Date Mailed: February 2, 2026
Docket No.: 25-038351
Case No.: [redacted]
Petitioner: [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, 42 CFR 431.200 *et seq*. and 42 CFR 438.400 *et seq*. upon Petitioner's request for a hearing.

After due notice, a hearing was held on January 29, 2026. [redacted], Petitioner's mother and Guardian, appeared and testified on Petitioner's behalf.

Elizabeth Adams, Training Coordinator, appeared and testified on behalf of Respondent, The Right Door for Hope (Respondent or Department). Additional witnesses included Melanie Zalis, Melissa Peterson, Kerry Possien, and Christopher Barnett.

Exhibits:

Petitioner	None
Respondent	A – J (Admitted)

ISSUE

Did the Respondent properly reduce Petitioner's respite?

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 Medicaid beneficiary receiving services through Respondent, including case management, community living supports (CLS), and respite. (Exhibit A; Testimony.)

2. In the prior year, Petitioner used 638 CLS units of the 1,020 units authorized and 1,533 units of the 1,996 units of respite authorized. (Exhibit A; Testimony.)

3. On July 22, 2025, Respondent sent Petitioner an Adverse Benefit Determination reducing Petitioner's respite services from 1,996 units to 1,456 units. (Exhibit A; Testimony.)

4. On July 23, 2025, Petitioner requested a local level appeal. (Exhibit A; Testimony.)

5. On August 18, 2025, Respondent issued an appeal decision affirming the respite reduction. The review noted Petitioner's prior authorization authorized 1,996 units while actual usage was 1,533 units. The review also noted that while respite services were reduced slightly below last year's prior usage rate, CLS services were increased from 1,020 units to 1,196 units adding an approximate 44 hours a year. (Exhibit A; Testimony.)

6. On October 22, 2025, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a request for hearing.

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 (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 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]

[1] 42 CFR 430.0.
[2] 42 CFR 430.10.

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 (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service.

The Respondent is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The Medicaid Provider Manual articulates Medicaid policy for Michigan. It states, in relevant part:

> **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:

[3] 42 USC 1396n(b).

- 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; and

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and

- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and

- Made within federal and state standards for timeliness; and

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

- 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; and

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and

- 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;

    - 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.[4]

Respondent is under contract with MDHHS to provide Medicaid-covered services and is required to assess medical necessity and authorize services accordingly. Respondent used its respite assessment tool, reviewed historical utilization, and applied person-centered planning principles when determining the current authorization.

The record shows that in the prior PCP year, Petitioner was authorized 1,996 units of respite but utilized only 1,533 units (≈7.37 hours/week). At the same time, Respondent increased CLS hours from 1,020 units to 1,196 units, adding approximately 44 hours/year to support Petitioner's goals. These changes demonstrate that Respondent considered the overall service mix and increased CLS to offset respite reduction.

Petitioner testified to increased caregiver burden and additional needs; however, most of these changes; including her spouse's health decline and new behavioral concerns occurred after Respondent made its decision to reduce respite. Further, it does not appear like this information was communicated for consideration prior to the appeal.

Respondent also offered alternative resources and services to address any remaining need, including the Listening Ear activity group, potential placement at Just Like Home, and assistance with Home Help hours. These options provide additional opportunities for respite and community integration if utilized.

Finally, if Petitioner exhausts the currently authorized respite units and demonstrates that additional hours are medically necessary, Respondent's process allows for reassessment and adjustment of services at any time.

Petitioner bears the burden of proving by a preponderance of the evidence that the reduced respite allocation is insufficient and that additional hours are medically necessary. Based on the evidence, Petitioner did not meet this burden. Respondent's decision was consistent with Medicaid policy, supported by assessment scoring, historical utilization, increased CLS hours, and the availability of alternative supports.

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 additional respite services.

[4] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, October 1, 2025, pp 13-15.

IT IS, THEREFORE, ORDERED that:

The 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.

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