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

Date Mailed: August 11, 2025
Docket No.: 25-023229
Case No.: [redacted]
Petitioner: [redacted]

[redacted] MI [redacted]

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

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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 11, 2025
Docket No.: 25-023229
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 by Petitioner [redacted] (Petitioner).

After due notice, a telephone hearing was held on August 7, 2025. Petitioner appeared and testified on his own behalf. Aimee Page, Chief Clinical and Healthcare Strategy Officer, appeared and testified on behalf of Respondent AgeWays Nonprofit Senior Services (Respondent). Molly Dobrzeniecki, Appeals Analyst, also testified as a witness for Respondent.

The following exhibits were admitted into the record without objection:

Exhibit #1: Petitioner's Request for Hearing, pages 1-5
Exhibit #2: Invoices dated 9/28/24 and 10/28/24, pages 1-3
Exhibit #3: Invoice dated 6/23/25, one page
Exhibit #4: Photograph, one page
Exhibit #5: Photograph, one page
Exhibit #6: Photograph, one page
Exhibit #7: Photograph, one page
Exhibit #8: Photograph, one page
Exhibit #9: Photograph, one page
Exhibit #10: Photograph, one page

Exhibit A: Respondent's Evidence Packet, pages 1-99

At the onset of the hearing, Respondent moved for dismissal of the case due to a lack of jurisdiction. The undersigned ALJ denied that request and the hearing then proceeded on the merits.

ISSUE

Did Respondent properly deny Petitioner's request for reimbursement for bills he incurred in purchasing 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 enrolled in the MI Choice Waiver Program and receives services through Respondent. (Testimony of Petitioner; Testimony of Respondent's representative).

2. In 2024, Respondent approved chore services for Petitioner to have his home, including the carpet, deep cleaned. (Testimony of Petitioner; Testimony of Respondent's representative).

3. The parties dispute whether the services were rendered. (Testimony of Petitioner; Testimony of Respondent's representative).

4. Petitioner subsequently paid for cleaning services on his own. (Testimony of Petitioner; Testimony of Appeals Analyst).

5. He also requested reimbursement for the bills he incurred in purchasing those services. (Testimony of Petitioner; Testimony of Appeals Analyst).

6. Respondent verbally denied the request for reimbursement. (Testimony of Petitioner; Testimony of Appeals Analyst).

7. No written adverse benefit determination denying the request was sent to Petitioner. (Testimony of Petitioner; Testimony of Respondent; Testimony of Appeals Analyst).

8. On June 24, 2025, MOAHR received a request for hearing filed in this matter. (Exhibit #1, pages 1-5).

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. 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.

Petitioner is receiving services through the Department's Home and Community Based Services for Elderly and Disabled. The waiver is called MI Choice in Michigan. The program is funded through the federal Centers for Medicare and Medicaid to the Michigan Department of Health and Human Services. Regional agencies, in this case Respondent, function as the Department's administrative agency.

> Waivers are intended to provide the flexibility needed to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of beneficiaries. Waivers allow exceptions to State plan requirements and permit a State to implement innovative programs or activities on a time-limited basis, and subject to specific safeguards for the protection of beneficiaries and the program. Detailed rules for waivers are set forth in subpart B of part 431, subpart A of part 440, and subpart G of part 441 of this chapter.
>
> *42 CFR 430.25(b)*

Types of services that may be offered through the waiver program include:

> Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:
>
> (1) Case management services.
>
> (2) Homemaker services.
>
> (3) Home health aide services.
>
> (4) Personal care services.
>
> (5) Adult day health services
>
> (6) Habilitation services.
>
> (7) Respite care services.
>
> (8) Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.
>
> (9) Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization.
>
> *42 CFR 440.180(b)*

The Medicaid Provider Manual (MPM) outlines the governing policy for the MI Choice Waiver program and, with respect to services in general, the applicable version of the MPM states in part:

SECTION 4 – SERVICES

The array of services provided by the MI Choice program is subject to the prior approval of CMS. Waiver agencies are required to provide any waiver service from the federally approved array that a participant needs to live successfully in the community, that is:

- indicated by the current assessment;
- detailed in the person-centered service plan; and
- provided in accordance with the provisions of the approved waiver.

Services must not be authorized unless they are defined in the PCSP and must not precede the establishment of a PCSP. Waiver agencies cannot limit in aggregate the number of participants receiving a given service or the number of services available to any given participant. Participants have the right to receive services from any willing and qualified provider within the waiver agency's provider network. When the waiver agency does not have a willing and qualified provider within their network, the waiver agency must utilize an out-of-network provider at no cost to the participant until an in-network provider can be secured. (Refer to the Providers section of this chapter for information on qualified provider standards.)

MDHHS, waiver agencies, and direct service providers must not impose a copayment or any similar charge upon participants for waiver services. MDHHS and waiver agencies do not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Although MI Choice participants must have services approved by the waiver agency, participants have the option to select any participating provider in the waiver agency's provider network, thereby ensuring freedom of choice.

Services paid for with MI Choice funds must not duplicate nor replace services available through the State Plan. Where applicable, the participant must use State Plan, Medicare, or

other available payers first. MI Choice is the funding source of last resort.

The participant's preference for a certain provider is not grounds for declining another payer in order to access waiver services.

Providers must have previous relevant experience or training for the tasks specified and authorized in the PCSP. The waiver agency must deem the chosen provider capable of performing the required tasks.

For services involving transportation paid for with MI Choice funds, the Secretary of State must appropriately license all drivers and vehicles, and all vehicles must be appropriately insured as required by law.

Healthcare Common Procedure Coding System (HCPCS) codes for each service can be found in the Directory Appendix of the Medicaid Provider Manual.

MPM, October 1, 2024 version
MI Choice Waiver Chapter, page 18

Here, as discussed above, Respondent verbally denied Petitioner's request for reimbursement from Respondent for bills he had incurred in purchasing services.

Specifically, Petitioner testified and argued that, while Respondent technically approved chore services, the services were not actually rendered and Petitioner had no choice but to privately pay for deep cleaning services in order to ensure that a necessary personal care aide could come into his home and assist him. Petitioner also testified and argued that, given his desperate need for an aide, he just paid for the services himself and asked for reimbursement later, only to be denied.

Respondent argued that any appeal of a reimbursement denial should be dismissed because it is outside of the scope of this hearing, which only involved a denial of a later request for chore services; Petitioner's appeal of that denial; an appeal decision by Respondent affirming the denial; and then Respondent subsequently approving the services in light of new evidence. Respondent also questioned if a denial of a request for reimbursement is an adverse benefit determination that gives rise to the right to a hearing. Petitioner's witnesses further testified why Petitioner's request for reimbursement was verbally denied, though Respondents' representative also noted that she could not cite any specific law or policy because she did not think the hearing was about that issue.

As discussed above, the undersigned ALJ denied Respondent's motion to dismiss on the record. Moreover, for the some of the same reasons that motion was denied, the undersigned ALJ also finds upon review that Petitioner has demonstrated that Respondent erred.

While not entirely clear from the request for hearing he filed, Petitioner is appealing the denial of his request for reimbursement for bills for services he purchased. Respondent was also aware of that issue, with Respondent's Notice of Appeal Decision – Denial specifically noting that "what [Petitioner] really wants is to be reimbursed that money" (Exhibit A, page 17). Moreover, Respondent's Appeals Analyst also testified that Petitioner's request for reimbursement was verbally denied during the appeals process.

Additionally, while Respondent questioned whether the denial of a request for reimbursement for services a beneficiary paid for is an adverse benefit determination that gives rise to the right to a hearing, the undersigned ALJ finds that such an action falls within the definition of adverse benefit determination found in 42 CFR 438.400:

> *Adverse benefit determination* means, in the case of an MCO, PIHP, or PAHP, any of the following:
>
> (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
>
> (2) The reduction, suspension, or termination of a previously authorized service.
>
> (3) The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) of this chapter is not an adverse benefit determination.
>
> (4) The failure to provide services in a timely manner, as defined by the State.
>
> (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
>
> (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her

right, under § 438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

42 CFR 438.400(b)

Given that the disputed denial falls within the definition of an adverse benefit determination, Respondent was required to send Petitioner written notice of its decision. 42 CFR 438.404. In particular, that notice must explain:

(1) The adverse benefit determination the MCO, PIHP, or PAHP has made or intends to make.

(2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

(3) The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal described at § 438.402(b) and the right to request a State fair hearing consistent with § 438.402(c).

(4) The procedures for exercising the rights specified in this paragraph (b).

(5) The circumstances under which an appeal process can be expedited and how to request it.

(6) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with

> state policy, under which the enrollee may be required to pay the costs of these services.
>
> *42 CFR 438.404(b)*

Here, it is undisputed that no such notice was sent and that Petitioner's request was only verbally denied. Respondent therefore erred.

Moreover, given the lack of written notice, Respondent's appeal system, including deadlines for Petitioner requesting an appeal with Respondent or requesting a State fair hearing with MOAHR, were never triggered; and, to the extent Respondent argues that Petitioner's appeal is untimely or that Petitioner failed to exhaust Respondent's appeal process, its argument is rejected.

Additionally, by Respondent failing to send the required written notice, Petitioner was never advised in writing, as required, of the reasons for the adverse benefit determination and the specific facts or policy he must respond to, which impeded his opportunity to present his case. Respondent was also hindered, with its representative unprepared to argue the issue at hand.

It is not clear from the record if Petitioner's request should be approved. However, the ALJ does find that Respondent erred by failing to send proper, written notice and that the denial of Petitioner's request for reimbursement must therefore be reversed at this time.

Respondent is to reassess the request and, if the request is denied again, issue proper notice, with Petitioner retaining the ability to appeal any adverse benefit determination with Respondent and/or subsequently request a State fair hearing if and when appropriate.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that, given the lack of proper notice, Respondent improperly denied Petitioner's request for reimbursement.

IT IS THEREFORE ORDERED that:

- Respondent's decision is **REVERSED,** and it must initiate a reassessment of Petitioner's request for reimbursement, with proper notice issued if Respondent subsequently decides to deny the request again.

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 Electronic Mail:

Community Health Representative
AGEWAYS
C/O LORI SMITH
29100 Northwestern Hwy Ste 400
SOUTHFIELD, MI 48034
LSMITH@AGEWAYS.ORG

Agency/Department Representative
HEATHER HILL
MDHHS
400 S PINE ST 5TH FL
LANSING, MI 48933
HILLH3@MICHIGAN.GOV

Via First Class Mail:

Petitioner
[redacted]
[redacted] MI [redacted]