[redacted]

Date Mailed: September 16, 2019
MOAHR Docket No.: 19-004382
Agency No.: [redacted]
Petitioner: OIG
Respondent: [redacted]

ADMINISTRATIVE LAW JUDGE: John Markey

HEARING DECISION FOR INTENTIONAL PROGRAM VIOLATION

Upon the request for a hearing by the Department of Health and 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, 42 CFR 431.230(b), and 45 CFR 235.110, and with Mich Admin Code, R 400.3130 and 400.3178. After due notice, a telephone hearing was held on August 26, 2019, from Detroit, Michigan. The Department was represented by Amber Johnson, Regulation Agent of the Office of Inspector General (OIG). Respondent appeared and represented herself. During the hearing, a 65-page packet of documents was offered and admitted into evidence as Exhibit A, pp. 1-65.

ISSUES

1. Did Respondent receive an overissuance (OI) of Medicaid (MA) 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) with respect to MA?

FINDINGS OF FACT

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

1. On June 20, 2016, Respondent began working full-time for [redacted]. Respondent was paid a gross wage of $3,846.16 every two weeks. In addition to her wages, Respondent was provided with health insurance through [redacted], as demonstrated by the paycheck stubs showing a deduction of approximately $73 every two weeks. Exhibit A, pp. 37-54.

2. On June 22, 2016, the Department received an application for MA benefits in Respondent's name. Exhibit A, pp. 8-36.

3. The application was signed, thereby certifying the truth of the information contained in the application and receipt of the instructions in the booklet titled "Important Things to Know." Exhibit A, p. 18.

4. The "Important Things to Know" booklet informed contained instructions. It was explained that the applicant was required report certain types of changes in circumstances to the Department within ten days of the change. Regarding starting employment, the booklet required a report of the change to the Department within ten days of receiving first payment. Further, the instructions stated that failure to properly report a change could result in penalties for fraud. Exhibit A, p. 19.

5. The Department approved the MA application submitted in Respondent's name. However, no Health Care Coverage Determination Notice was issued.

6. Respondent continued to be covered by the Department-issued MA until September 30, 2017. Exhibit A, pp. 62-64.

7. During the entire time period of being provided coverage, Respondent was unaware of such coverage and never utilized the benefits.

8. On April 17, 2019, the Department's OIG filed a hearing request to establish an IPV with respect to MA. The Department considers the alleged fraud period to be July 1, 2016 through September 30, 2017. During that time, the Department expended $10,315.79 in MA benefits on Respondent's behalf. The Department asserts that Respondent was not entitled to any MA coverage during that time as her income exceeded the income limit for coverage. The Department's hearing request sought to establish an overissuance of MA benefits of $10,315.79. Exhibit A, pp. 1-6; 62-64.

9. A notice of hearing was mailed to Respondent at the last known address and was not returned by the United Stated Postal Service as undeliverable.

10. Respondent did not have any apparent mental or physical impairment that would limit her understanding or ability to fulfill her reporting requirements. Exhibit A, p. 65.

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 Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Department of Human Services) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

The Department's position is that Respondent committed an IPV with respect to MA by allegedly misrepresenting her income on an MA application, causing the Department to overissue Respondent MA benefits for the period from July 1, 2016 through September 30, 2017.

Overissuance

An overissuance is the amount of benefits issued to the client group in excess of what it was eligible to receive. BAM 700 (October 2016), p. 1; 7 CFR 273.18. When a client group receives more benefits than it is entitled to receive, the Department must attempt to recoup the overissuance. BAM 700, p. 1.

In this case, Respondent received more benefits than she was entitled to receive. The Department determined Respondent's eligibility without budgeting her wages from her employment with [redacted], which caused Respondent's income to be understated. When factored into the equation, Respondent's income rendered Respondent ineligible for MA coverage. Thus, the Department has established that Respondent received MA coverage that she was not entitled to receive. The overissuance value was shown to be $10,315.79.

However, for MA purposes, the Department may only initiate recoupment of an overissuance due to client error or an intentional program violation, not when the overissuance is due to agency error. BAM 710 (October 2016), p. 1. An agency error overissuance is an overissuance caused by incorrect actions of the Department, including the Department's failure to take proper action. BAM 705 (January 2016), p. 1. If an overissuance cannot be considered a client error or IPV overissuance, it must be recorded as an agency error overissuance. BAM 705, p. 1.

The application for MA coverage filed in Respondent's name was received by the Department on June 22, 2016. The Department approved the application. However, at no point did the Department issue a Health Care Coverage Determination Notice or otherwise issue any other notifications to Respondent, as required by Department policy. BAM 220 (July 2016), p. 21.

Respondent credibly testified that she did not file the application and otherwise was completely unaware of the coverage being provided by the Department. Given that Respondent was gainfully employed making good money at a job that provided health insurance at the time the application was filed, her testimony is credited as true. Had

the Department followed policy and issued a Health Care Coverage Determination Notice to Respondent, it may have resulted in the problem being identified earlier and prevented the wrongful coverage from being provided for such a long time.

The overissuance in this case was certainly not a client error or IPV overissuance as Respondent did not file the application and was completely unaware of having any MA benefits from the Department during the entire period the benefits were provided. As it was neither of those types of overissuance, it must be deemed an agency error overissuance. Because the Department is prohibited from seeking to initiate recoupment of an agency error MA overissuance, the Department is prohibited by policy from pursuing the overissuance in this case from Respondent.

Intentional Program Violation

The Department's policy in effect at the time of Respondent's alleged IPV defined an IPV as an overissuance in which the following three conditions exist: (1) the client intentionally failed to report information or intentionally gave incomplete or inaccurate information needed to make a correct benefit determination; (2) the client was clearly and correctly instructed regarding his or her reporting responsibilities; and (3) the client has no apparent physical or mental impairment that limits his or her understanding or ability to fulfill his or her reporting responsibilities. BAM 720 (January 2016), p. 1; 7 CFR 273.16(c).

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, page 1; see also 7 CFR 273.16(e)(6). Clear and convincing evidence is evidence which is so clear, direct, weighty, and convincing that it enables a firm belief as to the truth of the allegations sought to be established. *In re Martin*, 450 Mich 204, 227; 538 NW2d 399 (1995) (citing *In re Jobes*, 108 NJ 394 (1987)).

The Department has not met its burden of proof in this matter. Respondent credibly testified that she did not have any relationship with the Department and only found out about this whole ordeal after the case had already been closed. Thus, Respondent was never subject to any reporting requirements. Accordingly, the Department failed to meet its burden of showing by clear and convincing evidence that Respondent committed an IPV with respect to MA by either making a false statement or intentionally failing to report a change.

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 failed to establish by clear and convincing evidence that Respondent committed an IPV with respect to her MA benefits.

2. The Department has not established an overissuance of MA benefits that it has the right to recoup and/or collect.

IT IS FURTHER ORDERED that the Department must delete the alleged MA overissuance from July 1, 2016 through September 30, 2017.

JM/cg

John Markey
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

Via Email:

MDHHS-Oakland-3-Hearings
OIG Hearings
Recoupment
MOAHR

Respondent – Via First-Class Mail:

[redacted]