Date Mailed: February 23, 2026
Docket No.: 25-047441
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 held on January 27, 2026. [redacted], Petitioner's daughter, appeared and testified on Petitioner's behalf. Brenda Reeves, Quality Manager, appeared and testified on behalf of Respondent PACE Central Michigan (Respondent), a Program of All-Inclusive Care for the Elderly (PACE) organization. Mary Beach, Nurse Practitioner; Alok Saraiya, Physical Therapist; and Charis Bly, Social Worker; also testified as witnesses for Respondent.

During the hearing, Respondent submitted an evidence packet that was admitted into the record without objection as Exhibit A, pages 1-69. No other proposed exhibits were submitted by either party.

ISSUE

Did Respondent properly deny Petitioner's request for an in-home assessment?

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 organization that contracts with the Michigan Department of Health and Human Services ("MDHHS" or "Department") and oversees PACE in Petitioner's geographical area.

2. Since February 1, 2022, Petitioner has been enrolled in PACE and receiving services through Respondent. (Exhibit A, page 2).

3. Petitioner is an [redacted] who has been diagnosed with vitamin B deficiency, edema, hypothyroidism, bilateral knee pain, hyperlipidemia, vitamin D deficiency, allergic rhinitis, restless leg syndrome, pseudophakia, osteoarthritis of knee, atrophic vulvitis, uncontrolled type 2 diabetes, gastroesophageal reflux disease, morbid obesity, major depressive disorder, tinea pedis of both feet, degenerative disc disease, lumbar stenosis, and atrophic vaginitis. (Exhibit A, pages 3-4).

4. She also requires the use of a walker and tub bench. (Exhibit A, page 2).

5. Petitioner's Participant Care Plan with Respondent indicates that she has no interest in attending Respondent's day center, but would use transportation through Respondent as necessary if her representative is not available. (Exhibit A, pages 5-6, 12).

6. Since Petitioner's enrollment, Respondent has conducted assessments of her approximately every 6 months. (Exhibit A, page 14).

7. Some of the assessments were conducted at Respondent's clinic while others were conducted in Petitioner's home. (Exhibit A, page 14).

8. On November 10, 2025, Petitioner requested that an upcoming assessment be conducted in her home. (Exhibit A, pages 14-15, 17).

9. Respondent's interdisciplinary team (IDT) then reviewed Petitioner's request and determined that it should be denied. (Exhibit B, page 14).

10. On November 12, 2025, Respondent sent Petitioner written notice that the request for an in-home assessment had been denied. (Exhibit A, pages 21-22).

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

> You have no medical need for an in-home assessment and transportation can be provided by PACE safety for you to come to the clinic.
>
> *Exhibit A, page 21*

12. On December 1, 2025, Petitioner's representative filed an appeal with Respondent with respect to that denial. (Exhibit A, pages 24-26).

13. In that appeal, Petitioner's representative wrote that they were told when enrolling that Petitioner would only have to go into the center one time a year unless necessary. (Exhibit A, page 25).

14. She also wrote that they are requesting that the assessment in the second half of the year be completed at home because that is what they signed up for and coming into the center is difficult given Petitioner's anxiety and physical unsteadiness. (Exhibit A, pages 26-27).

15. On January 6, 2026, Respondent sent Petitioner written notice that her appeal had been denied. (Exhibit A, pages 64-65).

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

> PACE is designed as a center-based program that partners with participants, families, and caregivers to deliver comprehensive, coordinated care in the PACE Center setting.
>
> The participant's current care plan identifies transportation as an area of support, with the goal of maintaining the ability to attend appointments independently or with assistance from identified supports. This plan includes attendance at scheduled assessments conducted at the PACE Center.
>
> Conducting assessments at the PACE Center allows the team to complete a comprehensive evaluation using all required assessment tools and resources, which are readily available at the Center.

Exhibit A, page 64

17. On December 26, 2025, MOAHR received the request for hearing filed in this matter with respect to that denial. (Exhibit A, page 23).

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.

PACE services are available as part of the Medicaid program and, with respect to the program and eligibility for it, the Medicaid Provider Manual (MPM) provides:

> **SECTION 1 – GENERAL INFORMATION**
>
> 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 federal 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
- *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

MPM, October 1, 2025, version
PACE Chapter, pages 1-2
(Italics added for emphasis)

Moreover, with respect to the assessments referenced in the above policy, 42 CFR 460.104(c) provides:

> *Semi-annual reassessment*. On at least a semi-annual basis, or more often if a participant's condition dictates, the following members of the interdisciplinary team must conduct an in-person reassessment:
>
> (1) Primary care provider.
>
> (2) Registered nurse.
>
> (3) Master's-level social worker.
>
> (4) Other team members that the primary care provider, registered nurse and Master's-level social worker determine are actively involved in the development or implementation of the participant's plan of care.

Here, Petitioner has been approved for PACE services at all times relevant to this matter and it is only the denial of her request for an in-home assessment that is in dispute.

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ is limited to reviewing Respondent's decision in light of the information available at the time the decision was made.

Given the record and available information in this case, Petitioner has failed to meet her burden of proof, and Respondent's decision must therefore be affirmed.

The Code of Federal Regulations expressly requires that Respondent complete in-person semi-annual reassessments of participants such as Petitioner with at least a primary care provider, registered nurse and master's level social worker present.

Respondent has been completing such reassessments as required in this case, with some conducted in Petitioner's home and others conducted at Respondent's center.

Respondent has now denied Petitioner's request for a reassessment be completed in Petitioner's home on the basis that it is not medically necessary to do so. In particular, its witnesses testified that there is no medical reason Petitioner cannot come into the center, with Respondent able to provide any necessary transportation and all of the required staff and equipment onsite at the center.

Rather than arguing that an in-home assessment is medically necessary, Petitioner's representative instead asserts that she and Petitioner were told that Petitioner would only have to complete one assessment per year at the time of her enrollment and that it is difficult to travel with Petitioner.

However, while transporting Petitioner may be difficult or inconvenient given her conditions, especially during winter, that alone does not equate to medical necessity, and it is undisputed that Petitioner is capable of attending outside appointments as needed or on a semi-annual basis.

Moreover, even if Petitioner's representative's testimony that they were told at the time of enrollment that Petitioner would only have to come into the center for one assessment per year is true, that testimony is likewise insufficient to meet the burden of proof in this case. The undersigned ALJ is bound by the applicable policy and there is no basis in policy for upholding a promise to provide services in a way that is not medically necessary or as a matter of equity. Petitioner is free to file a recipient's right complaint on such grounds, but that would be outside of the scope of this proceeding.

To the extent Petitioner's circumstances have changed or she has additional information to provide, she can always request an in-home assessment again in the future along with that information. With respect to the issue in this case however, Respondent's decision is 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 an in-home assessment.

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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