Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

Date Mailed: August 4, 2025
Docket No.: 25-016165
Case No.: [redacted]
Petitioner: [redacted]

[redacted]

This is an important legal document. Please have someone translate the document.

هذه وثيقة قانونية مهمة. يرجى أن يكون هناك شخص ما يترجم المستند.

এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

Este es un documento legal importante. Por favor, que alguien traduzca el documento.

这是一份重要的法律文件。请让别人翻译文件。

Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

Date Mailed: August 4, 2025
Docket No.: 25-016165
Case No.: [redacted]
Petitioner: [redacted]

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon a request for hearing filed on behalf of Petitioner [redacted] (Petitioner).

After due notice, a telephone hearing was held on July 9, 2025. [redacted] Petitioner's legal guardian/mother, appeared and testified on Petitioner's behalf. Stacy Coleman, Contractor, appeared and testified on behalf of Respondent Macomb County Community Mental Health (Respondent).

During the hearing, Petitioner's request for hearing was admitted into the record without objection as Exhibit #1, pages 1-5. Respondent also submitted an evidence packet that was admitted into the record without objection as Exhibit A, pages 1-39.

ISSUE

Did Respondent properly deny Petitioner's request for additional Community Living Supports (CLS) and respite care services?

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 a [redacted] year-old Medicaid beneficiary with a legal guardian and who has been diagnosed with borderline intellectual functioning; other specified chromosome abnormalities; and an unspecified disruptive, impulse-control, and conduct disorder. (Exhibit #1, page 5; Exhibit A, pages 16, 32; Testimony of Petitioner's representative).

2. Due to his diagnoses and needs, Petitioner has been approved for services through Respondent through Michigan's Habilitation Supports Waiver (HSW). (Exhibit A, pages 16-39).

3. Petitioner is also approved for Home Help Services (HHS) through the Michigan Department of Health and Human Services (MDHHS). (Testimony of Petitioner's representative).

4. Prior to June of 2024, Petitioner's services through Respondent included 180 hours per month of CLS and 96 hours per month of respite care services. (Testimony of Petitioner's representative; Testimony of Respondent's representative).

5. Since that time, his services have included 80 hours per month of CLS and 20 hours per month of respite care services. (Testimony of Petitioner's representative; Testimony of Respondent's representative).

6. Petitioner's legal guardian did not request an administrative hearing with respect to that the change in Petitioner's services in June of 2024. (Testimony of Petitioner's representative).

7. On November 21, 2024, a Person-Centered Plan (PCP) meeting was held with respect to Petitioner's PCP for the upcoming plan year, *i.e.* December 8, 2024 to December 7, 2025. (Exhibit A, pages 16-39).

8. In the PCP, it was noted that Petitioner goes to school 5 days a week during the school year and that his mother/legal guardian is his primary natural support. (Exhibit A, page 16).

9. His identified goals included improving his communication, safety skills and overall functional abilities; accessing available services; increasing his independence; getting the medical care he needs; controlling the hiring of staff; attending occupational therapy; increasing his range of motion; having respite for his mother; attending a vocational day program; and utilizing shared parenting program services. (Exhibit A, pages 17-32).

10. As part of his services, Petitioner requested 180 hours per month of CLS and 96 hours per month of respite care services. (Exhibit #1, page 3).

11. On December 2, 2024, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that the request for additional services had been denied. (Exhibit A, pages 3-7).

12. With respect to the reason for that denial, the notice stated in part:

> Your clinician requested Community Living Supports (CLS) 180 hours per month and Respite 96 hours per month for dates of service 12/08/2024-06/07/2025. Based on a review of the documentation in the record and in conjunction with the Medicaid Provider Manual the medical necessity of the requested volume of this service is not supported.

> These services were authorized in the following amount, CLS Services in the amount of 80 hours per month and Respite in the amount of 20 hours per month which are sufficient in amount, scope, and duration to meet your treatment needs.
>
> *Exhibit A, page 3*

13. On December 13, 2024, Petitioner filed an Internal Appeal with Respondent with respect to that decision. (Exhibit A, page 10).

14. On January 10, 2025, Respondent sent Petitioner a Notice of Appeal Denial stating that the Internal Appeal had been denied. (Exhibit A, pages 10-15).

15. With respect to the reason for that decision, the notice stated in part:

> Your Internal Appeal was denied for the service/item listed above because:
>
> You asked for 180 hours per month of Community Living Supports (CLS) and 96 hours per month of Respite for the dates 12/8/24 to 6/7/25. [redacted] behaviors have not changed in amount or type. [redacted] also gets Home Help. Based on a review of the record, [redacted] does not meet medical necessity for the number of units requested. CLS is approved at 80 hours per month and Respite for 20 hours per month.
>
> Reviewed by PREST Psychiatrist:
> Certified in Psychiatry by the American Board of Psychiatry and Neurology with a Board Certification Subspecialty in Child/Adolescent Psychiatry
>
> *Exhibit A, page 10*

16. On May 2, 2025, MOAHR received the request for hearing filed in this matter with respect to Petitioner's CLS and respite care services. (Exhibit #1, pages 1-5).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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.
>
> *42 CFR 430.0*

> 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.
>
> *42 CFR 430.10*

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 services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…
>
> *42 USC 1396n(b)*

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 Department of Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, this case concerns Community Living Supports (CLS) and respite care services through Michigan's Habilitation Supports Waiver (HSW).

With respect to the HSW in general, and CLS and respite care services specifically, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**
>
> Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid State Plan covered services. A HSW beneficiary must receive at least one HSW habilitative service per month to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in their individual plan of services (IPOS) developed through the person-centered planning process.
>
> HSW beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:
>
> - Has a developmental disability (as defined by Michigan law);
> - Is Medicaid-eligible;
> - Is residing in a community setting;
> - If not for HSW services, would require ICF/IID level of care services; and
> - Chooses to participate in the HSW in lieu of ICF/IID services.

The PIHP's enrollment process responsibilities also include confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. MDHHS continues to review bed size as part of the waiver enrollment which includes a limit of no more than 12 beds. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, does not receive at least one HSW habilitative service per month, moves out of the state, withdraws from the program voluntarily, or dies. An OBRA assessment must be provided for disenrollment due to nursing facility placement. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Bureau of Specialty Behavioral Health Services. (Refer to the Directory Appendix for contact information.)

PIHPs must report inactive status on HSW beneficiaries not living in community settings (e.g., hospital, nursing facility, Child Caring Institution [CCI], jail, prison, or juvenile detention facility). HSW beneficiaries can be on inactive status for 90 days. After the 90-day period, the PIHP shall start the disenrollment process if there is no transition planning for returning to the community.

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

* * *

15.1.A. COMMUNITY LIVING SUPPORTS (CLS)

NOTE: This is a habilitative service.

Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or Medicaid State Plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential setting, respite). The supports are:

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:
  - Meal preparation;
  - Laundry;
  - Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services);
  - Activities of daily living, such as bathing, eating, dressing, personal hygiene; and
  - Shopping for food and other necessities of daily living.
- Assisting, supporting and/or training the beneficiary with:
  - Money management;
  - Non-medical care (not requiring nurse or physician intervention);
  - Socialization and relationship building;

- Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through MDHHS or health plan) from the beneficiary's residence to community activities, among community activities,

  and from the community activities back to the beneficiary's residence);

- Leisure choice and participation in regular community activities;

- Attendance at medical appointments; and

- Acquiring goods and/or services other than those listed under shopping and non-medical services.

- Reminding, observing, and/or monitoring of medication administration.

CLS does not include costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping may be used to complement Home Help services when the beneficiary's needs for this assistance have been officially determined to exceed MDHHS allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, Medicaid State Plan coverage of Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP must assist with

applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect their needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision.

CLS provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to ADL, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

* * *

15.1.N. RESPITE CARE

Respite care services are provided to a waiver eligible beneficiary on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).

- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with periods in between.

- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.

- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid Medicaid State Plan (e.g., home help) or waiver service (e.g., CLS) or service through other programs (e.g., school).

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service but may be available at other times throughout the day when the caregiver is not paid.

Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work. The beneficiary's record must clearly differentiate respite hours from CLS services. Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver.

Respite services may be provided in the following settings:

- Waiver beneficiary's home or place of residence.

- Licensed foster care home.

- Facility approved by the State that is not a private residence, such as:

  - Group home; or

  - Licensed respite care facility.

- Home of a friend or relative (not the parent of a minor beneficiary, the spouse of the beneficiary served, or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with respite worker training, if needed, by the beneficiary or family.

These sites are approved by the beneficiary and identified in the IPOS.

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) or MDHHS-approved day program site is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from CLS services.

MPM, October 1, 2024 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 121-123, 140-142

Moreover, while CLS and respite care services are covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. *See* 42 CFR 440.230. Regarding medical necessity, the MPM also provides:

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or

- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and

- Documented in the individual plan of service.

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;

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

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

- 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.

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;

- that are 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.

MPM, January 1, 2024 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 13-15

Here, as discussed above, Respondent denied Petitioner's request for additional CLS and respite care services.

In appealing that action, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ is limited to reviewing the Respondent's decision in light of the information it had at the time it made the decision.

Given the record and applicable policies in this case, and for the reasons discussed below, the undersigned ALJ finds that Petitioner has failed to meet his burden of proof and that Respondent's decision must therefore be affirmed.

The authorization of CLS and respite care services for Petitioner is significant and it appears to be sufficient to meet the needs and the goals identified in his PCP, especially considering Petitioner's other services, including HHS since he turned eighteen-years-old; attendance at school; and natural supports.

Moreover, Petitioner has been approved for that current amount of services since June of 2024, and while Petitioner's representative generally testified regarding Petitioner's increased negative behaviors since June of 2024, her testimony is unsupported. At

most, Petitioner's representative notes that Petitioner has obtained a new diagnosis of an unspecified disruptive, impulse-control and conduct disorder. However, a new diagnosis alone does not warrant additional services and there is nothing in the record to suggest any new symptoms or needs.

Rather than focusing on Petitioner's current needs or the request for additional services, Petitioner's representative instead seeks to challenge the change in Petitioner's services in June of 2024. However, the time for requesting an administrative hearing with respect to that action has long since passed and the mere fact that Petitioner was approved for more services in the past does not demonstrate that he should be approved for that greater amount now.

To the extent Petitioner's circumstances have changed or his legal guardian has additional information to provide in support of a need for more services, then Petitioner's guardian can always submit another request for more services in the future along with that information. With respect to the decision at issue in this case however, Respondent's decision must be affirmed given the available information and applicable policies.

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 additional CLS and respite care services.

IT IS THEREFORE ORDERED that:

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

Steven Kibit

STEVEN KIBIT
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to LARA-MOAHR-DCH@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

Via First Class & Electronic Mail:

Authorized Hearing Representative
[redacted]

Via Electronic Mail:

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Petitioner
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