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

IN THE MATTER OF:

[redacted]

Reg. No.: 15-004767
Issue No.: 2005; 2006; 7007
Case No.: [redacted]
Hearing Date: June 25, 2015
County: WAYNE-DISTRICT 55

ADMINISTRATIVE LAW JUDGE: Eric Feldman

HEARING DECISION FOR INTENTIONAL PROGRAM VIOLATION

Upon the request for a hearing by the Department of Health and Human Services (Department or DHHS), 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 and 45 CFR 235.110; and with Mich Admin Code, R 400.3130 and 400.3178. After due notice, a three-way telephone hearing was held on June 25, 2015, from Detroit, Michigan. The Department was represented by [redacted], Regulation Agent of the Office of Inspector General (OIG). Participants on behalf of Respondent included: Respondent, [redacted].

ISSUES

1. Did Respondent receive an overissuance (OI) of Adult Services Program (ASP) and/or Adult Home Help (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)?

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 March 30, 2015, to establish an OI of benefits received by Respondent as a result of Respondent having allegedly committed an IPV.

2. Respondent was a recipient of AHH benefits issued by the Department.

3. Respondent was aware of the responsibility to report changes as required.

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

5. The Department's OIG indicates that the time period it is considering the FAP fraud period is April 1, 2014 to May 31, 2014 (fraud period).

6. During the fraud period, Respondent was issued [redacted] in AHH benefits by the State of Michigan, and the Department alleges that Respondent was entitled to $0.00 in such benefits during this time period.

7. The Department alleges that Respondent received an OI in AHH benefits in the amount of [redacted].

8. This was Respondent's first alleged IPV.

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 Health and Human Services Bridges Administrative Manual (BAM), Bridges Eligibility Manual (BEM), Adult Services Manual (ASM), and Reference Tables Manual (RFT).

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 Department of Human Services), 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 (October 2014), pp. 12-13; ASM 165 (May 2013), pp. 1-7.

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 (May 2014), p. 7; BAM 720, p. 1.

An IPV is also suspected for a client who is alleged to have trafficked FAP benefits. BAM 720, p. 1.

An IPV requires that the Department establish by 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 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.

The Department is responsible for correctly determining accurate payment for services. ASM 165, p. 1. When payments are made in an amount greater than allowed under Department policy, an overpayment occurs. ASM 165, p. 1. Four factors may generate

overpayments: (i) client errors; (ii) provider errors; (iii) administrative errors; and (iv) Department upheld at an administrative hearing. ASM 165, p. 1.

Client errors occur whenever information given to the Department, by a client, is incorrect or incomplete. ASM 165, p. 1. This error may be willful or non-willful. ASM 165, p. 1. Regarding AHH services, 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.

ASM 165, pp. 1-2.

In this case, the Department alleges that Respondent committed an IPV of his AHH benefits. The Department testified that Respondent cashed two home help warrants without the signature of the Home Help Provider (HHP) and therefore; not paying the provider for his services. See Exhibit A, p. 1. The OIG investigation report further stated the nature of the complaint is that the Respondent allegedly forged and cashed two checks and did not pay the provider. See Exhibit A, p. 4.

First, the Department presented Respondent's application for Adults Service (DHS-390) received on November 14, 2006, which Respondent acknowledged his responsibility to report changes as required. See Exhibit A, pp. 10-11.

Second, the Department presented the Home Help Services Statement of Employment signed by the Respondent and provider in December of 2007. See Exhibit A, p. 15.

Third, the Department presented documentation from the Department detailing collateral contact between the provider and the Department for the time period of July 2-3, 2014. See Exhibit A, p. 42. On July 2-3, 2014, the provider left a voicemail and spoke to the Department indicating that he has not been paid for work and/or received checks and that he has not worked for the Respondent since May 8, 2014. See Exhibit A, p. 42. The documentation provided further details of the conversations that took place on July 2-3, 2014. See Exhibit A, p. 42.

Fourth, the Department presented Respondent's Personal Care Services Provider Logs (provider logs) for services rendered from July of 2008 to March of 2014. See Exhibit A, pp. 16-41. However, there were no provider logs from April 2014 to June 2014.

Fifth, the Department presented a history and the actual payroll checks issued to Respondent and the provider from January 9, 2014 to June 5, 2014. See Exhibit A, pp. 46-57. Moreover, the Department had a forensic report (laboratory report) be completed by the Michigan Department of State Police – Forensic Science Division on March 11, 2015. See Exhibit A, pp. 61-64. The specialist reviewed questioned writings (checks dated May 8, 2014 and June 5, 2014) and compared them to known writing of both the Respondent and provider. See Exhibit A, pp. 61-64. The specialist concluded that following:

- it is probable that provider did not write the questioned endorsement on check one (May 8, 2014) and indications that the provider did not write the questioned endorsement on check two (June 5, 2014);
- the quality of both check copies submitted for comparison precludes a more conclusive opinion; and
- the questioned provider endorsements on the checks can neither be identified nor eliminated with the known writing of Respondent and the Respondent signatures are a different name and are not comparable with the questioned provider signatures.

See Exhibit A, p. 63.

Sixth, the Department provided a signed affidavit from the provider dated December 22, 2014, in which he stated that he did not receive the checks in question and that he did not sign those checks. See Exhibit A, p. 59. Also, the Department presented a signed affidavit from the Respondent dated January 2, 2015, in which he stated that he paid the provider $276 cash and that his aunt can confirm. See Exhibit A, p. 60. The OIG Investigation Report further indicated that Respondent spoke with the agent several times, in which he denied the allegations. See Exhibit A, p. 4.

At the hearing, Respondent argued that he did not commit an IPV of his AHH benefits. Respondent denied forging any checks and/or the provider's name. As to the affidavit Respondent signed on January 2, 2015, his testimony appeared to indicate that he just paid his provider [redacted] of his own personal money (via his aunt as a third party) because the provider claimed he did not receive payment. Additionally, testimony was provided by the Respondent as well as the Department in regards to the provider logs.

The Adult Services Authorized Payments (ASAP) is the Michigan Department of Community Health payment system that processes adult services authorizations. ASM 140 (May 2013), p. 1.

Home help services payments to providers must be:

- Authorized for a specific period of time and payment amount. The task is determined by the comprehensive assessment in the Adult Services

Comprehensive Assessment Program (ASCAP) and will automatically include tasks that are a level three or higher.

- Authorized only to the person or agency actually providing the hands-on services.

. . .

- *Made payable jointly to the client and the provider*.

. . .

ASM 140, p. 1 (emphasis added).

Warrants reported lost, destroyed, not received or stolen may be replaced/rewritten after recovery is made on the original warrant. ASM 160 (May 2013), p. 9. Recovery means the value of the warrant has been credited back to the account it was written from or if a forged warrant has cleared Treasury, the party which cashed the forged warrant has reimbursed the state. ASM 160, p. 9.

Regarding stolen/forged warrants, if a warrant was issued and the disposition status shows paid, the warrant has been cashed. ASM 160, p. 11. If the payee claims they did not receive or cash the warrant, they must complete the 1778, Affidavit Claiming Lost, Destroyed, Not Received, or Stolen State Treasurer's Warrant form. ASM 160, p. 11. ASM 160 provides further detail on this process. See ASM 160, pp. 11-14.

Based on the foregoing information and evidence, the Department has failed to establish by clear and convincing evidence that Respondent committed an IPV of his AHH benefits. The undersigned finds that it is probable that the provider did not sign the two checks in question. See Exhibit A, p. 63. However, the Department must also prove that the Respondent committed the forgery. The evidence, though, fails to establish by clear and convincing evidence that Respondent is the actual individual who forged and cashed the two checks in question. Thus, in the absence of any clear and convincing evidence that Respondent intentionally withheld or misrepresented the information for the purpose of establishing, maintaining, increasing or preventing reduction of his AHH program benefits or eligibility, the Department has failed to establish that Respondent committed an IPV of AHH benefits.

Disqualification

A client who is found to have committed an IPV by a court or hearing decision is disqualified from receiving program benefits. BAM 720, pp. 15-16; BEM 708 (April 2014), p. 1. Clients are disqualified for ten years for a FAP IPV involving concurrent receipt of benefits, and, for all other IPV cases involving FIP, FAP or SDA, for standard disqualification periods of one year for the first IPV, two years for the second IPV, and lifetime for the third IPV. BAM 720, p. 16. CDC clients who intentionally violate CDC program rules are disqualified for six months for the first occurrence, twelve months for the second occurrence, and lifetime for the third occurrence. BEM 708, p. 1. A disqualified recipient remains a member of an active group as long as he lives with

them, and other eligible group members may continue to receive benefits. BAM 720, p. 16.

In this case, the Department has failed to satisfy its burden of showing that Respondent committed an IPV concerning AHH benefits. BAM 720, p. 16.

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.

As stated previously, the Department failed to show that Respondent committed an IPV of his AHH benefits. However, the Department can still proceed with recoupment of the OI when there is client error.

Based on the Department's case presentation, it seeks an overpayment from the Respondent based on a client error. Client errors occur whenever information given to the Department, by a client, is incorrect or incomplete. ASM 165, p. 1. This error may be willful or non-willful. ASM 165, p. 1. The willful client overpayment requirements are stated under the IPV analysis. But, 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.

ASM 165, pp. 2-3.

Based on the foregoing information, the Department failed to establish that Respondent committed a client error (both willful and non-willful) of his AHH benefits ($552.78). Because the Department failed to establish evidence that Respondent is the actual individual who forged and cashed the two checks in question, it also failed to establish an OI of his AHH benefits.

It should be noted that an issue also arose during the hearing in which the Department alleged that there were no provider logs submitted for the period of April 2014 to June 2014. See Exhibit A, p. 4. Policy regarding provider logs, DHS-721, can be found in ASM 135. See ASM 135 (December 2013), pp. 1-5. However, the undersigned will not address the provider log issue as the current IPV claim is based on the alleged forgery by the Respondent. In fact, on March 30, 2015, the Department sent Respondent an IPV Repayment Agreement (DHS-4350) stating the overpayment is based on an alleged forgery and not a failure to submit provider logs. See Exhibit A, p. 6. Moreover, there is no evidence that an Advance Negative Action Notice was sent to Respondent informing him that his case was suspended or terminated based on a failure to submit provider logs as required by policy. See ASM 150 (May 2013), p. 2. Thus, the failure to

submit provider logs is a different issue in which the undersigned will not address. Nonetheless, the Department failed to establish an OI of AHH benefits in this case.

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 program benefits in the amount of [redacted] from the AHH benefits.

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

Eric Feldman
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

Date Signed: **6/29/2015**

Date Mailed: **6/29/2015**

EJF/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. A copy of the claim or application for appeal must be filed with the Michigan Administrative Hearing System (MAHS).

cc: [redacted]