Date Mailed: February 6, 2026
Docket No.: 25-047428
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 February 4, 2026. [redacted], Petitioner, appeared and testified on his own behalf. [redacted], Social Worker, appeared as a witness for Petitioner. Alyssa Brandt, Quality Improvement Specialist, appeared and testified on behalf of Respondent, Senior Care Partners PACE. (PACE or Respondent). Sarah Riley, Nurse Practitioner (NP); Kelly Oviatt, Center Manager; and Calley Green, Associate Director, appeared as witnesses for Respondent.

Respondent's Exhibit A, pp. 1-106 was accepted into the record.

ISSUE

Whether Respondent properly denied Petitioner's request for referral to the Henry Ford Transplant Center for a kidney transplant.

FINDINGS OF FACT

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

1. PACE is an organization that contracts with the Michigan Department of Health and Human Services (MDHHS or Department) and oversees the PACE program in Petitioner's geographical area. (Exhibit A; Testimony.)

2. Petitioner is a [redacted] individual with end-stage renal disease (ESRD) who attends hemodialysis three times weekly (Monday/Wednesday/Friday) and receives interdisciplinary services through Senior Care Partners P.A.C.E. (Exhibit A, pp. 10, 23, 33; Testimony)

3. On September 30, 2025, Respondent issued a Denial of Service – Adequate Action Notice, declining Petitioner's requested authorization for "Kidney Transplant at Henry Ford." The notice expressly stated the reasons: "There is a need for better in-person support, improved medication compliance, and marijuana cessation." (Exhibit A, p. 2; Testimony)

4. The record shows Petitioner was previously denied transplant candidacy by the University of Michigan due to lack of a 24/7 support person for several weeks/months post-transplant, and because of concerns regarding medication compliance and regular marijuana use. Respondent's preferred transplant vendor is the University of Michigan, and its standard practice is to address root causes of any transplant denial before sending participants to another center. (Exhibit A, p. 43; Testimony)

5. At the SDR assessment on September 29, 2025, Petitioner acknowledged his prior rejection by the Ann Arbor team and that his support situation remained unchanged, while also reporting regular marijuana use for anxiety and a reliance on a medication wheel to maintain adherence. (Exhibit A, pp. 60–61; Testimony)

6. Following the IDT denial, Respondent's MSW contacted Petitioner's friend, [redacted], who agreed to meet with Petitioner and the PCP to understand the requirements of being Petitioner's 24/7 support person, and Respondent indicated willingness to schedule such a meeting. (Exhibit A, pp. 61, 63–64; Testimony)

7. On October 8, 2025, Petitioner appeared with [redacted] and reported he "has two dedicated support people available 24/7" and that he had stopped smoking marijuana; the PCP discussed transplant candidacy, emphasized the need for continued abstinence, and reviewed dialysis and access planning. (Exhibit A, p. 65; Testimony)

8. The record reflects intermittent coordination and adherence challenges, including a missed dialysis transport incident and Petitioner reporting he had been "out of meds since Friday evening" without contacting after-hours services, after which pharmacy support was arranged. (Exhibit A, pp. 66, 76; Testimony)

9. Respondent's care plans (Aug 2025–Jan 2026; Jan–July 2026) consistently document ESRD management, medication wheel use, fall risk, emergency planning, nutrition support, and ongoing interdisciplinary monitoring; Petitioner's long-term goal includes kidney transplant but short-term plans prioritize stabilization and dialysis optimization. (Exhibit A, pp. 23–27, 34–37; Testimony)

10. The Denial Notice advised Petitioner of his appeal rights, including local and external fair hearing processes, and Respondent offered assistance with paperwork. Subsequent communication indicates Petitioner had not completed the external appeal paperwork as of December 2025. (Exhibit A, pp. 3–6, 49; Testimony)

11. Petitioner's medical history includes multiple cardiac and vascular comorbidities (e.g., CAD with stents, CHF, aneurysms), and behavioral health notes describe minimal depression with monthly counseling, and average loneliness per UCLA scale; the PCP documented ongoing cardiology follow-up and plans to reassess screening and access decisions at regular intervals. (Exhibit A, pp. 21–27, 36, 67–71; Testimony)

12. On December 29, 2025, MOAHR received Petitioner's request for hearing. (Exhibit A, p.44)

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.

PACE services are available as part of the Medicaid program:

> The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model of community-based care that enables elderly individuals, who are certified by their state as needing nursing facility care, to live as independently as possible.
>
> PACE provides an alternative to traditional nursing facility care by offering pre-paid, capitated, comprehensive health care services designed to meet the following objectives:
>
> - Enhance the quality of life and autonomy for frail, older adults;
> - Maximize the dignity of, and respect for, older adults;
> - Enable frail, older adults to live in the community as long as medically and socially feasible; and
> - Preserve and support the older adult's family unit.
>
> The PACE capitated benefit was authorized by the Balanced Budget Act of 1997 and features a comprehensive service delivery system with integrated Medicare and Medicaid financing.
>
> An interdisciplinary team, consisting of professional and paraprofessional staff, assesses beneficiary needs, develops a plan of care, and monitors delivery of all services (including acute care services as well as nursing facility services, when necessary) within an integrated system for a seamless provision of total care.

Typically, PACE organizations provide social and medical services in an adult day health center supplemented by in-home and other services as needed.

The financing model combines payments from Medicare and Medicaid, allowing PACE organizations to provide all needed services rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems. PACE organizations assume full financial risk for beneficiary care without limits on amount, duration, or scope of services.

Physicians currently treating Medicaid patients who are in need of nursing facility care may consider PACE as an option. Hospital discharge planners may also identify suitable candidates for referral to PACE as an alternative to a nursing facility. (Refer to the Directory Appendix for PACE contact information.)

SECTION 2 – SERVICES

The PACE organization becomes the sole source of services for Medicare and Medicaid beneficiaries who choose to enroll in a PACE organization.

The PACE organization is able to coordinate the entire array of services to older adults with chronic care needs while allowing elders to maintain independence in the community for as long as possible. The PACE service package must include all Medicare and Medicaid covered services, in addition to other services determined necessary by the interdisciplinary team for the individual beneficiary. Services must include, but are not limited to:

- Adult day care that offers nursing, physical, occupational and recreational therapies, meals, nutritional counseling, social work and personal care
- All primary medical care provided by a PACE physician familiar with the history, needs and preferences of each beneficiary, all specialty medical care, and all mental health care
- Interdisciplinary assessment and treatment planning
- Home health care, personal care, homemaker and chore services
- Restorative therapies
- Diagnostic services, including laboratory, x-rays, and other necessary tests and procedures
- Transportation for medical needs

- All necessary prescription drugs and any authorized over-the-counter medications included in the plan of care
- Social services
- All ancillary health services, such as audiology, dentistry, optometry, podiatry, speech therapy, prosthetics, durable medical equipment, and medical supplies
- Respite care
- Emergency room services, acute inpatient hospital and nursing facility care when necessary
- End-of-Life care

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3.13 APPLICANT APPEALS

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3.13.C. PACE SERVICES

Noncoverage or nonpayment of services by the PACE organization for a beneficiary enrolled in PACE is an adverse action. If the beneficiary and/or representative disagrees with the noncoverage or nonpayment of services by the PACE organization, they have the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found on the MOAHR website. (Refer to the Directory Appendix for website information.) The beneficiary may request continuation of the disputed service with the understanding that he may be liable for the cost of the disputed service if the determination is not made in his favor.

Medicaid Provider Manual
Program of All-Inclusive Care for the Elderly Chapter
July 1, 2025, pp 1-2, 7

With regard to medical necessity, the Medicaid Provider Manual indicates:

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.

Medicaid Provider Manual
Mental Health/Substance Abuse Chapter
July 1, 2025, pp 13-14

Respondent's Center Manager testified that Petitioner requested the transplant referral because he was frustrated with delays and requirements for peritoneal dialysis and wanted to move forward with transplant evaluation. Petitioner had previously attempted transplant in Maryland in 2017, but the process stalled due to COVID-19. He believed a transplant would help him emotionally and improve his quality of life.

Respondent's NP explained that the University of Michigan denied Petitioner's transplant candidacy due to strict guidelines requiring two in-home caregivers available 24/7 for several weeks to months post-surgery, as well as cessation of nicotine and marijuana use. Respondent's NP emphasized that these requirements are standard for kidney transplant recovery. She also noted Petitioner's complex medical history, including multiple aneurysms and significant cardiac issues, raising concerns about whether he could be medically cleared for such a major procedure.

Respondent stated that the Interdisciplinary Team (IDT) denied Petitioner's request for referral to Henry Ford because he lacked adequate in-person support, had ongoing medication compliance issues, and continued marijuana use. The team recommended focusing on consistent PCP visits and involving Petitioner's friend in discussions about support roles before reconsidering transplant referral.

Petitioner testified that he has wanted a transplant for years and has tried to comply with all requirements. He stated he quit marijuana use a couple of months ago, estimating around September or October 2025. He also claimed to have two friends willing to provide support, including one who would stay with him after surgery. Petitioner expressed frustration with delays and reiterated his desire for a transplant.

Petitioner's dialysis Social Worker (SW), questioned the necessity of 24-hour care, stating she was informed that such continuous support might not be required post-transplant. She also noted that some transplant centers now accept patients who use marijuana for medical purposes. Petitioner's SW clarified that Petitioner's prior denial in March 2024 was due to lack of a strong support system and a coronary artery aneurysm, not solely marijuana use.

She added that Henry Ford had previously indicated willingness to evaluate Petitioner under its own criteria, which differs from U of M's.

Respondent reaffirmed that PACE contracts exclusively with the University of Michigan for transplant services and does not refer to Henry Ford. They emphasized Petitioner's multiple aneurysms and complex health profile, as well as prior statements indicating continued marijuana use. Respondent maintained that their denial was based on U of M's requirements and the participant's current circumstances.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying the request for a kidney transplant. Based on the above evidence presented, this Administrative Law Judge finds that Petitioner has failed to meet this burden of proof.

Under 42 CFR Part 460, PACE organizations must furnish medically necessary services and may approve or deny requested services based on interdisciplinary team determinations grounded in clinical judgment, individualized care planning, and participant safety. The regulations require adequate notices and afford participants both internal and external appeal rights. (Exhibit A, p. 2; pp. 3–6)

The question before the Tribunal is not whether Petitioner might someday qualify for listing at a transplant center, but whether Respondent's September 30, 2025 denial of a referral to Henry Ford was reasonable and compliant with PACE requirements given the contemporaneous record. At that time, the record reflected: (a) a prior denial by U of M predicated on the absence of a sustained, 24/7 support plan, (b) ongoing marijuana use acknowledged as anxiety management, and (c) reliance on a medication wheel amidst concerns that post-transplant regimens involve multiple, frequently changing immunosuppressants necessitating highly reliable adherence. (Exhibit A, pp. 43, 60–61)

PACE standards permit Respondent to sequence care so that root causes of transplant ineligibility are addressed before making external referrals, particularly where the preferred vendor has already issued a denial and where the participant's comorbidities and social supports require stabilization to ensure safety and efficacy. Respondent articulated this rationale and documented a plan to engage the proposed support person(s) and to monitor and improve medication adherence and substance cessation in collaboration with the PCP and MSW. (Exhibit A, pp. 43, 61–64)

Petitioner's later-asserted improvements—reporting two support persons and cessation of marijuana on October 8, 2025—are encouraging developments, but they post-date the denial and do not retroactively render the IDT's decision arbitrary or contrary to law. The IDT properly relied on the record as it existed at the time of decision; it also pursued follow-up meetings to validate and operationalize the proposed support plan, consistent with PACE's emphasis on staged, participant-centered care planning. (Exhibit A, pp. 2, 65)

Additionally, intervening documentation of missed transportation and a medication lapse without after-hours contact underscores the IDT's reasonable concern that real-world adherence and logistics remain fragile and warrant continued care planning before an external transplant referral is clinically appropriate. The Tribunal recognizes Respondent's continued assistance with appeals paperwork and coordination, reflecting compliance with notice and appeal obligations under the PACE framework. (Exhibit A, pp. 66, 76; pp. 3–6, 49)

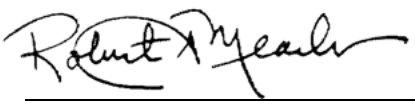
On this record, the Tribunal concludes that Respondent's denial was supported by substantial evidence, was consistent with 42 CFR Part 460, and reflected a reasonable, participant-safety-oriented application of PACE standards: namely, to stabilize support, adherence, and substance use before pursuing external transplant referrals. (Exhibit A, pp. 2–6, 43, 49, 61–65)

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that Respondent properly denied Petitioner's request for a kidney transplant referral.

IT IS THEREFORE ORDERED that:

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



ROBERT J. MEADE
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:

Department Contact
ROXANNE PERRY
MDHHS-PACE
400 S PINE ST
LANSING, MI 48933
MDHHS-MSA-PACE@MICHIGAN.GOV

Respondent
SENIOR CARE PARTNERS PACE
200 W MICHIGAN AVE
BATTLE CREEK, MI 49017
A.BRANDT@SENIORCAREPARTNERSMI.ORG

Via First Class Mail:

Petitioner
[redacted]
MI [redacted]