Date Mailed: December 1, 2025
Docket No.: 25-037031
Case No.: [redacted]
Petitioner: [redacted]

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) pursuant to MCL 400.9 and upon a request for hearing.

After due notice, a telephone hearing was held on November 19, 2025. [redacted], Petitioner's Guardian, appeared on behalf of Petitioner. Stacy Coleman, Consultant appeared on behalf of Respondent, Macomb County Community Mental Health.

Exhibits:

Petitioner	1. August 11, 2025, Re-Assessment
Respondent	A. Hearing Summary

ISSUES

Did Respondent properly deny Petitioner's request for Community Living Supports (CLS) and Respite 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 has been diagnosed with schizoaffective disorder and autism spectrum disorder. (Exhibit A; Testimony.)

2. Petitioner receives Medicaid covered specialty support and services from Respondent and is enrolled in the Certified Community Behavioral Health Clinic. (Exhibit A; Testimony.)

3. On or around July 9, 2025, Petitioner requested 25 hours per week of CLS, and 5 hours per week of Respite. (Exhibit A; Testimony.)

4. Petitioner requested CLS and identified a goal of increasing his independence and learn skills for hygiene, medication management, cooking, and home maintenance. (Exhibit A; Testimony.)

5. At all times relevant to this proceeding, Petitioner lived in a non-licensed independent setting and attended Academy of Dreams 4 times a week where he worked on developing organization skills, community inclusion, and building vocational skills. Petitioner did not have any unpaid caregivers. (Exhibit A; Testimony.)

6. At the time of review, the records reviewed did not indicate Petitioner as having limitations with activities of daily living.

7. On July 31, 2025, the Respondent sent Petitioner an Adverse Benefit Determination denying Petitioner's request for Respite and CLS. The notice indicated Petitioner did not meet the medical necessity requirements for the services being requested. (Exhibit A; Testimony.)

8. On September 15, 2025, Respondent sent Petitioner a Notice of Appeal Denial. The notice indicated Petitioner's appeal was denied and provided the following:

> You live on your own and have improved. There are no severe medical needs or new symptoms, and you are able to meet your daily living needs on your own. You receive therapy, reviews with the doctor, and services from a case manager. This can meet your needs. Medical necessity is not met for these services as requested and denial is upheld.[1]

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

[1] Exhibit A, p 10.

> directly by the State to the individuals or entities that furnish the services.[2]
>
> 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.[3]

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…[4]

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).

While CLS and respite care services are covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services.[5] Regarding medical necessity, the MPM also provides:

[2] 42 CFR 430.0.
[3] 42 CFR 430.10.
[4] 42 USC 1396n(b).
[5] 42 CFR 440.230.

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.[6]

[6] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, April 1, 2025, pp 13-15.

Here, as discussed above, Respondent has decided to deny Petitioner's request for CLS and Respite services.

In appealing those actions, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred.

Respondent indicated Petitioner lacked any unpaid caregivers; and there was no clear goal or need for Respite, and consequently, as a result, Petitioner's request for Respite was denied. Petitioner went on to indicate that none of the goals identified by Petitioner for CLS were measurable and failed to identify a specific skill to work on to achieve a goal. Respondent also indicated the documentation provided did not indicate Petitioner as having a limitation with activities of daily living.

Petitioner did not directly rebut the testimony of the Respondent and argued Petitioner has 24-hour staffing that it is a private group home; and Petitioner had been denied Home Help Services by the Michigan Department of Health and Human Services.

Given the record and applicable policies in this case, and for the reasons discussed above, the undersigned Administrative Law Judge finds that Petitioner has not met his burden of proof with respect to both of Respondent's; actions and that its decisions on CLS and respite care services 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 denied Petitioner's request for CLS and Respite services

IT IS THEREFORE ORDERED that:

The Respondent's decisions are **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 Electronic Mail:

Department Contact
BELINDA HAWKS
MDHHS-BPHASA
320 S WALNUT ST 5TH FL
LANSING, MI 48933
MDHHS-BHDDA-HEARING-NOTICES@MICHIGAN.GOV

Respondent
MACOMB COUNTY CMHSP
19800 HALL RD
CLINTON TOWNSHIP, MI 48038
MFHCORRESPONDENCE@MCCMH.NET

Via First Class Mail:

Petitioner
[redacted]
MI [redacted]

Authorized Hearing Representative
[redacted]
MI [redacted]