. The licensee must have a PIN number prior to accessing the ASAP billing system. To obtain a PIN number, the licensee must call the Provider Hotline at 1-800-979-4662.

Licensee providers will submit billing for services provided each month using one of two methods:

- In order to bill via the internet access, the provider uses the [MILogin](#) access or at address <https://milogintp.michigan.gov>.
- To bill via telephone access, the provider calls 1-800-798-1409.

The services dates authorized by the adult services worker must match what the provider is billing or no payment will be issued.

Web or phone billing access is available 24 hours a day, 7 days a week.

All months with partial service dates will result in a prorated payment to the AFC/HA.

Provider information on how to enroll in MILogin (scroll down to Provider and Advocate column) is available online at the [MILogin information page](#).

AFC/HA providers will be issued a 1099 form each January.

**WARRANTS
OVERVIEW**

Problems receiving the payments can result from the warrant being lost, undeliverable, or received but destroyed by post office machinery. Please see **ASM-160** for complete step-by-step instructions for warrant replacement or cancellation procedures.

Resolving Payment Problems

Some of the reasons of non-payment can be the result of such things as:

- Incomplete information when a licensee submits a claim to ASAP.
- A lack of correct dates on a payment authorization.
- Change in the licensee status from the Bureau of Community and Health Systems (BCHS)

To assist in determining a payment problem, an adult services worker can:

- Review the licensee information shown in ASCAP for incorrect mailing information, tax ID, or payment authorization time periods.
- Verify with the licensee provider that they also enrolled with the State of Michigan Vendor registration at www.michigan.gov/cpexpress.

A Troubleshooting ACP Payment Issues list can be found on the Adult Services intranet ACP home page for reference.

If the adult service worker is not able to determine the problem after following these directions, they should then contact Adult Service Policy Unit via the policy mailbox: MDHHS-Adult-Services-Policy@michigan.gov for additional assistance. In the email subject line enter **ACP payment issue**.

Recoupment

Notification is sent to the MDHHS Medicaid Collections Unit when an overpayment to an AFC has been discovered. The **DHS-567, Recoupment Letter for ACP/HA**, form is used specifically for recoupment of an overpayment to a licensed provider. When the DHS 567 is generated in ASCAP, the form is automatically sent to MDHHS Medicaid Collections Unit. If the adult services worker generates more than one form in error, then the Medicaid Collections unit must be notified with the correct request.

If the AFC is not cooperative regarding the overpayment, notification to the license consultant would be necessary as a rule violation may have occurred.

For more detailed information on the recoupment process, please see **ASM-165, Overpayment and Recoupment Process**.