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

Date Mailed: December 23, 2025
Docket No.: 25-035705
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
MI [redacted]

This is an important legal document. Please have someone translate the document.

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এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

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这是一份重要的法律文件。请让别人翻译文件。

Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

Date Mailed: December 23, 2025
Docket No.: 25-035705
Case No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey A. Arendt

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 telephone hearing was held on December 16, 2025. [redacted] Petitioner's Father, appeared and testified on Petitioner's behalf. [redacted] Petitioner's Mother, appeared as a witness for Petitioner.

George Motakis, Fair Hearing Officer, appeared on behalf of the Respondent, Health West (Respondent or Department). Jasmine Williams, and Michele Anguino, appeared as witnesses for the Department.

Exhibits:

Petitioner – None

Department –
A. Appeal Packet
B. Correct Adverse Benefit Determination
C. Appeal Request
D. Notice of Receipt of Appeal
E. LRE Notice of Appeal Denial
F. LRE Appeal Summary Report
G. Request for Hearing
H. Notice of Hearing
I. Jasmine Williams Credentials
J. Michelle Anguiano Credentials
K. Ann Gatt Credentials
L. Rebecca St. Clair Credentials

ISSUE

Did the Department properly terminate Petitioner from Home Based 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 through Department. (Exhibit A; Testimony.)

2. On August 28, 2025, the Department performed a MichiCans Comprehensive Assessment recommending a referral for mild-to-moderate mental health services. The assessment indicated the following:

   - Legal risk reduced from 2 to 0.
   - Danger to others reduced from 2 to 0.
   - Fire-setting reduced from 1 to 0.
   - No suicidal ideation reported.[1]

3. On September 11, 2025, Department initiated an internal referral to transition Petitioner from Home-Based Services to SED Outpatient, citing decreased behaviors, absence of self-harm or suicidal ideation, and Petitioner's ability to recognize and implement coping skills. (Exhibit A.)

4. On September 16, 2025, Department issued an Adverse Benefit Determination. The notice indicated Petitioner's Home-Based Services would terminate effective September 27, 2025, and that he would be moved to a different team for a lower level of care. (Exhibit B.)

5. On September 19, 2025, Petitioner submitted a request for an internal appeal. (Exhibit D.)

6. On September 29, 2025, Department issued a Letter of Appeal Denial. The notice indicated Petitioner's appeal was being denied as a result of Petitioner no longer qualifying for home-based services based on the MichiCan review. (Exhibit E; Testimony.)

7. On or around October 13, 2025, the Michigan Office of Administrative Hearings and Rules received from Petitioner, a request for hearing. (Exhibit G.)

[1] Exhibit A.

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:

> 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 title, may waive such requirements of section 1902 (other than subsection (s)) (other than sections 1902(a)(15), 1902(bb), and 1902(a)(10)(A) insofar as it requires provision of the care and services described in section 1905(a)(2)(C) as may be necessary for a State --

[2] 42 CFR 430.0.
[3] 42 CFR 430.10.

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 Michigan Department of Health and Human Services (MDHHS) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Health and Human Services to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service.[4]

The CMH is mandated by federal regulation to perform an assessment for the Petitioner to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services.

The Medicaid Provider Manual articulates Medicaid policy for Michigan. It states in relevant part:

> **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

[4] 42 CFR 440.230.

- 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; and

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and

- 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;

  - 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.
>
> * * *

With regard to Home Based Services, the Medicaid Provider Manual indicates:

> **7.2.C. AGE SEVEN THROUGH SEVENTEEN**
>
> **NOTE:** For EPSDT, this same criteria should be utilized to determine eligibility for home-based services for young adults ages 18-21.
>
> Decisions regarding whether a child or adolescent has a serious emotional disturbance and is in need of home-based services is determined by using the following dimensions: the child has a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities, and duration of the condition. For children age seven through seventeen, the Child and Adolescent Functional Assessment Scale (CAFAS) is used to make discriminations within the functional impairment dimension. All of the dimensions, as well as family voice and choice, must be considered when determining if a child is eligible for home-based services.[5]

Petitioner argued that Petitioner is not ready for a reduction in services and may regress if Home-Based Services are terminated. While these concerns are understandable, the governing standard is whether Home-Based Services remain medically necessary. The MichiCANS assessment and progress notes show significant improvement, including reductions in risk scores and no suicidal ideation. Under MPM section 2.5(C), services must be provided in the least restrictive setting, and the record supports that [redacted] needs can be met at SED Outpatient with continued supports such as individual therapy, CLS, respite, and parent support partner. If regression occurs, policy allows for reassessment and reinstatement of higher-level care.

[5] Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services, July 1, 2025, pp 14-16; 58.

Petitioner also argued that losing the current therapist will harm progress. Continuity of care is important, but Medicaid policy does not guarantee a specific provider; it requires that services be clinically appropriate and accessible. Respondent testified that outpatient therapy and ancillary supports remain available, and any provider assignment concerns should be addressed through person-centered planning and grievance processes.

Petitioner further argued that the family was not adequately notified or prepared for the assessment and transition. The record shows Respondent issued an Adverse Benefit Determination citing legal authority and appeal rights, and the Lakeshore Regional Entity conducted an independent review. While communication could have been clearer, procedural compliance with notice and appeal requirements under 42 CFR 438.404 and Michigan grievance policy was met.

Finally, Petitioner argued that Petitioner continues to need intensive support due to cognitive limitations and trauma history. The record acknowledges ongoing needs such as anxiety and coping skills, but these do not automatically require Home-Based intensity. Under MPM section 2.5(D), PIHPs may reduce services when another appropriate, less restrictive service meets medical necessity. Testimony from Jasmine Williams and Michelle Anguiano confirmed that [redacted] progress and current risk profile support outpatient care with ancillary supports to maintain stability.

Based on the evidence and applicable law, Petitioner has not shown by a preponderance of the evidence that Respondents determination violated Medicaid policy or that Home-Based Services remain medically necessary. The decision to transition to SED Outpatient is consistent with MPM section 2.5, federal regulations, and the principle of least restrictive care.

DECISION AND ORDER

The Administrative Law Judge, based on the above Findings of Fact and Conclusions of Law, decides that the Respondent properly terminated Petitioner from Home Based Services.

IT IS THEREFORE ORDERED that:

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

COREY A. ARENDT
ADMINISTRATIVE LAW JUDGE

25-033705

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.

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