Date Mailed: February 4, 2026
Docket No.: 25-037041
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 initiated on November 18, 2025. However, the hearing was not completed within the scheduled time, and it was determined that the hearing must therefore be continued.

After due notice, the telephone hearing was continued and completed on January 8, 2026.

Attorney Noel J. Ravenscroft represented Petitioner. Attorney Mark Kopson represented Respondent Aetna Better Health Premier Plan (Respondent), the Respondent Integrated Care Organization (ICO).

During the hearing, the following exhibits were admitted into the record without objection:

Petitioner's Exhibit:

Exhibit A: Request for Hearing

Respondent's Exhibits:

Exhibit #1: 11/4/24 Michigan HCBS Needs Tool / Personal Care Assessment

Exhibit #2: Medicaid Provider Manual (MPM), January 1, 2016 version, MI Health Link Chapter, Section 5

Exhibit #3: 4/21/25 Michigan HCBS Needs Tool / Personal Care Assessment

Exhibit #4: 9/5/25 Notice of Denial of Medical Coverage

Exhibit #5: 9/11/25 Michigan HCBS Needs Tool / Personal Care Assessment

Exhibit #6: 9/15/25 Level 1 Appeal

Exhibit #7: 10/9/25 Notice of Appeal Decision

Exhibit #8: 10/28/25 Notice of Hearing;

Exhibit #9: MPM, January 1, 2017, version, Medicaid Health Plan Chapter, pages 1-2

Exhibit #10: MPM, January 1, 2017, version, General Information for Providers Chapter, Section 8

The following witnesses also testified:

Petitioner's Witnesses:

[redacted], Petitioner

[redacted] Petitioner's Caregiver

Respondent's Witnesses:

Erin Finos, Nurse Care Manager

Laquinda Bates, Manager for Clinical Health Services

Dr. Tiffany Wedlake, Medical Director

Emily Nguyen, Manager of Paid Services Division

ISSUE

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

FINDINGS OF FACT

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

1. 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.

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

3. As part of her services, Petitioner was approved for 46 hours per week of personal care services. (Testimony of Petitioner; Testimony of Nurse Care Manager).

4. Those services were authorized following the completion of a personal care assessment, in which Respondent's staff utilized the Michigan Home and Community Based Services (HCBS) Needs Tool, on November 4, 2024. (Exhibit #1, pages 1-9).

5. Specifically, the approval was to include 84 minutes per week of assistance with light housework/cleaning; 270 minutes per week of assistance with laundry; 280 minutes per week for assistance with taking medications; 180 minutes per week of assistance with shopping; 350 minutes per week of assistance with meal preparation; 630 minutes per week of assistance with eating; 315 minutes per week for assistance with bathing; 140 minutes per week of assistance with dressing; 84 minutes per week of assistance with grooming; 210 minutes per week of assistance with toileting; 126 minutes per week of assistance with mobility; and 70 minutes per week of assistance with transferring. (Exhibit #1, pages 1-9).[1]

6. On April 21, 2025, Respondent's Nurse Care Manager completed a routine reassessment with Petitioner, again utilizing the same Michigan HCBS Needs Tool. (Exhibit #3, pages 1-9; Testimony of Nurse Care Manager).

7. During that assessment, Petitioner's daughter acted as an interpreter for Petitioner. (Testimony of Nurse Care Manager).

8. Following that assessment, Petitioner requested the reauthorization of 46 hours per week of personal care services. (Testimony of Nurse Care Manager).

9. On September 5, 2025, Respondent sent Petitioner written Notice of Denial of Medical Coverage in which it stated that Petitioner's request for 46 hours per week of Personal Care Services had been denied and that, instead, only 29 hours per week of such services would be approved as of September 25, 2025. (Exhibit #4, pages 1-10).

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

> You were previously approved for Aetna Better Health of MI Premier Plan to cover 46 hours of Personal Care Services per week through the health plan Benefit. Records show that you require 29 hours of Personal Care Services per

[1] The approved assistance added up to 45.65 hours per week, which Respondent rounded up to 46 hours per week. (Exhibit #1, page 9; Testimony of Nurse Care Manager).

week, based on our assessment of your needs, and this amount is approved. Your assessment does not support the additional 17 hours of personal Care Services per week you have requested to manage your care needs.

Personal Care Services include:
-bathing/toileting
-walking/transferring
-dressing
-hair care/grooming
-meal prepping/eating/feeding
-shopping
-Laundry
-Housekeeping/cleaning

Your services will be reduced to 29 hours of Personal Care Services per week beginning on 9/25/2025.

Exhibit #4, pages 3-4

11. In that decision, Petitioner was approved for 42 minutes per week of assistance with light housework/cleaning; 98 minutes per week of assistance with laundry; 210 minutes per week for assistance with taking medications; 55 minutes per week of assistance with shopping; 350 minutes per week of assistance with meal preparation; 280 minutes per week of assistance with eating; 154 minutes per week for assistance with bathing; 112 minutes per week of assistance with dressing; 84 minutes per week of assistance with grooming; 182 minutes per week of assistance with toileting; 112 minutes per week of assistance with mobility; and 56 minutes per week of assistance with transferring. (Exhibit #3, pages 1-9).[2]

12. The reductions in assistance with light housework/cleaning and shopping were based on a finding that Petitioner lived in a shared household with at least one other adult, and that assistance with those tasks therefore had to be prorated. (Exhibit #3, pages 1-2; Testimony of Nurse Care Manager).

13. Petitioner subsequently began living alone again; another assessment was completed on September 11, 2025; and assistance with light housework/cleaning and shopping was subsequently returned to their original amount. (Exhibit #5, pages 1-2; Testimony of Nurse Care Manager).

[2] The approved assistance added up to 28.92 hours per week, which Respondent rounded up to 29 hours per week. (Exhibit #3, page 9; Testimony of Nurse Care Manager).

14. The other reductions to assistance with the tasks of laundry, taking medication, eating, bathing, dressing, toileting, mobility and transferring, remained in place. (Exhibit #5, pages 1-9; Testimony of Nurse Care Manager).

15. Petitioner then filed an Internal Appeal with Respondent regarding the decision to reduce her services. (Exhibit A, pages 10-13).

16. On October 9, 2025, Respondent sent Petitioner a Notice of Appeal Decision in which it stated that Petitioner's appeal was denied. (Exhibit #7, pages 1-22).

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

> We denied your appeal for the service/item listed above because:
>
> Your appeal was reviewed by our Medical Director. They are Board Certified in Preventative Medicine. They are a licensed Medical Doctor. The review was completed on 10/8/2025.
>
> The denial of coverage for seventeen (17) hours each week of personal care services is upheld. We reviewed the information and records provided.
>
> Based on the information we have about your medical condition, your medical history, and your current medical needs we are still not able to approve this request.
>
> We do not see that:
>
> - Your needs are not met with the twenty-nine (29) hours each week of personal care services you are receiving.
>
> The denial is upheld. If you have any questions, please discuss them with your doctor.

> We made this decision using Michigan minimum operations standards that determine the amount, scope and length of services based on the care assessment and the condition of medical need, section 5. State Plan Personal Care Services.
>
> *Exhibit #7, page 3*

18. On October 16, 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 1-15).

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.

MPM, July 1, 2025 version
MI Health Link Chapter, pages 1, 5-7

Here, Petitioner had been approved for 46 hours per week of personal care services through Respondent; Respondent decided to reduce Petitioner's services; 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 her services. Moreover, the undersigned Administrative Law Judge 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 not met that burden of proof, and the Respondent's decision must therefore be affirmed.

Petitioner was previously authorized for 46 hours per week of personal care services, but that alone is insufficient to merit reversal, each assessment stands on its own, and Petitioner must show an error in the decision at issue.

In support of that decision, the Nurse Care Manager who conducted the assessments at issue for Respondent credibly and fully described the basis for Respondent's decision and the reduced authorizations.

For example, with respect to bathing, while no improvement was identified and Petitioner continued to be ranked as a 5 on the five-point scale identified by the above policy and used by Respondent, the time for assistance was reduced to that recommended by the Reasonable Time Schedule (RTS) used in policy because there was no basis identified in either the previous assessment or the ones at issue in this case for exceeding the time recommended by the RTS for bathing assistance for individuals ranked as a 5. Moreover, neither Petitioner nor her caregiver, nor any of her documentation, identified a basis for exceeding the RTS.

Similarly, with respect to laundry, Petitioner continued to be ranked a "5"; Respondent authorized the time recommended by the RTS; and there is no basis in the record for going beyond that recommended time. Even if Petitioner has occasional incontinence, she is still just one person and the 270 minutes that had been authorized appears very excessive, especially given that, as correctly noted by the Nurse Care Manager, the approval is just for the hands-on assistance with laundry, and not the waiting while the machines are running (and while the caregiver can do other things).

Additionally, other reductions based on a change in Petitioner's rankings from a 5 to a 4 on the five-point scale, and the times recommended in the RTS for a ranking of 4, were also proper. For example, with respect to mobility, the record demonstrates that Petitioner performs the activity with a great deal of assistance from assistive technology and her caregiver and there is no basis in the record for going beyond the time recommended in the RTS. The Nurse Care Manager also described the findings as to why Petitioner was now ranked as a 4 in dressing, toileting, eating and transferring, and, while the assessment notes are less detailed as to what aspects of those tasks Petitioner can perform, her testimony is both credible and uncontradicted.

Rather than disputing the specific findings regarding bathing, laundry, dressing, toileting, eating and transferring, Petitioner's witnesses and evidence only spoke in broad generalities regarding Petitioner's diagnoses, needs, and the inaccuracy of the more recent assessments; and the undersigned ALJ finds those general arguments to be unpersuasive

Petitioner's diagnoses appear to be undisputed, but it is the effect of those diagnoses and Petitioner's need for assistance that is at issue and simply listing the diagnoses is minimally probative.

Similarly, simply claiming that the assessments fail to accurately reflect Petitioner's needs is likewise unconvincing. Per policy, Petitioner's ADLs and IADLs are to be specifically ranked during the assessment and assistance authorized on a task-by-task basis, as they were here, and broad statements about the insufficiency of the total approval fail to rebut those specific findings

One specific dispute Petitioner did identify was that no interpreter was offered for Petitioner, who does not speak English, and her daughter/caregiver was required to act as an interpreter despite not being fully comfortable doing so, which could have led to inaccuracies. Petitioner also asserted that the more recent assessments were shorter than the previous one that led to the approval of 46 hours per week of personal care services

However, Petitioner and her caregiver notably had an interpreter at the hearing, as well as much time as they wanted to testify, with the hearing continued after it was not completed as scheduled on the original hearing date, and, with the one exception discussed below, they did not identify any specific errors in the assessments and their broad claims are unpersuasive.

The one specific task that was directly disputed by Petitioner was the reduction to assistance with taking medications, where Petitioner's assistance was reduced from 280 minutes per week to 210 minutes per week. Petitioner's ranking and the time per task remained the same for assistance with taking medications, and the reduction was based solely on how many times per day the assistance was performed, with Petitioner previously approved for 4 times a day and now approved for 3 times per day.

However, while Petitioner's caregiver testified during the hearing that the assistance is provided four times per day, that testimony is both unsupported and directly contradicted by the reports completed at the time of the assessments, and which the Nurse Care Manager credibly testified were based directly on the reports of Petitioner and the caregiver.

To the extent Petitioner's circumstances have changed or she has specific additional or updated information to provide regarding her need for more personal care services, then Petitioner 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 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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