Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
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Date Mailed: December 22, 2025
Docket No.: 25-031076
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
[redacted] MI [redacted]

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Date Mailed: December 22, 2025
Docket No.: 25-031076
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 December 10, 2025. Attorney Daniel R. Wojciak represented Petitioner. Katie Feher, Senior Manager of Denials and Appeals, represented Respondent Meridian Complete (Respondent).[1]

During the hearing, the following witness testified:

Dawn Garceau, Manager of Case Management, Respondent

The following exhibits were also entered into the record without objection:

Petitioner's Exhibits[2]

Exhibit #1: MI Health Link Service Level Plan, December 3, 2024

Exhibit #2: Periscope Assessment, May 21, 2025

Exhibit #3: Notice of Appeal Decision, July 21, 2025

Exhibit #4: Excerpts from Minimum Operating Standards for MI Health Link Program and MI Health Link HCBS Waiver, March 2025

Respondent's Exhibit

Exhibit A: Evidence Packet

ISSUE

Did Respondent properly decide to reduce Petitioner's personal care services?

[1] By agreement of the parties and order of the ALJ, the hearing in Petitioner's case was consolidated with the hearing for a related case in Docket No. 25-031074.
[2] Petitioner numbered her exhibits collectively, and the ALJ will refer to those stamped page numbers in this Decision and Order

FINDINGS OF FACT

The ALJ, 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 has been diagnosed with dementia, type 2 diabetes, benign prostatic hyperplasia, high blood pressure, arthritis, blindness in the left eye, high cholesterol, insomnia, urinary incontinence, and constipation. (Exhibit A, page 20).

2. Respondent is an Integrated Care Organization (ICO) contracted by the Michigan Department of Health and Human Services (Department or MDHHS) and the Centers for Medicare & Medicare Services (CMS) to provide covered services through the MI Health Link managed care program.

3. Petitioner is enrolled in the MI Health Link program and has been authorized for services through Respondent. (Testimony of Manager of Care Management).

4. As part of his services, Petitioner has been approved for 36.75 hours per week of personal care services. (Exhibit #1, page 8; Testimony of Manager of Care Management).

5. Those services were authorized following the completion of an assessment on December 3, 2024. (Exhibit A, pages 18-23).

6. In that approval, assistance with the Activities of Daily Living (ADLs) of grooming, dressing, toileting, bathing, and transferring, as well as assistance with the Instrumental Activity of Daily Living (IADL) of taking medications, was authorized above the times recommended by the Reasonable Time Schedule (RTS) found in the Minimum Operating Standards for MI Health Link Program and MI Health Link HCBS Waiver. (Exhibit A, pages 18-23; Testimony of Manager of Care Management).

7. Petitioner was also approved for assistance with range of motion exercises, hand massages, and other services. (Exhibit A, pages 18-23).

8. Following that assessment, Respondent received additional training and education from MDHHS regarding services through the MI Health program. (Testimony of Manager of Care Management).

9. On May 21, 2025, Respondent, through its paid contractor Periscope, completed a reassessment with Petitioner and Petitioner's daughter. (Exhibit #2, pages 9-29).

10. There were no significant changes in Petitioner' health between the December 3, 2024, assessment and the May 21, 2025, assessment. (Testimony of Manager of Care Management).

11. Unlike the December 2024 assessment, the May 2025 assessment did not find that Petitioner has need for assistance with range of motion exercises or hand massages. (Exhibit #2, pages 9-29; Exhibit A, pages 24-29; Testimony of Manager of Care Management).

12. Moreover, Respondent also determined that, based on the May 2025 assessment and additional training Respondent had received from MDHHS, none of Petitioner's needs for assistance with ADLs or IADLs rose to a level over that recommended by the RTS. (Exhibit #2, pages 9-29; Exhibit A, pages 24-29; Testimony of Manager of Care Management).

13. On May 22, 2025, Respondent sent Petitioner a written Notice of Denial of Medical Coverage in which it stated that Petitioner's personal care services would be reduced from 36.75 hours per week to 27.25 hours per week as of June 6, 2025. (Exhibit A, pages 30-40).

14. With respect to the reason for that decision, the notice stated:

> We reduced the medical services/items listed above because: On 5/21/25 Meridian assessed how much help you need in the home. Personal care hours are allowed when a person needs help with daily tasks. To qualify for these services, you must need help with at least one daily task. This could be help with eating, going to the bathroom, bathing, grooming, dressing, and being able to get around. Based on your assessment, your personal care hours have been reduced from 36.75 weekly hours to 25.75 weekly hours. This change starts on 6/6/25. This decision was based on the MI Health Link Minimum Operating Standards. If your needs change, please call your care coordinator at 855-323-4578 Monday-Friday from 8am-8pm. We will come to your home for a new assessment.. [sic]
>
> *Exhibit A, page 31*

15. On July 1, 2025, Petitioner filed an Internal Appeal with Respondent regarding that decision. (Exhibit #3, page 31).

16. On July 18, 2025, Respondent sent Petitioner a Notice of Appeal Decision in which it stated that Petitioner's appeal was denied. (Exhibit #3, pages 31-34).

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

> We received your appeal request about your reduced Personal Care Service hours. We reviewed the in-person assessment done on 05/21/2025. Your assessment completed shows you did not have a medical need for the previous number of hours you were receiving. Your assessment shows you need a lot of help (total dependent) with some of your daily tasks (eating, toileting, bathing, grooming, and dressing). Your assessment also shows you use a walker for transfers and moving around with some help (hands on assistance). Your assessment shows your caregiver does daily tasks of meal preparation and cleanup, shopping, and light house cleaning for you and your spouse at the same time. Your reduced weekly hours reflect this (time was prorated for these tasks). The notes show the given weekly hours are reflected in the amount of help you need. Based on your in-person assessment, your personal care hours were reduced from 36.75 weekly hours to 25.75 weekly hours. This decision was based on the MI Health Link Minimum Operating Standards.

Exhibit #3, page 31

18. On August 29, 2025, MOAHR received the request for hearing filed in this matter with respect to the decision to reduce Petitioner's personal care services. (Exhibit A, pages 1-11).

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.

As discussed above, Petitioner has been authorized for Personal Care Services through Respondent pursuant to the MI Health Link program. With respect to that program in general and Personal Care Services in particular, the applicable version of the Medicaid Provider Manual (MPM) states in part:

SECTION 1 – GENERAL INFORMATION

Effective March 1, 2015, the Michigan Department of Health and Human Services (MDHHS), in partnership with the Centers for Medicare & Medicaid Services (CMS), implemented a new managed care program called MI Health Link. This program integrates into a single coordinated delivery system all physical health care, pharmacy, long term supports and services, and behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid. The goals of the program are to improve coordination of supports and services offered through Medicare and Medicaid, enhance quality of life, improve quality of care, and align financial incentives.

MDHHS and CMS have signed a three-way contract with managed care entities called Integrated Care Organizations (ICOs) to provide Medicare and Medicaid covered acute and primary health care, pharmacy, dental, and long term supports and services (nursing facility and home and community based services). The MI Health Link program also includes a home and community-based services (HCBS) waiver for MI Health Link enrollees who meet nursing facility level of care, choose to live in the community rather than an institution, and have a need for at least one of the waiver services as described in this chapter. This waiver is called the MI Health Link HCBS Waiver.

The Michigan Prepaid Inpatient Health Plans (PIHPs) in the four demonstration regions are responsible for providing all Medicare and Medicaid behavioral health services for individuals who have mental illness, intellectual/developmental disabilities, and/or substance use disorders. The Eligibility and Service Areas section provides a list of the regions and related counties.

* * *

SECTION 5 – COVERED SERVICES

MI Health Link offers the following services:

- Medicare covered services, including pharmacy

- Medicaid State Plan services, including personal care services and hearing aid coverage

- Dental services

  - Equivalent to the Medicaid adult dental benefit as described in the Dental Chapter of this manual.

- Long Term Supports and Services (LTSS)

  - Nursing facility services

  - State Plan personal care services

  - Supplemental Services for individuals who live in the community and do not meet nursing facility level of care as determined by the LOCD.

  - MI Health Link HCBS Waiver services for individuals who live in the community and meet nursing facility level of care as determined by the LOCD

- Services provided through PIHPs for individuals' needs related to behavioral health (BH), intellectual/developmental disability (I/DD) and substance use disorders (SUD)

The MI Health Link program waives the requirement for a three-day hospital stay prior to receiving rehabilitation or skilled care in a Michigan licensed nursing facility. Admission requirements include a physician-written order for nursing facility services, a completed LOCD, and a completed Pre-Admission Screening and Resident Review (PASRR).

5.1 STATE PLAN PERSONAL CARE SERVICES

For individuals enrolled in the MI Health Link program, State Plan personal care services will be provided and paid for by the ICO and will no longer be provided through the Medicaid Home Help program. Personal care services are available to individuals who require hands-on assistance in activities of daily living (ADLs) (i.e., eating, toileting, bathing, grooming, dressing, mobility, and transferring) as well as hands-on assistance in instrumental activities of daily living (IADLs) (i.e., personal laundry, light housekeeping, shopping, meal

preparation and cleanup, and medication administration).

Personal care services are available to individuals living in their own homes or the home of another. Services may also be provided outside the home for the specific purpose of enabling an individual to be employed.

Providers shall be qualified individuals who work independently, contract with, or are employed by an agency. The ICO may directly hold provider agreements or contracts with independent care providers of the individual's choice, if the provider meets MDHHS qualification requirements, to provide personal care services. Individuals who currently receive personal care services from an independent care provider may elect to continue to use that provider. The individual may also select a new provider if that provider meets State qualifications. Paid family caregivers will be permitted to serve as a personal care provider in accordance with the state's requirements for Medicaid State Plan personal care services.

* * *

5.1.B. ASSESSMENT REQUIREMENTS

During the Level I Assessment, ICO Care Coordinators (or designee who meets the qualifications for an ICO Care Coordinator) must consider if the individual may need personal care services. If the ICO Care Coordinator believes the individual may be eligible for MI Health Link personal care services, the ICO Care Coordinator will conduct the Personal Care Assessment. The face-to-face, comprehensive assessment is the basis for determining and authorizing the amount, scope and duration, and payment of services. The individual needs to be reassessed at least quarterly or with a change of functional and/or health status to determine and authorize the amount, scope and duration, and payment of services. The reassessment must be face-to-face.

ADLs and IADLs are ranked by the ICO Care Coordinator during the Personal Care Assessment. Through the assessment, ADLs and IADLs are assessed according to the following five point scale,

where 1 is totally independent and 5 requires total assistance.

Independent	The individual performs the activity with no human assistance.
Verbal assistance	The individual performs the activity with verbal assistance such as reminding, guiding or encouraging.
Minimal human assistance	The individual performs the activity with some direct physical assistance and/or assistance technology.
Moderate human assistance	The individual performs the activity with a great deal of human assistance and/or assistive technology.
Dependent	The individual does not perform the activity even with human assistance and/or assistance technology.

An individual must be assessed with need for assistance with at least one ADL to be eligible to receive personal care services. Payment for personal care services may only be authorized for needs assessed at the level three (3) ranking or greater.

In addition, the individual must have an ADL functional ranking of three (3) or greater to be eligible for IADL services. Once an individual is determined eligible for personal care services, his/her authorized ADL and IADL services and the amount, scope and duration must be included in the Individual Integrated Care and Supports Plan (IICSP).

* * *

5.1.D. REASONABLE TIME AND TASK

When a task (activity) is assigned to a specific provider, the rank of the activity is used against a Reasonable Time Schedule (RTS) table to determine the recommended time that activity should be assigned. Providers should use the RTS table provided by MDHHS to record and report minutes spent delivering services. The maximum amount is across all assigned providers for an individual, so these are case maximums. When an individual's needs exceed the hours recommended by the RTS, a rationale must be provided and maintained in the individual's record.

5.1.F. REIMBURSEMENT AND RATES

After enrollment and according to the requirements of the three-way contract, the ICO must maintain the individual's current personal care providers and amount, scope and duration of services until the IICSP is reviewed and updated and providers are secured with individual approval. An ICO should use the Medicaid Home Help Payment Schedule to continue paying providers as scheduled. (Refer to the Directory Appendix for additional information.) An ICO should follow this schedule until the ICO and personal care provider agree upon a new payment schedule, which should be defined in the contract between the ICO and the personal care provider. The ICO must publish a pay cycle and must pay these claims on the next available pay cycle date.

Furthermore, an ICO should use the Individual and Agency County Rates to determine payment rates for the transition period until the ICO and personal care provider agree upon a rate that is defined in the ICO and personal care provider contract. (Refer to the Directory Appendix for additional information.)

After the transition period, payment rates for personal care services are established by the ICO. Tasks are assigned minute values which are converted to hours and billed as a total at the end of the ICO's preferred pay period. Reimbursement is subject to any state or federal laws that may be applicable in the future.

> A request for higher or lower hours than shown on the RTS is permissible. A textual rationale is required if the amount of services needed is different than the RTS. Possible reasons for using higher hours include incontinence, severely impaired speech, paralysis and obesity. Possible reasons for lower hours include shared living arrangements (specifically for IADLs, except for administering medications) and responsible relatives able and available to assist.
>
> If the individual does not require the maximum allowable hours for IADLs, only the amount of time needed for each task shall be authorized. Assessed hours for IADLs (except medication administration) **must be prorated by one half** in shared living arrangements where other adults reside in the home as personal care services are only for the benefit of the individual. This does not include situations where others live in adjoined apartments, flats or in a separate home on shared property and there is no shared common living area. In shared living arrangements where it can be clearly documented that IADLs for the enrolled individual are completed separately from others in the home, hours for IADLs do not need to be prorated.
>
> *MPM, April 1, 2025 version*
> *MI Health Link Chapter, pages 1, 5-7*

Here, Petitioner has been approved for 36.75 hours per week of personal care services through Respondent; Respondent decided to reduce Petitioner's services to 25.75 hours per week; and Petitioner requested an administrative hearing with respect to that decision.

In appealing, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in deciding to reduce his services. Moreover, the undersigned ALJ is limited to reviewing Respondent's decision in light of the information that was available at the time the decision was made.

Given the available information and applicable policies in this case, Petitioner has failed to meet that burden of proof, and the Respondent's decision must therefore be affirmed.

Petitioner was previously approved for 36.75 hours per week of personal care services, but that alone is insufficient to meet his burden of proof, and the remainder of the record supports a finding that Respondent's decision is proper.

For example, the May 2025 assessment did not identify any continuing need for assistance with range of motion exercise or hand massages, and there is no testimony or other evidence contradicting those findings

Similarly, while the record does not reflect any change or improvement that would warrant less personal care services with respect to the tasks where assistance was reduced, the basis for those reductions was likewise uncontradicted and proper. Respondent's witness credibly explained why Respondent now found that the assistance Petitioner needed with those tasks did not rise above the times recommended in the RTS identified in policy. Respondent's witness further credibly explained that Respondent did not treat the recommended times as maximums, but how, based on the training and education it received from MDHHS, the assistance Petitioner needed was encompassed within the recommended times. Petitioner also did not produce any testimony or evidence demonstrating that the reduced times were insufficient.

Accordingly, for the reasons discussed above, Petitioner has failed to meet his burden of proof and Respondent's decision must therefore be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly decided to reduce Petitioner's personal 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 Electronic Mail:

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