Date Mailed: February 2, 2026
Docket No.: 25-042577
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 January 28, 2026. Jennifer Vandermark appeared and testified on Petitioner's behalf. Stacy Coleman, Contractor, appeared and testified on behalf of the Respondent Macomb County Community Mental Health (Respondent).

Exhibits:

Petitioner	None
Respondent	A – Hearing Summary

ISSUE

Did Respondent properly deny Petitioner's request for reauthorization of services in a licensed specialized residential setting?

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 Medicaid beneficiary diagnosed with Autism Spectrum Disorder, Borderline Intellectual Functioning, Specific Learning Disorder, GERD and seasonal allergies. (Exhibit A.)

2. Petitioner resides in a licensed specialized residential home and previously received personal care services and community living supports (CLS) under Medicaid. (Exhibit A; Testimony.)

3. On or around April 8, 2025, Petitioner's Individualized Plan of Service (IPOS) was completed and included goals requiring supervision, prompting, and occasional physical assistance with ADLs, meal preparation, and safety monitoring. (Exhibit A; Testimony.)

4. On October 21, 2025, Respondent issued an Adverse Benefit Determination denying personal care and CLS for the period of December 1, 2025, through May 31, 2026, citing lack of medical necessity. (Exhibit A; Testimony.)

5. The denial was based on Respondent concluding Petitioner did not require "hands-on" personal care assistance. (Exhibit A; Testimony.)

6. On November 21, 2025, Respondent issued a Notice of Appeal Denial. The notice indicated Petitioner's appeal was denied and the decision to terminate CLS services was affirmed. (Exhibit A; Testimony.)

7. On or around November 25, 2025, Petitioner requested a Medicaid Fair Hearing. (Exhibit A.)

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 plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a

[1] 42 CFR 430.0.

> 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, while Petitioner has been receiving CLS and personal care services through Respondent in a licensed specialized residential setting, Respondent has denied the reauthorization of such services and has decided to transition Petitioner to a lower level of care.

With respect to the location and medical necessity of services through Respondent, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **2.3 LOCATION OF SERVICE [CHANGES MADE 4/1/2025]**
>
> 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.[4]

[2] 42 CFR 430.10.
[3] 42 USC 1396n(b).
[4] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, October 1, 2025, p 11.

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 treatments:

- 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 function in order to achieve their goals of community inclusion and participating, 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;

- 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;
  - 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.[5]

Moreover, with respect to personal care in licensed specialized settings and CLS specifically, the applicable version of the MPM also stats:

> **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

[5] *Id* at 14-15.

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).[6]

[6] *Id.* at 90.

The Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, Section 11, states that personal care services include assisting the beneficiary by performing tasks, performing tasks along with the individual (hands-on), or otherwise assisting the individual to perform tasks themselves by prompting, reminding, or being in attendance while the beneficiary performs the task(s).

Respondent's interpretation requiring "hands-on" assistance as a prerequisite for personal care services is inconsistent with the Medicaid Provider Manual and federal regulations at 42 CFR 438.210, which prohibit PIHPs from imposing limitations more restrictive than the State Plan.

The evidence shows that Petitioner requires supervision, prompting, and occasional assistance to complete ADLs and maintain health and safety. These needs fall within the scope of "assisting" as defined by Medicaid policy. Consequently, given the record, the undersigned finds that Respondent erred and the decision at issue in this case must be reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent improperly denied Petitioner's request for reauthorization of services in a licensed specialized residential setting.

IT IS THEREFORE ORDERED that:

The Respondent's decision is **REVERSED**.

Within 10 days of the receipt of this Decision, the CMH must take steps to reassess Petitioner's needs consistent with this Decision and Order.

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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