STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:
[redacted]

Reg. No: 201014213
Issue No: 6052
Case No: [redacted]
Load No:
Hearing Date:
April 21, 2010
Marquette County DHS

ADMINISTRATIVE LAW JUDGE: Robert J. Chavez

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37, 7 CFR 273.16, MAC R 400.3130, and MAC R 400.3178 upon the Department of Human Services' request for a disqualification hearing. After due notice, a telephone hearing was held on April 21, 2010. Respondent did not appear at the hearing and it was held in respondent's absence pursuant to 7 CFR 273.16(e). MAC R 400.3130(5), or MAC R 400.3187(5).

ISSUE

Did the respondent commit an Intentional Program Violation (IPV) and did the respondent receive an over-issuance of benefits that the Department is entitled to recoup?

FINDINGS OF FACT

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

1) Respondent was a recipient of CDC benefits during the period of August 5, 2007 through March 28, 2009.

2) On June 30, 2008, respondent was first approved for CDC benefits and was informed that her CDC provider was authorized to bill for the times respondent was working.

3) All payments were sent to the respondent, and respondent was to turn over the payments to the CDC provider.

4) During the time period in question, respondent's CDC providers billed for hours far in excess of the hours needed, as shown by job and work activity verifications turned in when the issue was discovered.

5) This over-billing resulted in the Department issuing checks for more CDC benefits than respondent was legally entitled to receive.

6) There is no evidence respondent kept the checks; all monies involved were turned over to the CDC provider.

7) On December 8, 2009, the Department's Office of Inspector General (OIG) filed a hearing request to establish an over-issuance of benefits received by respondent as a result of respondent having committed an Intentional Program Violation (IPV); the OIG also requested that respondent be disqualified from receiving program benefits.

8) It is unknown if the OIG ever investigated the CDC providers in the current case.

9) A Notice of Disqualification Hearing was mailed to respondent at the last known address and was not returned by the U.S. Post Office as

undeliverable. Respondent's last known address is [redacted], [redacted].

10) OIG Agent [redacted] represented the Department at the hearing; respondent did not appear.

11) This is respondent's second alleged IPV.

CONCLUSIONS OF LAW

The Child Development and Care program is established by Titles IVA, IVE and XX of the Social Security Act, the Child Care and Development Block Grant of 1990, and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The program is implemented by Title 45 of the Code of Federal Regulations, Parts 98 and 99. The Department of Human Services (DHS or Department) provides services to adults and children pursuant to MCL 400.14(1) and MAC R 400.5001-5015. Department policies are contained in the Bridges Administrative Manual (BAM), the Bridges Eligibility Manual (BEM) and the Bridges Reference Manual (BRM).

In this case, the Department has requested a disqualification hearing to establish an over-issuance of benefits as a result of an IPV and the Department has asked that respondent be disqualified from receiving benefits. The Department's manuals provide the following relevant policy statements and instructions for Department caseworkers:

> **Suspected IPV** means an OI exists for which all three of the following conditions exist:
>
> . The client **intentionally** failed to report information **or intentionally** gave incomplete or inaccurate information needed to make a correct benefit determination, **and**
>
> . The client was clearly and correctly instructed regarding his or her reporting responsibilities, **and**

. The client has no apparent physical or mental impairment that limits his or her understanding or ability to fulfill their reporting responsibilities.

Intentional Program Violation (IPV) is suspected when there is clear and convincing evidence that the client or CDC provider has intentionally withheld or misrepresented information for the purpose of establishing, maintaining, increasing or preventing reduction of program benefits or eligibility. BAM, Item 720, p. 1.

Therefore, the undersigned may only find an IPV if there is clear and convincing evidence that the respondent intentionally made a false or misleading statement or withheld information for the purpose of defrauding the Department.

Furthermore, the Administrative Law Judge, after a thorough review of the Program Administrative Manual, notes several more regulations that have a direct impact on a case involving CDC provider fraud.

Before continuing, it should be noted that there are three general types of errors in benefit over-issuance cases: Agency Error, Client/Provider Error, and IPV. Agency error is made when the error at hand is directly attributable to the actions of the Department, through no fault of the client. BAM 700. A client error over-issuance occurs when the client received more benefits than they were entitled to because the **client** gave incorrect or incomplete information to the Department. BAM 700 (emphasis added). As stated above, an IPV is a type of client error which was caused because the client **intentionally** gave incorrect or incomplete information.

Thus, client errors and IPVs are related, in that both are caused by the actions of the client; the difference is that a client error is considered an unintentional error,

whereas an IPV is established when there is definitive proof that the client intentionally gave the Department incorrect information.

However, there is another category of error, somewhat related to the category of client error: provider errors. BAM 700 and 715 define provider errors thusly:

> **Provider errors** are OIs caused by a provider.
>
> **Note:** Day care aide payments are issued to the client. Treat OIs involving client checks as client OIs unless OIG determines an IPV occurred by the aide. The day care aide's IPV is sent to the local office fiscal unit for collection. BAM 700, 715.

Provider errors differ from client errors in that the error was caused by the provider. However, in situations such as the one presently at hand, a provider error can be treated as a client error if the OIG does not determine that an IPV was committed by the provider. More importantly, the manual in BAM 700 immediately gives an example of such a case when the provider error should be treated as a client error:

> **Example:** It is considered CDC client error when clients do not use funds sent to them to pay their day care aide for care provided and billed by the day care aide.

It is important to note two very important things from these two passages: A) the manuals contemplated a situation involving a client not paying a provider when describing over-issuances involving client error in CDC situations, and thus specifically stated that the over-issuance must involve "client checks" in order to find client error in a CDC case; this must therefore necessarily limit the finding of client error over-issuances to only those issues involving "client checks" and; B) even if the situations involving "client checks" is interpreted broadly, meaning potentially any situation (because all benefits are paid by client checks, and therefore, any over-issuance must necessarily

include them), OIG must first make a determination as to whether there was an IPV involving the provider, before assigning blame to the client/respondent.

The Administrative Law Judge feels that this is a reasonable interpretation of the regulations. The regulations specifically provide for provider error. However, if all error and IPVs involving CDC could simply be foisted upon the client, regardless of the actual circumstances, there would be no need for a provider error category. As the regulations go out of their way to affirm a provider error category, the Administrative Law Judge feels that it is not unreasonable for the investigating agents to actually use this category, instead of taking the arguably easier way out of holding the clients responsible for any fraud, regardless of whether or not they committed the fraud.

Subsequent regulations affirm this interpretation:

> A suspected provider IPV is an OI caused by a provider's intentional false billings or intentional inaccurate statements. Examples of provider OIs that may be IPV are:
>
> - Failing to bill correctly.
> - Receiving DHS payment for care paid for by a third party.
> - Receiving DHS payment for hours when the child was not in care and the absence was not due to the child's illness or an allowable holiday.
> - Receiving payment from DHS for a greater amount than the general public is charged for the same care. BAM 700, 720

The regulations specifically point out situations that are provider error or IPV, specifically distinguishing them from the situations that are client error/IPV. This is support for the interpretation that not every situation involving CDC error can necessarily be charged to the client; in order for CDC error to be client error, it must involve client checks. As stated, the Administrative Law Judge believes that a client check situation would be one that is similar or analogous to the example given in BAM

700. Because a specific example is given, the undersigned is reluctant to use a broader definition that interprets the regulation to mean almost anything involving a CDC payment. Such a broad interpretation, encompassing every possible situation, should be avoided as a general legal principal when far narrower definitions are available, unless there appears to be a definite intention to have a regulation interpreted as broadly as possible. The Administrative Law Judge sees no evidence in the regulations that the CDC provisions of client error were meant to be interpreted that broadly, however.

That being said, even if the definition is interpreted broadly, the regulations still state that the OIG must first make a determination as to whether the provider committed an IPV, before charging that IPV to the client.

In the current case, there are several facts that are uncontested. First, the Department has submitted substantial evidence that respondent's day care providers billed the Department for many hours that the day care provider was not authorized for. Second, the Department has shown that the Department paid benefits for these unauthorized hours, proving that there was a definite over-issuance. Third, there is no evidence that the respondent's culpability extended beyond delivering the checks to the day care provider, which she was required to do to avoid being charged with client error for not paying the provider. Fourth, the respondent is being charged with an IPV and recoupment based solely on the fact that she had the checks in her hand at one point in time, and probably knew her providers were overcharging the Department. Fifth, there is no evidence that the respondent ever kept or shared in any of the ill-gotten gains.

Thus, the undersigned is not convinced that the Department has met its burden of proof in providing clear and convincing evidence that the **respondent** intended to defraud the Department.

The burden of proof that the Department must meet in order to prove Intentional Program Violation is very high. It is not enough to prove that the respondent was aware of the requirements to report at some point, nor is it enough to prove that the respondent did not report in a timely manner or merely held the checks and turned them over to the aide. The Department must prove in a clear and convincing manner, that, not only did the respondent withhold critical information, but that the respondent withheld this information with the intent to defraud the Department. In other words, the Department must prove that the respondent did not simply forget to meet their obligations to report or deliver the checks, but rather, actively sought to defraud or aid in the defrauding of the Department.

The Administrative Law Judge, in fact, believes that the respondent probably knew what was going on. This is her second IPV case, and over the course of a year and a half, respondent had three different providers, all who vastly overcharged the Department for services. Respondent had every reason to know what was going on and probably did.

Probably is, unfortunately, a far lower standard than clear and convincing.

Clear and convincing requires some evidence that the respondent knew and contributed to what was going on. The evidence in the case does not show that—the evidence shows that respondent applied for benefits, respondent's providers over-billed

for services, and benefits were over-issued. At no point does the evidence clearly and convincingly show that respondent had a hand in all of this.

Furthermore, given that it was the providers who actually billed and submitted hours to the Department, thus causing the over-issuance, the Administrative Law Judge would be reluctant to determine that there was even a client error, much less an IPV. A provider error is defined as an over-issuance caused by a provider. In the current case, the over-issuance is directly attributable to the provider's falsification of hours upon their billing invoices to the Department.

The respondent should have examined the hours attached to the payment warrant a little more closely; however, the Department has not proven that the respondent actively knew and helped perpetuate the fraud, which would be required to find an IPV. The Department has not proven anything that clearly and convincingly shows that respondent was more than an innocent carrier signing over the CDC benefit checks as she thought she had to do. Additionally, given the extremely low rate that day care aides may statutorily be paid, it is debatable as to whether a low income individual with limited experience would even notice the modest increase between the wages for the hours billed and wages for the hours that the provider was eligible for.

Regardless, the current situation is directly contemplated by the regulations, as recited above—the regulations for provider IPV. The Administrative Law Judge will not determine client error—much less client IPV—by broadly interpreting the client error regulations, when the provider error regulations specifically and narrowly list the false billing situation as a direct example of provider IPV. The Administrative Law Judge admits that the regulations under client error could certainly be considered in a very

broad sense, to contain anything involving a CDC check, and the current situation contains a CDC check. He chooses not to do so here, and interprets the regulations narrowly, for the reasons listed above. Furthermore, other regulations specifically account for the current situation, and it would be a miscarriage of justice to stretch one regulation from its obvious intentions to the breaking point, when a subsequent regulation neatly encapsulates the case in a nutshell.

Even if the client error regulations could be considered to allow this situation to be attributed to the respondent, the Administrative Law Judge notes that it can only be done if the OIG has made a determination, one way or the other, as to whether an IPV was committed by the providers.

There is no evidence that the OIG has investigated the providers and found the providers to be responsible for an IPV.

As for recoupment, if the client has not committed an IPV, and if the client has not been found in error, no recoupment can be authorized. The Administrative Law Judge holds that the Department has not proven that the client has committed an IPV or client error. However, even if the respondent was found to have committed an IPV or client error, the client would be the wrong person to recoup from. BAM 700 states:

> If provider error and CDC client error or CDC client IPV occurred and care was authorized and paid by DHS to the provider but care was not provided, recoup from the provider.

Thus, in such situation, even if the respondent was partially at fault, the regulations specifically state to recoup from the provider. No recoupment actions have been taken against the provider. This is incorrect. The correct action is for a

recoupment action to be instated against the provider. Thus, the Department's recoupment request in the current case must be denied.

DECISION AND ORDER

The Administrative Law Judge decides the Department has not established that respondent committed an Intentional Program Violation, or a client error of the CDC program. Furthermore, the Department has not established that it has a legal right to recoup the over-issuance from the respondent.

Both the Department's request for disqualification, and request for recoupment is, accordingly, DENIED.

Robert J. Chavez
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: 08/11/2010

Date Mailed: 08/11/2010

NOTICE: The law provides that within 30 days of receipt of the above Decision and Order, the respondent may appeal it to the circuit court for the county in which he/she lives.

RJC/dj

cc: [redacted]