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

Date Mailed: November 17, 2025
Docket No.: 25-026356
Case No.: [redacted]
Petitioner: [redacted]

[redacted]

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

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

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[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 a hearing filed on behalf of Petitioner [redacted] (Petitioner).

After due notice, a telephone hearing was held on October 2, 2025, and November 13, 2025. [redacted] Petitioner's sister and Guardian, appeared and testified on Petitioner's behalf. George Motakis, Fair Hearings Officer, appeared on behalf of Respondent Lakeshore Regional Entity (Respondent).

Witnesses:

Petitioner	[redacted]
Respondent	Alyssa Stone

Exhibits:

Petitioner

1. Petitioner's Diagnoses
2. Pictures of Madison Home
3. Letter for Hearing
4. [redacted] Letter
5. Specturm Letter
6. Base Care v Light Residential Rate
7. Corrected Reason for Appeal
8. MSA Bulletin 04-03
9. Personal Care Guidelines
10. Misc. Guidelines

11. Misc. Records
12. 42 CFR 438.400
13. Medicaid Provider Manual Excerpt
14. Personal Care Guidelines
15. Job Description

Respondent

A. Letter of Adverse Benefit Determination
B. Appeal Request
C. Notice of Receipt of Appeal
D. Notice of Appeal Denial
E. LRE Appeal Summary
F. Request for State Fair Hearing version 1
G. Request for State Fair Hearing version 2
H. Notice of Hearing
I. LARA Credentials (AS)
J. LARA Credentials (MA)
K. LARA Credentials (TR)

ISSUE

Did Respondent properly decide to reduce Petitioner's 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 who resides at Spectrum Community Services, Madison Adult Faster Care (AFC) Home in Kentwood, Michigan. (Exhibit A; Testimony.)

2. Since 2012, Petitioner has resided in the Madison AFC Home. (Exhibit A; Testimony.)

3. Petitioner is diagnosed with autism spectrum disorder (ASD), insomnia, and profound intellectual disabilities. (Exhibit A; Testimony.)

4. Petitioner has a history of physical aggression in the form of scratching and pinching other people. (Exhibit A; Testimony.)

5. In March 2025, Respondent conducted a review of Petitioner's authorization of services following a request to continue services at their prior level (Base Level of Care). (Exhibit A; Testimony.)

6. Petitioner had been receiving services at the Base Level of Care as a result of issues with scratching and pinching. (Testimony.)

7. On March 24, 2025, Respondent issued an Adverse Benefit Determination indicating Petitioner's needs could be met at a Light Residential Level of Care as a result of Petitioner's scratching and pinching occurring monthly or less. (Exhibit A; Exhibit B; Testimony.)

8. On April 11, 2025, Petitioner filed an internal appeal. (Exhibit A; Exhibit C; Testimony.)

9. On May 6, 2025, Respondent issued a Notice of Appeal Denial. At this time, it was noted Petitioner had made improvement with her goals and skills and no longer met the medical necessity criteria to justify services at the Base Level of Care, and that Petitioner's needs could be met at a Light Residential Level of Care. (Exhibit A; Exhibit D; Testimony.)

10. On July 23, 2025, Petitioner filed a request for a Medicaid State Fair Hearing. (Exhibit F; Exhibit G; Testimony.)

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.[1]
>
> 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

[1] 42 CFR 430.0.

> 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.[2]

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…[3]

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, Petitioner has been authorized for community living supports (CLS) and personal care services through Respondent, with the services paid at a per diem Base Residential Rate Level of Care (LOC).

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

> **SECTION 2 – PROGRAM REQUIREMENTS**
>
> **2.1 MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES**
>
> Mental health and developmental disabilities services (state plan, HSW, and additional/1915(i) SPA) must be:
>
> - Provided under the supervision of a physician, or other licensed health professional whose profession is relevant to the services being provided. This includes professionals who are licensed or certified in Michigan in a human services field typically associated with

[2] 42 CFR 430.10.
[3] 42 USC 1396n(b).

mental health or developmental disabilities services. (Refer to Staff Provider Qualifications later in this section.)

- Provided to the beneficiary as part of a comprehensive array of specialized mental health or developmental disabilities services.

- Coordinated with other community agencies (including, but not limited to, Medicaid Health Plans [MHPs], family courts, local health departments [LHDs], MI Choice waiver providers, school-based services providers, and local MDHHS offices).

- Provided according to an individual written plan of service that has been developed using a person-centered planning process and that meets the requirements of Section 712 of the Michigan Mental Health Code. A preliminary plan must be developed within seven days of the commencement of services or, if a beneficiary is hospitalized, before discharge or release. Pursuant to state law and in conjunction with the federal Balanced Budget Act of 1997, Section 438.10 (f)(6)(v), each beneficiary must be made aware of the amount, duration, and scope of the services to which they are entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service. The beneficiary must receive a copy of their plan of services within 15 business days of completion of the plan.

- The individual plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary's health and welfare needs or changes in the beneficiary's preferences for support). A beneficiary or their guardian or authorized representative may request and review the plan at any time. A formal review of the plan with the beneficiary and their guardian or authorized representative shall occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction. The review may occur during person-centered planning.

- Provided without the use of aversive, intrusive, or restrictive techniques unless identified in the individual plan of service and individually approved and monitored by a behavior treatment plan review committee.

* * *

2.3 LOCATION OF SERVICE

Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in integrated locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.

Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. Mental health case management may be provided off-site, as necessary, to meet individual needs when case management is purchased as a component of a licensed service. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's home.

* * *

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.

* * *

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 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 themself by prompting, reminding, or by

being in attendance while the beneficiary performs the task(s).

* * *

17.4.A. COMMUNITY LIVING SUPPORTS (CLS)

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, facilitating a beneficiary's achievement of their goals of community inclusion and participation, independence or productivity. The supports may be provided in the beneficiary's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting (that exceeds State Plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:

  - meal preparation
  - laundry
  - routine, seasonal, and heavy household care and maintenance
  - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
  - shopping for food and other necessities of daily living

  CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or State Plan services, e.g., Personal Care (assistance with activities of daily living in a certified specialized residential setting) and Home Help (assistance in the beneficiary's own, unlicensed home with meal preparation, laundry, routine

household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, 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 case manager or supports coordinator must assist them in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.

- CLS staff providing assistance, support and/or training with activities such as:

  - money management

  - non-medical care (not requiring nurse or physician intervention)

  - socialization and relationship building

  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)

  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)

  - attendance at medical appointments

  - acquiring or procuring goods, other than those listed under shopping, and non-medical services

  - Reminding, observing and/or monitoring of medication administration

  - Staff assistance with preserving the health and safety of the beneficiary in order that they may

> reside or be supported in the most integrated, independent community setting.
>
> CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through Medicaid FFS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving CLS.
>
> CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help services when the beneficiary's need for this assistance has been officially determined to exceed the allowable parameters. 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. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help.
>
> CLS provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the beneficiary'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 beneficiary. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For beneficiaries up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings.[4]

Here, as discussed above, Respondent has decided to reduce Petitioner's services and only authorize his CLS and personal care services at a lower level of care pursuant to the above policies and on the basis that the higher, more restrictive level of care is not

[4] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, April 1, 2025, pp 9-10, 13-15, 90, 150-152.

medically necessary. Specifically, the fact that Petitioner's assessments concluded Petitioner's only behavioral goal had a significant decrease in behavioral events (pinching/scratching). Petitioner then appealed that decision.

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

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has not met that burden of proof; and Respondent's decision must, therefore, be affirmed.

Petitioner has lived in her current foster care home and has received her services there at the Base Residential Rate LOC since at least 2012. It is undisputed that Petitioner has made significant progress in her targeted goals and issues since that time.

Moreover, per policy, Respondent may deny services 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. Here, it is undisputed that CLS and personal care services based on the Light Residential rate are less restrictive than services through the Base Residential Rate LOC; and, given Petitioner's significant progress and stabilization, the record demonstrates both that the reduced services through the Light Residential rate can satisfy the standards for medically necessary services for Petitioner; and that the reduction in Petitioner's services from the Base Residential Rate LOC to the Light Residential rate is proper.

Petitioner's guardian testified that they do not want Petitioner's services to change given her improvement, with Petitioner's staff and the services responsible for the success and stabilization that she has had. However, while understandable, Petitioner's guardian's testimony does not change the applicable policy and its provision that Respondent may deny services for which there exists other appropriate and less-restrictive services or settings that otherwise meet Petitioner's needs. Petitioner's past services have met her needs, but that alone is insufficient to meet Petitioner's burden. The record in this case reflects both that Petitioner has improved to such a point that a less restrictive level of care can meet Petitioner's need and that a reduction in services is appropriate.

To the extent that Petitioner's guardian has additional information to provide or Petitioner's circumstances change, then Petitioner's guardian can always request additional 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 reduced Petitioner's services.

IT IS THEREFORE ORDERED that:

Respondent's decision is **AFFIRMED**.

COREY A. ARENDT
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 MOAHR-BSD-Support@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 and Electronic Mail:

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Authorized Hearing Representative
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