[redacted]
[redacted] MI [redacted]

Date Mailed: May 19, 2025
MOAHR Docket No.: 24-012602
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Appellant's request for a hearing.

After due notice, a hearing was commenced on April 15, 2025, and concluded on April 23, 2025. Patricia Dudek, Attorney, appeared on behalf of Petitioner. Seth Koches, Attorney, appeared on behalf of Respondent.

Witnesses:

Petitioner	[redacted] (Petitioner)
Respondent	Jarett Cup

Exhibits:

Petitioner	1. Hearing Summary
	2. Office of Recipient Rights Status Report
	3. Letter from [redacted] Group Services
	4. [redacted] Residency Agreement (January 11, 2025)
	5. [redacted] Residency Agreement (January 11, 2024)
Respondent	A. Hearing Summary

ISSUE

Did the Respondent properly determine whether or not Petitioner no longer met the criteria for placement in a Specialized Residential Setting (SRS)?

FINDINGS OF FACT

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

1. Petitioner is an adult Medicaid beneficiary who is eligible to receive services through Respondent. (Exhibit A; Testimony)

2. Since February 2020, Petitioner has resided at [redacted] Foster Care Home ([redacted]); a SRS. (Exhibit A; Testimony)

3. On or around May 20, 2024, Petitioner requested another year of SRS services. (Exhibit A; Testimony)

4. On May 20, 2024, Respondent completed a review as a result of Petitioner's request for SRS services and concluded Petitioner no longer met the criteria for placement in an SRS. (Exhibit A; Testimony)

5. On May 20, 2024, Respondent issued Petitioner a Notice of Adverse Benefit Determination. The notice provided the following:

> Your request for continued specialized residential placement at [redacted] was reviewed by Jarrett Cupp, MA, LPC, CHC on 5/20/24 and partially denied. What this means is that you were authorized enough units of H2016 and T1020 to maintain your placement at Unity II for the next three months. It is recommended that you step down to a less restrictive level of care such as Community Living Supports (CLS) home. When making this decision, your assessment, treatment plan, LOCUS and past six months of progress notes were reviewed. Section 11.1 of the Behavioral Health and Intellectual Disability Supports and Services section of the Medicaid manual state that personal care services include assistances with food prep, laundry, housekeeping, eating, toileting, bathing, grooming, dressing, transferring, ambulation and assistance with medications. It was noted that you are able to provide care for yourself and your environment, thus you do not meet criteria for personal care services which is a requirement for specialized residential care. Additionally, moving to a new less restrictive environment would help you achieve your goal of moving out of your current home. The Code of Federal Regulations 42

> CFR 440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or utilization control procedures.[1]

6. On June 19, 2024, Respondent received from Petitioner, a request for an internal appeal. (Exhibit A.)

7. On July 18, 2024, Respondent conducted an internal appeal and concluded a CLS supports home would be adequate in meeting the Petitioner's needs. (Exhibit A; Testimony.)

8. On July 18, 2024, Respondent issued Petitioner a Notice of Appeal Denial. The notice provided the following:

> After a review by Travis Kohl, LPC, CAADC-CCC on July 18, 2024, it is in his clinical opinion to uphold the decision to decrease your level of care from your current placement at Unity II.
>
> Per Section 11.1 of Behavioral Health and Intellectual Disability Supports and Services section of the Medicaid Manual states "that personal care services included assistance with food prep, laundry, housekeeping, eating, toileting, bathing, groom, dressing, transferring, ambulation, and assistance with medication" You do not require this level of care.
>
> It is recommended that a service such as a Community Living Supports Home would be adequate in meeting your needs.[2]

9. On September 9, 2024, Petitioner signed an amendment to the Petitioner's treatment plan "to add CLS/SIL home objective/authorize additional transition period."[3]

10. The amendment was effective May 28, 2025. (Exhibit A)

11. At the time treatment plan was amended, Petitioner indicated he wanted to get out of the Unity II placement when "the time was right".[4]

12. On November 18, 2024, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a request for hearing. (Hearing File)

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[1] Exhibit A, p 4.
[2] Exhibit A, p 7
[3] Exhibit A, pp 18-23.
[4] Exhibit A, p 18.

13. On December 4, 2024, Respondent conducted a utilization review and concluded a CLS Supports Home would be adequate to meet Petitioner's needs with the following supports.[5] (Exhibit A; Testimony)

14. Petitioner is able to cook, clean his room, take his medicine and would like to work again in the future. (Testimony)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.[6]
>
> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.[7]

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection(s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and

[5] Petitioner would receive 12 hours of CLS in a CLS home that will always be staffed.
[6] 42 CFR 430.0.
[7] 42 CFR 430.10.

> services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Michigan Department of Health and Human Services (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with MDHHS to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service.[8]

The Respondent is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The applicable sections of the Medicaid Provider Manual (MPM) provide:

> **SECTION 11 – PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS**
>
> Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing their own personal daily activities. For children with serious emotional disturbance, personal care services may be provided only in a licensed foster care setting or in a Child Caring Institution (CCI) if it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec. 1(f) under Act No. 116 of the Public Acts of 1973, as amended. For children with intellectual/ developmental disabilities, services may be provided only in a licensed foster care or CCI setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by MDHHS.
>
> Personal care services are covered when authorized by a physician or other health care professional in accordance with an individual plan of services and rendered by a qualified person. Supervision of personal care services must

[8] *See 42 CFR 440.230.*

be provided by a health care professional who meets the qualifications contained in this chapter.

11.1 SERVICES

Personal care services include assisting the beneficiary to perform the following:

- Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food);
- Eating/feeding;
- Toileting;
- Bathing;
- Grooming;
- Dressing;
- Transferring (between bed, chair, wheelchair, and/or stretcher);
- Ambulation; and
- Assistance with self-administered medications.

"Assisting" means staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); or otherwise assists the individual to perform the tasks himself/herself by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).

11.2 PROVIDER QUALIFICATIONS

Personal care may be rendered to a Medicaid beneficiary in a Foster Care or CCI setting licensed and certified by the state under the 1987 Michigan Department of Health and Human Services Administrative Rule R330.1801-09 (as amended in 1995). For children birth to 21, personal care may be rendered to a Medicaid beneficiary in a Child Caring Institution setting with a specialized residential program facility licensed by the State for individuals with I/DD under

Act No. 116 of the Public Acts of 1973, as amended, and Act No. 258 of the Public Acts of 1974, as amended.

11.3 DOCUMENTATION

The following documentation is required in the beneficiary's file in order for reimbursement to be made:

- An assessment of the beneficiary's need for personal care.
- An individual plan of services that includes the specific personal care services and activities, including the amount, scope and duration to be delivered that is reviewed and approved at least once per year during person-centered planning.
- Documentation of the specific days on which personal care services were delivered consistent with the beneficiary's individual plan of service.

* * * *

17.2 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF BEHAVIORAL HEALTH 1915(I) STATE PLAN AMENDMENT (SPA) SUPPORTS AND SERVICES [RE-NUMBERED, TITLE REVISED & CHANGES MADE 4/1/23]

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by BH 1915(i) SPA supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to ensure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether BH 1915(i) SPA supports and services alone, or in combination with State Plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports

and services should assist the individual to attain outcomes that are typical in their community; and without such services and supports, would be impossible to attain.

* * * *

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies. (Emphasis added)

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

Deny services that are:

- deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

- experimental or investigational in nature; or

- for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or

- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.[9]

Petitioner must prove, by a preponderance of the evidence, that he meets the above medical necessity criteria for Personal Care in a Specialized Residential setting.

Petitioner's arguments were not very clear other than the Respondent was retaliating against Petitioner for advocating on his own behalf. The remainder of the Petitioner's arguments appear to be misplaced.[10]

Based on the evidence presented, it is undisputed that Petitioner's condition has improved and his behaviors have also improved, even in the absence of a behavioral management plan. Furthermore, the evidence does not reveal Petitioner as needing assistance with personal care activities. As Petitioner continues to improve, a supported independent living setting that also provides CLS is a perfect level of support as Petitioner continues to build his skills.

Petitioner bears the burden of proving by a preponderance of the evidence that Personal Care in a SRS are a medical necessity in accordance with the Code of Federal Regulations (CFR) and Medicaid policy. Petitioner did not meet the burden to establish that such services are a medical necessity.

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[9] Medicaid Provider Manual, Behavioral Health and Intellectual Disability Supports and Services, July 1, 2025, pp 12-14, 90-91, 145-146.

[10] Petitioner's Attorney identified a different beneficiary by the name of [redacted] along with identifying the wrong respondent [redacted] CMH". Petitioner's Closing Brief, April 30, 2025, pp 3-4.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied Petitioner's request for Personal Care in a Specialized Residential setting.

IT IS THEREFORE ORDERED that:

The Respondent's decision is **AFFIRMED**.

CA/pe

Corey Arendt
Administrative Law Judge

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 30763
Lansing, Michigan 48909-8139

Via Electronic Mail:

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