STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

[redacted]

Reg. No.: 14-006388
Issue No.: 2005
Case No.: 1[redacted]
Hearing Date: October 30, 2014
County: SAGINAW

ADMINISTRATIVE LAW JUDGE: Lynn Ferris

HEARING DECISION FOR INTENTIONAL PROGRAM VIOLATION

Upon the request for a hearing by the Department of Human Services (Department), this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, and in accordance with Titles 7, 42 and 45 of the Code of Federal Regulation (CFR), particularly 7 CFR 273.16, 45 CFR235.110 and 45 CFR 235.113, and with Mich Admin Code, R 400.3130 and R 400.3178. After due notice, a telephone hearing was held on October 30, 2014, from Detroit, Michigan. The Department was represented by [redacted], Regulation Agent of the Office of Inspector General (OIG).

Respondent did not appear at the hearing and it was held in Respondent's absence pursuant to 7 CFR 273.16(e), Mich Admin Code R 400.3130(5), or Mich Admin Code R 400.3178(5).

ISSUES

1. Did Respondent receive an overissuance (OI) of Adult Home Health (AHH) benefits that the Department is entitled to recoup?

2. Did the Department establish, by clear and convincing evidence, that Respondent committed an Intentional Program Violation (IPV)?

3. Should Respondent be disqualified from receiving benefits for Adult Home Health (AHH) benefits?

FINDINGS OF FACT

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

1. The Department's OIG filed a hearing request on July 16, 2014, to establish an OI of benefits received by Respondent as a result of Respondent having allegedly committed an IPV.

2. The OIG has not requested that Respondent be disqualified from receiving program benefits.

3. Respondent was a recipient of Adult Home Health benefits issued by the Department.

4. Respondent was aware of the responsibility to report changes within 10 days.

5. Respondent did not have an apparent physical or mental impairment that would limit the understanding or ability to fulfill this requirement.

6. The Department's OIG indicates that the time period it is considering the fraud period is October 2011 through March 2012 (fraud period).

7. During the fraud period, Respondent was issued [redacted] in Adult Home Health benefits by the State of Michigan, and the Department alleges that Respondent was entitled to $0 in such benefits during this time period.

8. The Department alleges that Respondent received an OI in Adult Home Health benefits in the amount of $[redacted].

9. A notice of hearing was mailed to Respondent at the last known address and was not returned by the US Post Office as undeliverable.

CONCLUSIONS OF LAW

Department policies are contained in the Department of Human Services Bridges Administrative Manual (BAM), Department of Human Services Bridges Eligibility Manual (BEM), Adult Service Manual and Department of Human Services Reference Tables Manual (RFT). Prior to August 1, 2008, Department policies were contained in the Department of Human Services Program Administrative Manuals (PAM), Department of Human Services Program Eligibility Manual (PEM), and Department of Human Services Reference Schedules Manual (RFS).

The Adult Services Program (ASP), which provides for AHH benefits, is established by Title XIX of the Social Security Act, 42 USC 1346 *et seq,* 42 CFR 440.170(f), the Social Welfare Act, and MCL 400.14(1)(p). The Department of Human Service (formerly known as the Family Independence Agency), along with the Michigan Department of Community Health (DCH), administers independent living services (home help) for personal care services pursuant to the Medicaid State Plan.

Effective October 1, 2014, the Department's OIG requests IPV hearings for the following cases:

- Willful overpayments of $500.00 or more under the AHH program.

- FAP trafficking overissuances that are not forwarded to the prosecutor.

- Prosecution of welfare fraud or FAP trafficking is declined by the prosecutor for a reason other than lack of evidence, **and**

  - The total amount for the FIP, SDA, CDC, MA and FAP programs combined is $500 or more, **or**

  - the total amount is less than $500, **and**

    - the group has a previous IPV, **or**
    - the alleged IPV involves FAP trafficking, **or**
    - the alleged fraud involves concurrent receipt of assistance (see BEM 222), **or**
    - the alleged fraud is committed by a state/government employee.

BAM 720 (10/1/11), p. 12; ASM 165 (11/1/11), p. 1.

Intentional Program Violation

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 reporting responsibilities.

BAM 700 (1/1/11), p. 5; BAM 720, p. 17.

An IPV requires that the Department establish by clear and convincing evidence that the client has intentionally withheld or misrepresented information for the **purpose** of establishing, maintaining, increasing or preventing reduction of program benefits or eligibility. BAM 720, p. 1 (emphasis in original); see also 7 CFR 273(e)(6). Clear and convincing evidence is evidence sufficient to result in a clear and firm belief that the proposition is true. See M Civ JI 8.01.

In this case, the Department seeks a recoupment of the Respondent's Adult Home Help payments that it alleges the Respondent received, but did not receive services and cashed the checks on her own behalf. The Department seeks an IPV. The Department does not seek a disqualification of the Respondent.

Policy found in the Adult Services Manual which governs this matter provides the following:

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.

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. ASM 165 (11/1/11), pp. 1-2.

In this case, the Department presented the following evidence. The Respondent and her home health Provider signed a Statement of Employment (MSA 4676) on April 29, 2009. The Statement advised that the Provider is an employee of the named beneficiary, [redacted]). Any change should be reported to the FIA Services Worker. If the Provider is paid for services she did not provide, the Provider must repay the State of Michigan. The Provider will complete and return a Provider Log on time. Exhibit 1, p.11. The Respondent also signed an application on March 17, 2009 which required Respondent to report changes within 10 days and give full and correct information about your situation. Exhibit 1, p. 10.

The Department presented Personal Care Services Provider Logs which had signatures it alleged did not appear consistent with the signature of the Respondent's Provider, [redacted] when compared to the signature on the Statement of Employment Exhibit 1 p. 11. See Exhibit 1, pp. 26 (10/1/09 signature). No annual review information for any time period after the original application in March 2009 was submitted.

Department issued joint checks to the Respondent and [redacted], which were also produced with the endorsement signatures on the back of each check. Several signatures appeared different for [redacted] than shown on the Statement of Employment. Admittedly, the signatures of the Provider on the checks do not appear consistent, however no handwriting analysis by an expert was made. Exhibit 1 , 15, 17, 21and 23.

The Department also presented a report titled General Narrative which the Department testified was prepared by a Department case worker, who it named by name as [redacted] was not present at the hearing, only his unsigned case notes were provided. The case notes do not indicate how the contact by the Provider was made.

The Regulation Agent testified that he met with the Respondent, who denied that [redacted] did not provide the services and assured him that the checks would have all been signed by [redacted]. In addition, Respondent stated that [redacted] was going through emotional problems. The Agent further testified that the Respondent was a little dramatic about her reporting, but this alone does not establish by clear and convincing evidence that an IPV was committed.

Overall, the evidence presented by the Department did not provide sufficient evidence to support a finding of an IPV by clear and convincing evidence.

Disqualification

In this case, the Department did not request a disqualification.

Overissuance

When a client group receives more benefits than they are entitled to receive, the Department must attempt to recoup the OI. BAM 700, p. 1.

In this case, based upon the evidence presented as summarized above, it is determined that the Department's evidence for the same reason does not demonstrate that an over-issuance of AHH benefits occurred.

DECISION AND ORDER

The Administrative Law Judge, based upon the above Findings of Fact and Conclusions of Law, and for the reasons stated on the record, if any, concludes that:

1. The Department has not established by clear and convincing evidence that Respondent committed an IPV.

2. Respondent did not receive an OI of Adult Home Help program benefits in the amount of $[redacted]

3. The Department is ORDERED to delete the OI and cease any recoupment action.

Lynn Ferris
Administrative Law Judge
for Maura Corrigan, Director
Department of Human Services

Date Signed: **11/24/2014**

Date Mailed: **11/24/2014**

LMF/tm

NOTICE: The law provides that within 30 days of receipt of the above Hearing Decision, the Respondent may appeal it to the circuit court for the county in which he/she lives or the circuit court in Ingham County.

cc: [redacted]