STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

Date Mailed: January 21, 2020
MOAHR Docket No.: 19-009074
Agency No.:
Petitioner: OIG
Respondent:

ADMINISTRATIVE LAW JUDGE: Christian Gardocki

HEARING DECISION FOR INTENTIONAL PROGRAM VIOLATION AND TO ESTABLISH DEBT

Upon the request for a hearing by the Michigan Department of Health and Human Services (MDHHS), 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 scheduled for January 6, 2020, from Detroit, Michigan. The hearing was held on the scheduled hearing date and at least 30 minutes after the scheduled hearing time. MDHHS was represented by Ryan Sevenski, regulation agent, with the Office of Inspector General. Respondent did not appear for the hearing.

ISSUES

The first issue is whether MDHHS established a claim for overissued Medicaid benefits.

The second issue is whether MDHHS established by clear and convincing evidence that Respondent committed an intentional program violation (IPV) which justifies imposing a disqualification.

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 [redacted], 2017, Respondent electronically submitted to MDHHS an application requesting Food Assistance Program (FAP) and Medicaid benefits. Respondent reported being between the ages of 19 and 64 years,

a household with no other members, and no disability. Boilerplate application language stated that clients are to report income changes to MDHHS within 10 days. Exhibit A, pp. 11-24.

2. On October 19, 2017, MDHHS mailed to Respondent a Notice of Case Action stating that Respondent was approved for FAP benefits beginning October 2017. The notice included boilerplate language that clients are to report changes in income to MDHHS within 10 days. Exhibit A, pp. 25-29. The mailing included a Change Report stating that clients can submit the form to report any changes. Exhibit A, pp. 30-31.

3. On October 26, 2017, Respondent started employment with ██████ ████████ (hereinafter, "Employer").

4. From November 3, 2017, through July 2018, Respondent received ongoing income from Employer.

5. On December 18, 2017, MDHHS mailed Respondent a Health Care Coverage Determination Notice stating that Respondent was approved for Medicaid beginning January 2018. Exhibit A, pp. 32-35.

6. From January 2018 through July 2018, Respondent received $1,344 in FAP benefits.

7. From January 2018 through July 2018, Respondent's gross income from Employer ranged from $2,308 to $9,428 (dropping cents).

8. From January 2018 through July 2018, MDHHS issued Medicaid benefits to Respondent at a cost totaling $3,108.59.

9. On April 26, 2018, MDHHS mailed a Wage Match Client Notice to Respondent which requested verification of income from Employer. Exhibit A, pp. 36-37.

10. On August 8, 2018, MDHHS calculated that Respondent received an overissuance (OI) of $1,344 in FAP benefits from January 2018 through July 2018. The calculation factored that Respondent failed to timely report income from Employer. MDHHS also factored that Respondent's actual issuances from the OI period totaled $1,344 and that Respondent's "correct" issuances totaled $0.

11. On or after August 8, 2018, MDHHS established a recipient claim against Respondent for $1,344 in overissued FAP benefits from January 2018 through July 2018.

12. On August 7, 2019, MDHHS requested a hearing to establish a claim for $3,108.59 in allegedly overissued Medicaid benefits. Additionally, MDHHS sought to establish an IPV justifying imposing a 1-year disqualification period. Exhibit A, p. 1.

CONCLUSIONS OF LAW

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. MDHHS policies are contained in the Bridges Administrative Manual (BAM), Bridges Eligibility Manual (BEM), and Reference Tables Manual (RFT).

MDHHS requested a hearing to establish a debt of $3,108.59 for Medicaid benefits allegedly overissued to Respondent from June 2017 through August 2017. Exhibit A, p. 1. MDHHS' Hearing Summary and testimony alleged the OI was caused by unbudgeted and unreported employment income.

MDHHS may request a hearing to establish a debt. BAM 600 (October 2017) p. 5. For all programs, when a client group receives more benefits than it is entitled to receive, MDHHS must attempt to recoup the overissuance. BAM 700 (January 2016) pp. 1-2. An overissuance is the amount of benefits issued to the client group in excess of what it was eligible to receive. *Id*. Recoupment is an MDHHS action to identify and recover a benefit overissuance. *Id*.

In the present case, MDHHS seeks to establish an OI of Medicaid. To establish an OI of Medicaid, a consideration of Medicaid categories is necessary.

The Medicaid program includes several sub-programs or categories. BEM 105 (April 2017), p. 1. To receive MA under a Supplemental Security Income (SSI)-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled. *Id*. Medicaid eligibility for children under 19, parents or caretakers of children, pregnant or recently pregnant women, former foster children, MOMS, MIChild and Healthy Michigan Plan (HMP) is based on Modified Adjusted Gross Income (MAGI) methodology. *Id*.

Persons may qualify under more than one MA category. *Id*., p. 2. Federal law gives them the right to the most beneficial category. *Id*. The most beneficial category is the one that results in eligibility, the least amount of excess income or the lowest cost share. *Id*.

Respondent applied for Medicaid on [redacted], 2017. Exhibit A, pp. 11-24. Respondent reported being 19-64 years old, not being a caretaker to minor children, not

pregnant, and not disabled. MDHHS testimony alleged the same circumstances applied to Respondent throughout the OI period. As no evidence suggested otherwise, Respondent's circumstances at the time of application will be found to apply throughout the alleged overissuance period. Under Respondent's circumstances, the only potential category for Medicaid is under Healthy Michigan Plan (HMP). MDHHS alleged that Respondent had excess income for HMP eligibility.

HMP is a health care program administered by the Michigan Department of Community Health, Medical Services Administration. The program is authorized under the Affordable Care Act of 2010 as codified under 1902(a)(10)(A)(i)(VIII) of the Social Security Act and in compliance with the Michigan Public Act 107 of 2013. HMP policies are found in the Medicaid Provider Manual and Modified Adjusted Gross Income Related Eligibility Manual (MAGIM).

HMP is based on Modified Adjusted Gross Income (MAGI) methodology. BEM 137 (October 2016), p. 1. Modified adjusted gross income (MAGI) is a methodology for how income is counted and how household composition and family size are determined. MAGIM (May 28, 2014), p. 14. It is based on federal tax rules for determining adjusted gross income. *Id.* It eliminates asset tests and special deductions or disregards. *Id.* Every individual is evaluated for eligibility based on MAGI rules. *Id.*

MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code.[1] 42 CFR 435.603 (e). Financial eligibility for Medicaid for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size. 42 CFR 435.603 (h)(1). In determining current monthly or projected annual household income and family size under paragraphs (h)(1) or (h)(2), the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. 42 CFR 435.603 (h)(3).

Respondent reported on his application having no other household members. The evidence supports finding that Respondent's HMP eligibility should be based on a group size of one person.[2]

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[1] Income exceptions are made for lump-sums which are counted as income only in the month received; scholarships, awards, or fellowship grants used for education purposes and not for living expenses; and various exceptions for American Indians and Alaska native. No known exceptions are applicable to the present case.

[2] For MAGI-related groups, the group includes tax dependents. BEM 211 (January 2016) pp. 1-2. A tax dependent does not always live in the household of a tax filer. For example, children may be away at college yet still be claimed as a tax dependent by parents. The evidence did not suggest this circumstance.

MDHHS presented documentation obtained from Employer which listed employment income to Respondent from November 3, 2017, through July 2018. Exhibit A, pp. 38-40. For each month from January 2018 through July 2018, Respondent's gross income was at least $2,308. For purposes of determining Respondent's income eligibility under HMP, Respondent's gross monthly income will be accepted to be $2,308 per month.

Common deductions and disregards which should be factored in determining a person's adjusted gross income include alimony payments, unreimbursed business expenses, Health Savings Account (e.g., 401k) payments, and student loan interest.[3] There was no evidence of applicable deductions.

HMP income limits are based on 133% of the federal poverty level. RFT 246 (April 2014), p. 1. For persons residing in the contiguous 48 states, the 2018 federal poverty level is $12,140 for a 1-person group.[4] For Respondent to be eligible for HMP in 2018, countable income would have to fall at or below $16,146.20 ($1,345.52 per month). Respondent's monthly income of at least $2,308 during the OI period exceeded the monthly HMP income limit. Thus, Respondent was ineligible to receive HMP from January 2018 through July 2018 due to excess income.

MDHHS delayed beginning an overissuance period until January 2018 despite Respondent receiving employment income beginning November 2017. The delay is compliant with policy which requires beginning a MA-OI period in the first full benefit month after the standard reporting period (10 days) plus the negative action period (12 days). BAM 710 (October 2016), p. 1.

For MA benefits, benefits may be recouped if the OI was caused by the client. BAM 710 (January 2018), p. 1. MDHHS may not establish a recoupment for an agency-caused error. *Id.* Thus, to establish a debt against Respondent, MDHHS must establish that Respondent was at fault for the OI of Medicaid.

MDHHS alleged that Respondent failed to timely report to MDHHS employment with Employer. Respondent did not appear for the hearing to present evidence indicating otherwise. The evidence established that Respondent received $1,344 in FAP benefits during the same time that Respondent was overissued Medicaid benefits. The overissuance of FAP benefits based on Respondent's failure to report income is directly applicable to finding that respondent was at fault for not reporting income concerning Medicaid benefits.

Respondent should have been aware of the obligation to report changes to MDHHS. Respondent's application dated [redacted], 2017, and notices of benefit approval dated October 19, 2017, and December 18, 2017, each included boilerplate language stating that clients are to report income changes (such as starting employment) to MDHHS within 10 days.

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[3] https://www.investopedia.com/terms/a/agi.asp
[4] https://aspe.hhs.gov/2017-poverty-guidelines

Generally, the amount of MA overissuance is the amount of MA payments incorrectly issued. *Id.*, p. 2. For an OI due to unreported income, the OI amount is the correct deductible (minus any amount already met) or the amount of MA payments, whichever is less. *Id.* Respondent was not eligible for any Medicaid categories for which a deductible may have been issued. Thus, the OI amount is the total of MA payments issued to Respondent.

MDHHS presented documentation of Respondent's MA costs during the OI period. Exhibit A, pp. 58-60. The documentation listed Medicaid costs totaling $3,108.59.

The evidence established that Respondent received an OI of medical benefits from January 2018 through July 2018 which cost the State of Michigan $3,108.59. The evidence also established that Respondent was at fault for the OI. Thus, MDHHS established a claim of $3,108.59 against Respondent.

MDHHS also requested a hearing to establish an IPV disqualification period against Respondent. MDHHS may request a hearing to establish an IPV. BAM 600 (October 2017) p. 5. MDHHS alleged that Respondent's IPV resulted in overissuances of FAP and MA benefits due to a failure to timely report income from Employer.

The types of recipient claims are those caused by agency error, unintentional recipient claims, and IPV. 7 CFR 273.18(b). An IPV shall consist of having intentionally:

(1) Made a false or misleading statement, or misrepresented, concealed or withheld facts; or
(2) Committed any act that constitutes a violation of SNAP, SNAP regulations, or any state statute for the purpose of using, presenting, transferring, acquiring, receiving, possessing or trafficking of SNAP benefits or EBT cards. 7 CFR 273.16(c).

An IPV requires clear and convincing evidence which demonstrates that the household member(s) committed, and intended to commit, an IPV. 7 CFR 273.16(e)(6). Clear and convincing evidence is strong enough to cause a clear and firm belief that the proposition is true; it is more than proving that the proposition is probably true. M Civ JI 8.01. It is a standard which requires reasonable certainty of the truth; something that is highly probable. Black's Law Dictionary 888 (6th ed. 1990).

Clients must report changes in circumstance that potentially affect eligibility or benefit amount. 7 CFR 273.12(a)(2). Changes in income must be reported within 10 days of receiving the first payment reflecting the change. *Id.*

FAP-OI budgets (Exhibit A, pp. 41-55), documentation of Respondent's income from Employer (Exhibit A, pp. 38-40), Respondent's history of FAP issuances (Exhibit A, p. 56) and MDHHS testimony established that Respondent received Medicaid and $1,344 in over-issued FAP benefits from January 2018 through July 2018 due to untimely reported employment income. For an IPV to be established, MDHHS must clearly and

convincingly establish that Respondent intentionally failed to report employment income.

MDHHS mailed Respondent a Wage Match Client Notice on April 26, 2018. Such notices are mailed when the income factored on a client's benefit case differs from income reported by employers to the State of Michigan. BAM 802 (January 2017) p. 1. The issuance of a Wage Match Client Notice suggests that MDHHS learned of Respondent's income from its own data exchanges, rather than from Respondent. This evidence is consistent with a failure to report by Respondent, but not necessarily an intentional failure.

MDHHS cited Respondent's application and multiple written notices as evidence that Respondent should have been aware of the need to report changes. Each of the documents cited by MDHHS included boilerplate language stating that clients are to report changes to MDHHS within 10 days. The documents established that Respondent should have been aware of the responsibility to report changes but not that Respondent was aware of the responsibility. The evidence did not clearly and convincingly establish that Respondent was read the instructions, absorbed the instructions, retained the instructions, and/or purposely chose to ignore the instructions.

Generally, a client's fraudulent intent is clear and convincing when income is falsely reported. There was no evidence that Respondent falsely reported income information to MDHHS.

Based on the evidence, MDHHS did not clearly and convincingly establish that Respondent intentionally failed to report employment income. Thus, MDHHS failed to establish that Respondent committed an IPV.

Individuals found to have committed an IPV shall be ineligible to receive FAP benefits. 7 CFR 273.16(b). The standard disqualification period is used in all instances except when a court orders a different period. IPV penalties are as follows: one year for the first IPV, two years for the second IPV, and lifetime for the third IPV. *Id.* and BAM 725 (January 2016), p. 16.

Without a finding that Respondent committed an IPV, an IPV disqualification cannot follow. Thus, MDHHS is denied its request to establish a one-year disqualification against Respondent.

DECISION AND ORDER

The administrative law judge, based upon the above findings of fact and conclusions of law, finds that MDHHS established that Respondent received an OI of $3,108.59 in Medicaid from January 2018 through July 2018. The MDHHS request to establish an OI claim against Respondent is **APPROVED**.

The administrative law judge, based upon the above findings of fact and conclusions of law, finds that MDHHS failed to establish that Respondent committed an IPV justifying a 1-year period of disqualification. The MDHHS request to establish an IPV disqualification against Respondent is **DENIED.**

CG/cg

Christian Gardocki
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-Gratiot-Hearings
OIG Hearings
Recoupment
MOAHR

Respondent – Via First-Class Mail: