ISSUE

Did Department properly deny Petitioner's request for additional Community Living Supports (CLS) and Respite 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. Petitioner is a Medicaid beneficiary receiving services from Respondent. (Exhibit A).

2. In March of 2025, Petitioner suffered a stroke and moved in with her son/legal guardian. (Exhibit A; Testimony.)

3. On June 5, 2025, an Integrated Biopsychosocial Intake Assessment was completed. The assessment documented a history of paranoid schizophrenia and bipolar, post-stroke cognitive decline and symptoms that included delusions of people entering the home and a need for redirection. (Exhibit A; Testimony.)

4. On July 8, 2025, a psychiatric evaluation took place; and it was recommended that Petitioner take an antipsychotic. The recommendation was declined. (Exhibit A.)

5. On or around July 11, 2025, Person Center Plan (PCP) was developed that included a request for respite and CLS to assist with community inclusion, self-care, chores, exercises, and meal prep. The PCP specifically requested 5.5 hours of respite a week due to 24/7 supervision needs and fall risk/memory issues. (Exhibit A.)

6. The PCP identified natural supports and an authorization request for targeted case management, psychiatric evaluation, and medication reviews. (Exhibit A.)

7. Petitioner's intake assessment indicated Petitioner was relatively independent in several activities of daily living with a need for assistance with bathing/showring safety. The assessment also indicated Petitioner uses a walker and has a capacity for independent living with physical assistance needed in certain areas and limitations in community safety/travel. (Exhibit A.)

8. On December 2, 2025, Respondent sent Petitioner an Adverse Benefit Determination. The notice indicated Petitioner's request for CLS and Respite was denied as the request lacked medical necessity. (Exhibit A; Testimony.)

9. Petitioner submitted an internal appeal. (Exhibit A; Testimony.)

10. On January 7, 2026, the Respondent issued a Letter of Appeal Denial. The notice upheld the December 2, 2025, Adverse Benefit Determination. The Determination provided the following:

> You are asking for 20 hours per week of Community Living Supports (CLS). We looked at REDACTED's records. CLS is meant to help with her symptoms related to her mental health. Her current symptoms are not related to her mental health. Her symptoms are related to a medical condition. Medical Necessity is not met and denial is upheld.
>
> You are also asking for 5.5 hours of Respite per week. We looked at REDACTED's records. She lives with her son and daughter-in-law. Other people who live in the house can help take care of her. She could use natural supports for a break. Medical Necessity is not met and denial is upheld.[1]

11. Petitioner timely filed a request for an Administrative Hearing. (Hearing File.)

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.[2]
>
> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of

[1] Exhibit A, p 3.
[2] 42 CFR 430.0.

> 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.[3]

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…[4]

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 has been receiving Respite through Department and is now seeking additional Respite and CLS. With respect to services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

> **17.3.B. COMMUNITY LIVING SUPPORTS**
>
> NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.
>
> Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence, or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).
>
> Coverage includes:

[3] 42 CFR 430.10.
[4] 42 USC 1396n(b).

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:

  - meal preparation
  - laundry
  - routine, seasonal, and heavy household care and maintenance
  - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
  - shopping for food and other necessities of daily living

  CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (MDHHS). CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.

- Staff assistance, support and/or training with activities such as:

- money management
- non-medical care (not requiring nurse or physician intervention)
- socialization and relationship building
- transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
- participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
- attendance at medical appointments
- acquiring or procuring goods, other than those listed under shopping, and non-medical services

- Reminding, observing and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through MDHHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed

the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

17.3.I. RESPITE CARE SERVICES

Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).

- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.

- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.

- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).

- Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.)

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service, but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence

- Licensed family foster care home

- Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility)

- Home of a friend or relative chosen by the beneficiary and members of the planning team
- Licensed camp
- In community (social/recreational) settings with a respite worker trained, if needed, by the family
- Licensed family child care home

Respite care may not be provided in:

- day program settings
- ICF/IIDs, nursing homes, or hospitals

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- beneficiary's guardian
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.[5]

While CLS and Respite services are a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services.[6] Regarding medical necessity, the MPM also provides:

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

[5] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, January 1, 2026, pp 132-133, 145-146.
[6] *See* 42 CFR 440.230.

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.[7]

The Tribunal has jurisdiction over this Medicaid fair-hearing matter, and the Petitioner bears the burden of proving that the Department failed to follow applicable laws or policies or otherwise erred in issuing the adverse action (Testimony). Under 42 CFR 440.230(d) and the Michigan Medicaid Provider Manual governing Community Living Supports (CLS) and Respite Services, the Department may limit services based on medical necessity and utilization control procedures. The Adverse Benefit Determination dated December 1, 2025, and mailed December 2, 2025, applied these standards and concluded that medical necessity was not met for the requested 20 hours per week of CLS and 5.5 hours per week of Respite for the period November 24, 2025, through May 23, 2026.[8] The ABD states that Petitioner's functional impairments appear related to a medical condition, specifically the effects of a March 2025 stroke, rather than a mental-health condition, and notes that natural supports are available in the home. The internal appeal denial dated January 7, 2026, reaffirmed this conclusion, finding that the records do not establish medical-necessity criteria for CLS or Respite because the needs are tied to medical deficits rather than behavioral-health symptoms.

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[7] *Id*, at pp14-15.

[8] (Exhibit A, p. 4).

The clinical documentation contained in Exhibit A, including the June 5, 2025, intake assessment and July 8, 2025, psychiatric evaluation, reflects post-stroke cognitive decline, refusal of the recommended antipsychotic medication, and requests for assistance primarily with activities of daily living, safety, and supervision. These records do not demonstrate that the requested CLS or Respite services are medically necessary to address functional impairments arising from a qualifying behavioral-health condition under Medicaid policy. At the hearing, the petitioner offered testimony describing paranoid behaviors, supervision needs, and a verbal assertion that a doctor later stated his mother does not have dementia; however, no documentary evidence supporting this statement was offered. The petitioner's testimony did not show that the Department misapplied Medicaid policy or that the requested services satisfy the behavioral-health medical-necessity criteria.

Accordingly, based on the evidence presented in the hearing record and Exhibit A, the Petitioner has not met the burden of proving that the Respondent erred in denying the requested CLS and Respite services for the dates of service in question. The Respondent's adverse action is therefore upheld.

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 CLS and Respite services.

IT IS THEREFORE ORDERED that

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