

ISSUE

Did Respondent properly deny Petitioner's request for goods and services?

FINDINGS OF FACT

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

1. On or around October 24, 2025, a request for goods and services was submitted, requesting two units per month of HSW Goods and Services for the period of October 24, 2025, through January 31, 2026, to fund participation at Soul Studio and Lifetime Fitness. (Exhibit A; Testimony.)
2. As of October 24, 2025, Petitioner's Individual Plan of Services (IPOS) in effect provided Petitioner would attend both Soul Studio and Lifetime Fitness with Community Living Supports (CLS) staff, and that CLS staff would remain present to implement CLS goals during those activities. (Exhibit A; Testimony.)
3. On November 6, 2025, Respondent issued an Adverse Benefit Determination (ABD) denying Petitioner's request for two hours of goods and services. The notice indicated the request did not meet the Medicaid Provider Manual definition of Goods and Services because the request did not substitute for human assistance and did not meet medical necessity criteria. (Exhibit A; Testimony.)
4. On December 4, 2025, Petitioner filed a local level appeal. (Exhibit A.)
5. On December 26, 2025, Respondent issued an Internal Appeal Denial. The notice upheld the internal appeal finding that Goods and Services require the item to increase independence or community inclusion and substitute for human assistance, and that the beneficiary's IPOS showed CLS staff would accompany him during the activities; therefore, substitution for human assistance was not met, and medical necessity was not established. (Exhibit A; Testimony.)
6. On January 20, 2026, the Michigan Office of Administrative Hearings and Rules received from Petitioner a request for 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 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, Petitioner is approved for services through Respondent through Michigan's Habilitation Supports Waiver (HSW) and, pursuant to that program,

¹ 42 CFR 430.0.

² 42 CFR 430.10.

³ 42 USC 1396n(b).

he has requested specific goods and services.

With respect to the HSW in general, and goods and service through it specifically, the applicable version of the Medicaid Provider Manual (MPM) states in part:

SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid covered state plan services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in their individual plan of services developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/IID level of care services; and
- Chooses to participate in the HSW in lieu of ICF/IID services.

The PIHP's enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, does not receive at least one HSW habilitative service per month, withdraws from the program

voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Division of Adult Home and Community Based Services. (Refer to the Directory Appendix for contact information.) The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services. Reimbursement for services rendered under the HSW is included in the PIHP capitation rate. Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver. Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

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<p>Goods and Services</p>	<p>The purpose of Goods and Services is to promote individual control over, and flexible use of, the individual budget by the HSW beneficiary using self-directed services and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. Goods and services must increase independence, facilitate productivity, or promote community inclusion and substitute for human assistance (such as personal care in the Medicaid State Plan and community living supports and other one-to-one support as described in the HSW or covered State Plan definitions) to the extent that individual budget expenditures would otherwise be made for the human assistance.</p> <p>A Goods and Services item must be identified using a person-centered planning process, meet medical</p>
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	<p>necessity criteria, and be documented in the IPOS. Purchase of a warranty may be included when it is available for the item and is financially reasonable.</p> <p>Goods and Services are available only to individuals who self direct their services whose individual budget is lodged with a fiscal intermediary.</p> <p>This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle.⁴</p>
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This appeal concerns Respondent’s November 6, 2025, denial of Petitioner’s October 24, 2025, request for Habilitation Supports Waiver (HSW) Goods and Services funding for Soul Studio and Lifetime Fitness memberships. The hearing record demonstrates that Petitioner is enrolled in the HSW, uses a self-directed service model, and that an IPOS addendum created at the time of the request identifies both services as planned activities with Community Living Supports (CLS) staff accompanying Petitioner during participation. Respondent denied the request primarily on the basis that Goods and Services must “replace human assistance” and that the items lacked medical necessity.

However, the HSW renewal approved by CMS, effective October 1, 2024, explicitly revised the Goods and Services criteria. Under *Major Changes* in the renewal application, Michigan removed “the parameter of must replace human assistance” from the Goods and Services service definition. (Habilitation Supports Waiver Renewal, MI.0167.R07.00, Major Changes, No. 6). The same renewal added a \$2,000 annual limit and expanded allowable items to include, for example, adaptive clothing. (HSW Renewal, Appendix C–Goods and Services).

In evaluating the denial, it is also necessary to acknowledge that the Michigan Medicaid Provider Manual (MPM) has not yet been revised to reflect the updated HSW Goods and Services criteria approved by CMS in the October 1, 2024, waiver renewal. Where a conflict exists between internal state policy (such as the MPM) and the binding terms of

⁴ Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, October 1, 2025, pp 128, 137.

the federally approved waiver agreement between CMS and the State of Michigan, the waiver prevails. The waiver constitutes Michigan's federal authority to operate the HSW and expressly supersedes contrary state-level guidance. Accordingly, where the MPM continues to reference the former "substitution for human assistance" requirement, that language cannot control; the operative standard is the revised Goods and Services definition in the CMS-approved waiver renewal.

The updated Goods and Services definition now requires only that the item or service:

1. Address a need identified through person-centered planning;
2. Increase independence, facilitate productivity, or promote, improve, or maintain community inclusion—or decrease the need for other Medicaid services;
3. Be documented in the IPOS with medical necessity; and
4. Be purchased through the beneficiary's self-directed budget. (HSW Renewal, Appendix C—Goods and Services Service Definition and Medical Necessity Criteria).

Because the legally operative waiver language no longer requires substitution for human assistance, Respondent's reliance on that prong of the prior standard was misplaced. The IPOS addendum clearly identifies Soul Studio and Lifetime Fitness as part of Petitioner's person-centered goals, and the presence of CLS staff during Petitioner's engagement in these community activities does not disqualify the requested items under the updated rule.

The hearing record also contains documentation supporting medical necessity within the revised framework. The IPOS addendum describes community-based goals related to independence, productivity, and social participation; testimony from the Petitioner's witnesses described observed benefits at Soul Studio; and Petitioner's treating physician issued a written prescription for participation at Lifetime Fitness. The updated waiver requires that the IPOS demonstrate how the requested item promotes independence or community inclusion, criteria that the record supports. (HSW Renewal, Appendix C—Goods and Services Medical Necessity Requirements).

Petitioner asserted additional concerns relating to the IPOS development process and Respondent's representation during the local appeal. The Administrative Law Judge correctly recognized that such procedural concerns do not alter the legal criteria governing the present Medicaid adverse action. The question before the tribunal is whether the denial complied with the current HSW Goods and Services standards.

In conclusion, because the controlling HSW renewal eliminated the substitution-for-human-assistance requirement and established revised medical necessity standards that the record satisfies, Respondent's November 6, 2025, denial was not consistent with the governing waiver provisions. The adverse action must,

therefore, be reversed; and the matter remanded for reevaluation of the request under the updated Goods and Services criteria.

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 goods and services.

IT IS THEREFORE ORDERED that:

Respondent's decision is **REVERSED**.

Respondent is ordered to reevaluate Petitioner's request under the updated Goods and Services criteria.