Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

Date Mailed: September 15, 2025
Docket No.: 25-027723
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
[redacted] MI [redacted]

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Petitioner: [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Petitioner's request for a hearing.

After due notice, a telephone hearing was held on September 10, 2025. Petitioner appeared and testified on his own behalf. Meagan Schinella, Fair Hearings Officer, represented the Respondent Monroe Community Mental Health Authority. Andrea Guertin, Director of Adult Services, appeared as a witness for Respondent

ISSUE

Did Respondent properly terminate Petitioner's individual therapy 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 who has been receiving services through Respondent. (Exhibit A; Testimony).

2. On August 13, 2024, Petitioner reported that he was only going to appointments to get to his spend down amount. Petitioner went on to indicate that he didn't care about the people at the clubhouse as most of them were low functioning. (Exhibit A; Testimony.)

3. On September 3, 2024, Petitioner discussed the transition of care and his positive accomplishments that he achieved during therapy. Petitioner and Respondent went on to discuss community services and resources. (Exhibit A; Testimony.)

4. On October 16, 2024, Petitioner reported that he has anxiety but that he thinks it is normal and that while he thought he might benefit from therapy, he might take a break. (Exhibit A; Testimony.)

5. On November 8, 2024, Petitioner reported areas that he was doing better, such as managing stress, anger, and anxiety. Petitioner also reported that meditation was helping. (Exhibit A; Testimony.)

6. On December 2, 2024, the Respondent and Petitioner met to discuss therapy resources that accept Petitioner's insurance. (Exhibit A; Testimony.)

7. On December 4, 2024, Petitioner and Respondent discussed finding other therapists in the community. Petitioner agreed to move to a community OPT. (Exhibit A; Testimony.)

8. On March 4, 2025, Respondent and Petitioner discussed how the clubhouse could help Petitioner develop his social skills. The parties also discussed Pure Psychiatry as a therapist that would accept Petitioner's insurance. (Exhibit A; Testimony.)

9. On March 5, 2025, the parties toured the clubhouse and Petitioner agreed to attend clubhouse on Fridays. (Exhibit A; Testimony.)

10. On May 8, 2025, Petitioner's OPT was ending with Respondent and Petitioner indicated he would look into going to Catholic Charities. (Exhibit A; Testimony.)

11. On May 23, 2025, Petitioner submitted an internal appeal. (Exhibit A; Testimony.)

12. On May 29, 2025, the Respondent sent Petitioner an Adverse Benefit Determination. The letter indicated Petitioner's individual therapy would be terminated effective June 9, 2025, as a result of Petitioner meeting his IPOS goals and objectives. (Exhibit A.)

13. On June 11, 2025, the Respondent sent Petitioner a letter of Appeal Denial. The notice indicated Petitioner's appeal was not approved and provided the following:

> The Review Committee looked at the criteria for individual therapy and agreed with ending therapy as it is no longer needed and is only being used to meet your Medicaid spend down. The Committee recommended that you use peer support services and clubhouse services to practice the skills you have learned in therapy. You agreed to end therapy and try peer supports and clubhouse at the time of the appeal meeting.[1]

14. On August 4, 2025, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing. (Exhibit A.)

[1] Exhibit A, p 59.

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 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]

[2] 42 CFR 430.0.
[3] 42 CFR 430.10.
[4] 42 USC 1396n(b).

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 individual therapy through Respondent and it is a reduction of those services that is at issue. With respect to such services, the Medicaid Provider Manual (MPM) provides:

> **3.12 INDIVIDUAL/GROUP THERAPY**
>
> Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices such as integrated dual disorder treatment for co-occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Individual/group therapy is performed by a mental health professional within their scope of practice or a limited licensed master's social worker supervised by a full licensed master's social worker.[5]

However, while individual therapy is a covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not affect the federal Medicaid regulation that requires that authorized services be medically necessary.[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, July 1, 2025, p 18.
[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]

Here, Respondent decided to reduce Petitioner's individual therapy sessions as a result of Petitioner agreeing to terminate services and Petitioner meeting all of his goals and objectives in his IPOS.

In support of that decision, Respondent provided notes reflecting Petitioner's growth over the prior year and the conversations between the parties about terminating services and seeking therapy from providers outside of Respondent that would accept Petitoiner's insurance. Respondent also provided testimony regarding Petitioner making comments that he was only using CMH services in order to meet his spend down.

Petitioner did not dispute the testimony provided by Respondent's witnesses and more or less indicated that it was a mistake to meet with them to discuss alternative treatment options and the appeal itself. Petitioner did indicate he continued to have a need for services but did not address how that need could not be met through other providers outside of CMH or how the club house could not continue to assist him.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred by terminating services.

Given the record in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof and that Respondent's decision must be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly terminated Petitioner's individual therapy services.

IT IS THEREFORE ORDERED that

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

COREY A. ARENDT

[7] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, July 1, 2025, pp 13-15.

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.

Via Electronic Mail:

Department Contact
BELINDA HAWKS
MDHHS-BPHASA
320 S WALNUT ST 5TH FL
LANSING, MI 48933
MDHHS-BHDDA-HEARING-NOTICES@MICHIGAN.GOV

Respondent
MONROE CMHA
1001 S RAISINVILLE RD
MONROE, MI 48161
MSCHINELLA@MONROECMHA.ORG

Via First Class Mail:

Petitioner
[redacted]
[redacted] MI [redacted]