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

**Date Mailed:** November 10, 2025
**Docket No.:** 25-019020-RC
**Case No.:** [redacted]
**Petitioner:** [redacted]

[redacted]
[redacted] MI [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:** November 10, 2025
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**Case No.:** [redacted]
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**SUPERVISING ADMINISTRATIVE LAW JUDGE: MARYA A. NELSON-DAVIS**

**ORDER GRANTING REQUEST FOR RECONSIDERATION**
**AND**
**DECISION AND ORDER OF RECONSIDERATION**

This matter is before the undersigned Supervising Administrative Law Judge pursuant to the timely request for reconsideration by Petitioner's attorney of the hearing decision issued by Administrative Law Judge (ALJ) Corey A. Arendt at the conclusion of the hearing conducted on July 2, 2025, continued on August 6, 2025, and mailed on August 12, 2025, in the above-captioned matter.

The rehearing and reconsideration process is governed by the Michigan Administrative Code, Rule 792.11015, *et seq.*, and applicable policy provisions articulated in the Bridges Administrative Manual (BAM), specifically BAM 600, which provide that a rehearing or reconsideration **may** be granted so long as the reasons for which the request is made comply with the policy and statutory requirements. MCL 24.287 also provides for rehearing if the hearing record is inadequate for judicial review.

A rehearing is a full hearing which **may** be granted if either of the following applies:

- The original hearing record is inadequate for purposes of judicial review; or
- There is newly discovered evidence **that existed** at the time of the original hearing that could affect the outcome of the original hearing decision.

A reconsideration is a paper review of the facts, law or legal arguments, and any newly discovered evidence that existed at the time of the hearing. It may be granted when the original hearing record is adequate for purposes of judicial review, and a rehearing is not necessary; but one of the parties is able to demonstrate that the Administrative Law Judge failed to accurately address all the relevant issues raised in the hearing request. Reconsiderations **may** be granted if requested for one of the following reasons:

- Misapplication of manual policy or law in the hearing decision, which led to the wrong decision;
- Typographical errors, mathematical errors, or other obvious errors in the hearing decision that affect the substantial rights of the petitioner; or
- Failure of the Administrative Law Judge to address other relevant issues in the hearing decision.

In hearing decision issued on August 12, 2025, the ALJ concluded that The Right Door agency (Respondent) properly reduced Petitioner's Community Living Supports (CLS) and respite care services. In the request for reconsideration, Petitioner's attorney argued that the ALJ made a finding that Petitioner's primary caregiver, his mother, stated during the hearing that the respite services were being used to provide relief to her during time periods in which she is working her full-time job away from Petitioner; however, this is not supported by the record. Petitioner's attorney stated the request for reconsideration is being submitted for the purpose of correcting the record on this point because it is an obvious error in the hearing decision that affects the substantial rights of Petitioner as well as a failure of the ALJ to address in the hearing decision relevant issues raised in the request for hearing.

Because Respondent alleged errors in the hearing decision that affect the substantial rights of Petitioner and the ALJ failed to address relevant issues raised in Petitioner's request for hearing, the request for reconsideration is **GRANTED**. The following Decision and Order of Reconsideration is based on a full review of the case file, all exhibits, the hearing record, and applicable statutory and policy provisions.

## DECISION AND ORDER OF RECONSIDERATION

## ISSUE

Did The Right Door agency (Respondent) properly reduce Petitioner's Community Living Supports (CLS) and respite care services?

## FINDINGS OF FACT

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

1. On July 2, 2025, a hearing was held under MOAHR docket no. 25-019020 and continued on August 6, 2025, in response to Petitioner's request for hearing to contest Respondent's decision to reduce his CLS and respite care services.

2. On August 12, 2025, the ALJ issued a hearing decision in this matter.

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3. The Findings of Fact numbers 1-11 in the August 12, 2025, hearing decision are incorporated by reference.

## 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.
>
> 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...

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 (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

## 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 covered state plan services. A HSW beneficiary must receive at least one HSW service per month in order 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 Pre-paid Inpatient Health Plan (PIHP) must be specified in their individual plan of services 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 also includes 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. 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, withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Division of Adult Home and Community Based Services. (Refer to the Directory Appendix for contact information.) 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. Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

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 state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, 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;
- Acquiring goods and/or services other than those listed under shopping and non-medical services; and
- Reminding, observing, and/or monitoring of medication administration.

The CLS does not include the 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 MDHHS has determined the individual's need for this assistance exceeds Home Help service limits. 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, 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.

Community Living Supports (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 activities of daily living, 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.

* * *

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 State Plan (e.g., home help) or waiver service (e.g., community living supports) 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 full-time.** In those cases, community living supports or other services of paid support or training staff should be used. **The beneficiary's record must clearly differentiate respite hours from community living support 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 or the spouse of the beneficiary served or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with a 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) is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from community living support services.

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. *See 42 CFR 440.230.*

The Medicaid Provider Manual articulates Medicaid policy for Michigan. It states, in relevant part:

> **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 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;

- 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 stndards 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.

*Medicaid Provider Manual Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter April 1, 2025*

In this case, the ALJ concluded in the hearing decision issued on August 12, 2025, that Respondent properly reduced Petitioner's CLS and respite care services based on the evidence on the record. In the request for reconsideration, Petitioner's attorney argued that the ALJ made a finding that Petitioner's mother/guardian/primary caregiver testified that respite services were being used to provide relief during time periods in which she was working her full-time job and away from Petitioner. Petitioner's attorney argued that this is not supported by the record. Petitioner's attorney stated the request for reconsideration is being submitted for the purpose of correcting the record on this point because it is an obvious error in the hearing decision that affects the substantial rights of Petitioner as well as a failure of the ALJ to address in the hearing decision relevant issues raised in the request for hearing.

At the time relevant to this matter, Petitioner was a [redacted]-year-old male who was diagnosed with autism spectrum disorder. The evidence on the record establishes that during Petitioner's individual plan of service review in March 2025, Respondent reduced Petitioner's CLS hours from 43.75 hours per week to 30 hours per week and reduced his respite hours from 86 hours per month down to 32 hours per month. Subsequently, Respondent determined that Petitioner should be getting 36 hours per month of respite care after a further review of Petitioner's Person-Centered Plan (PCP). Additionally, Petitioner was determined eligible for 62 hours of Home Help Services (HHS) per month by MDHHS.

Respondent's witnesses testified that their CLS and Respite committee created a new assessment tool that is used to determine support needs for CLS and respite. According

to the Respondent, Petitioner's authorized HHS weren't considered in determining his eligibility for CLS prior to March 2025, and it is not clear why Petitioner was approved for 86 hours per month of respite prior to 2025. Respondent stated that in reviewing Petitioner's eligibility for continued services, there was an in-depth review of Petitioner's circumstances, as well as phone calls with Petitioner's mother/guardian, his case manager, and the case management supervisor. Respondent's case manager and medical director testified that based on a review of Petitioner's PCP and his needs and goals, the CLS and respite service hours authorized were appropriate and in accordance with the applicable Medicaid policy.

Petitioner's mother has been his primary caregiver. During the hearing, she testified that Petitioner needs daily 24-hour care, and he has been receiving services since 2006. Based on the evidence on the record, Petitioner's mother was working full time, 8 hours during the week, and was not providing care to Petitioner while she worked. Petitioner's mother questioned how Respondent's new assessment tool can be an accurate way to measure the number of hours needed for CLS and respite because it produced such a different result than what was previously determined. She also questioned whether Respondent's assessment tool fully captured Petitioner's behavioral and supervision requirements and whether it gave adequate weight to her input about Petitioner's day-to-day care needs.

Medicaid policy allows PIHPs to use a structured assessment tool to determine service amounts if the process is individualized. Here, Respondent applied its CLS and respite assessment tool, reviewed the results through a multi-member clinical committee, and considered Petitioner's circumstances and his caregiver's input. Additionally, Petitioner was approved for approximately 62 hours per month of HHS to assist Petitioner with Activities of Daily Living and Instrumental Activities of Daily Living to enhance Petitioner's independence within the community. In accordance with Medicaid guidelines, HHS must be considered first when assessing the need for CLS hours. According to Respondent, the challenge was that the HHS aid that provided care to Petitioner was also his mother. It was recommended that Petitioner's mother explore the option of utilizing the HHS funding source to pay an additional support provider instead of having herself as the HHS provider.

Medicaid policy does not allow for duplication of services. This means that services provided under Home Help must not overlap with those offered through CLS. Additionally, Medicaid policy clearly states that respite care services are to be provided on a short-term, intermittent basis. Respite is not designed to serve as a substitute for ongoing routine care or to replace the role of a primary caregiver on a continuous basis.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent improperly reduced his CLS and respite care hours, and the previously authorized CLS and respite hours should remain the same. While the undersigned agrees that Petitioner's mother did not state that respite care hours were being used to provide relief while she is working, Petitioner has failed to prove by a preponderance of evidence that 43.75 hours of CLS per week and 86 hours of respite care per month are medically necessary. Petitioner did not present persuasive evidence that Respondent's assessment tool was applied incorrectly, that the process failed to consider Petitioner's

individual circumstances, or that the reduction in CLS and respite services violates Medicaid policy. As noted in the ALJ's hearing decision, Petitioner may wish to consider applying for Overnight Health and Safety Supports (OHSS). These services may be appropriate for addressing Petitioner's care needs during nighttime hours.

## DECISION AND ORDER

Based on the above Findings of Fact and Conclusions of Law, the undersigned finds that Respondent properly reduced Petitioner's CLS and respite services.

Accordingly, Respondent's decisions are **AFFIRMED**.

MN-D/pe

Marya A Nelson-Davis

**MARYA A. NELSON-DAVIS**
**SUPERVISING ADMINISTRATIVE LAW JUDGE**

**APPEAL RIGHTS:** Petitioner may appeal this Order to the circuit court within 30 days of receiving the Order. 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. A copy of the circuit court appeal should be sent to MOAHR.

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