



Date Mailed: February 5, 2026

Docket No.: 25-043393

Case No.: [REDACTED]

Petitioner: [REDACTED]

[REDACTED]
MI [REDACTED]

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Este es un documento legal importante. Por favor, que alguien traduzca el documento.

这是一份重要的法律文件。请让别人翻译文件。

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Date Mailed: February 9, 2026

Docket No.: 25-043393

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 on behalf of Petitioner [REDACTED] (Petitioner).

After due notice, a telephone hearing was held on January 13, 2026.

[REDACTED] and [REDACTED], the minor Petitioner's parents, appeared and testified on Petitioner's behalf. [REDACTED], Educational Advocate, and [REDACTED], Board Certified Behavior Analyst (BCBA), also testified as witnesses for Petitioner.

Kim Cereske, Customer Services Specialist, appeared and testified on behalf of Respondent Bay-Arenac Behavioral Health (BABH or Respondent). Also testifying as a witness for Respondent were Ashlee Grusnick, Case Manager, Respondent; Amanda Johnson, Supervisor of Children and Family Services, Respondent; Joelin Hahn, Director of Integrated Care, Respondent Barb Groo, Waiver Administrator, Mid-State Health Network (MSHN); and Brie Elsasser, State Plan Coordinator and BCBA, Mid-State Health Network.

During the hearing, Petitioner submitted four exhibits that were admitted into the record without objection as Exhibits A-D. Respondent also submitted thirty-two exhibits that were admitted into the record without objection as Exhibits #1-32.

ISSUE

Did Respondent properly reduce Petitioner's applied behavioral analysis (ABA) services?

FINDINGS OF FACT

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

1. Petitioner is a [REDACTED] Medicaid beneficiary who has been diagnosed with autism spectrum disorder. (Exhibit #7, page 1).

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2. Due to his diagnosis and need for assistance, Petitioner is approved for services through Respondent, a Community Mental Health Service Program (CMHSP) associated with the Prepaid Inpatient Health Plan (PIHP) Mid-State Health Network. (Testimony of Respondent's Representative).
 3. As part of his services, Petitioner was approved for 15 hours per week of ABA services. (Exhibit B, pages 9-12).
 4. The ABA services were provided by Paramount Children's Therapy Center. (Exhibit B, pages 20-25).
 5. They were also provided on Mondays through Fridays, with Petitioner first attending a half day of school before coming to ABA in the afternoon. (Exhibit B, page 18).
 6. In October of 2025, the [REDACTED] School District, where Petitioner is a student, determined that Petitioner should attend a full day of school. (Exhibit #7, pages 1-19; Testimony of Petitioner's Mother; Testimony of Case Manager).
 7. Petitioner's parents have disagreed with the school district's decision and are pursuing remedies to have it reversed. (Testimony of Petitioner's Mother; Testimony of Petitioner's Father).
 8. Petitioner's parents are not interested in having Petitioner's ABA services through Respondent provided at Petitioner's school. (Testimony of Petitioner's Father).
 9. Nor are they interested in switching Petitioner's ABA services from his current provider to another available provider. (Testimony of Petitioner's Mother; Testimony of Petitioner's Father).
 10. They also do not want Petitioner to receive ABA services on Saturdays or Sundays. (Testimony of Petitioner's Mother; Testimony of Petitioner's Father).
 11. Petitioner's current provider closes at 5:00 p.m. on Mondays through Fridays. (Testimony of Case Manager).
 12. Accordingly, given Petitioner's parents' preferences and his current provider's business hours, Petitioner cannot receive the previously-approved amount of ABA services if he also attends a full day of school. (Testimony of Petitioner's Father; Testimony of Case Manager)

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13. On October 10, 2025, Respondent sent Petitioner a Letter of Adverse Benefit Determination stating that, effective October 21, 2025, Petitioner's ABA services would be reduced to 7.5 hours per week. (Exhibit #6, pages 1-7).
 14. The Notice of Adverse Benefit Determination stated in part that the decision was based on the following:

School Based services are being provided and offered through FAPE in his IEP at [REDACTED] school until 3:35 p.m. and [Petitioner] cannot start ABA therapy services until after that time. Due to this change in his IEP, and the current provider (Paramount) only being available until 5 p.m., [Petitioner's] hours of ABA services will have to be reduced. If the family chooses they can change to a new provider that is open later hours to continue his current hours of ABA therapy services after school hours.

The school amended his IEP to take out that he can leave for a half day to attend ABA therapy services. School Based services are being provided and offered through FAPE in his IEP at [REDACTED] school until 3:35 p.m. and [Petitioner] cannot start ABA therapy services until after that time. Due to this change in his IEP and the current provider (Paramount) only being available until 5 p.m., [Petitioner's] hours of ABA services will have to be reduced. If the family chooses they can change to a new provider that is open later hours to continue his current hours of ABA therapy services after school hours.

Exhibit #5, pages 1-2

15. On October 17, 2025, Petitioner filed an Internal Appeal with Respondent regarding the decision to reduce ABA services. (Exhibit #5, pages 1-5).
16. On November 26, 2025, Respondent sent Petitioner a Letter of Appeal Denial. (Exhibit #4, pages 1-7).

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

Your appeal was not approved for the service(s)/item(s) listed above because: Bay Arenac Behavioral Health (BABH) Customer Service collaborated with the BABH Applied Behavioral Analysis (ABA) Coordinator, the BABH Child & Family Services Manager, and the BABH Director of Integrated Child & Family Services. Further, BABH collaborated with MidState Health Network (MSHN) PrePaid Inpatient Health Plan (PIHP). [Note: The PIHP manages the state Medicaid funding for and oversight of specialty mental health services and substance use disorder services for Region 5; BABH is one of the community mental health service programs within the MSHN PIHP region.] It has been decided that the reduction in [REDACTED] BABH-ftinded Applied Behavior Analysis (ABA) is being supported.

Per the Michigan Medicaid Provider Manual, “all children, including children with [Autism Spectrum Disorder] (ASD), must receive medically necessary treatment services, to correct or ameliorate any physical or behavioral conditions so that health problems are averted or diagnosed and treated as early as possible.” Further, it also states “services must be based on the individual, child, and the parent’s/guardian’s needs and must consider the child’s age, school attendance requirements, and other daily activities....” And, lastly, it states that “clinical determinations of service intensity, setting(s), and duration are designed to facilitate the individual’s goal attainment. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant responsibilities of educational or other authorities.”

You, as his guardian, stated that you do not want [Petitioner’s] BABH-funded ABA hours to be completed after a full day of school. You state that this makes for an extraordinary long day for a child. You prefer him to attend school for half of each school weekday and then ABA the other half of each school weekday like [Petitioner] did last school year.

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[Petitioner's] school Individualized Education Plan (IEP) from last year made accommodation for half school days to allow [Petitioner] to attend BABH-funded ABA services the other half of the day. This paralleled your chosen ABA provider's ability to provide ABA services, as its business hours allowed for such.

In collaboration with the school during [REDACTED] recent Individualized Education Plan (IEP), BABH learned that the school special education team indicated that [Petitioner's] adaptive behavior has progressed to a level that would allow him to return to full days at school. During this appeal, BABH, yourself, and your ARC advocate worked with the school to advocate for half school days to remain written in [Petitioner's] IEP to allow him to still attend BABH-funded ABA the other half of the day. However, the special education team indicated that they support him returning to full days at school due to his progress; such is written into his most recent IEP with special education supports to assist [Petitioner].

Unfortunately, [Petitioner's] current ABA provider chosen by you does not have business hours that would allow him to continue at his previously authorized ABA hour amount; you indicated that you want [Petitioner] to remain at his current ABA provider. However, the full school days in the IEP and the ABA provider business hours do not complement each other. You have indicated that you do not want to change to a different ABA provider that will have complementing business hours nor do you want [Petitioner] to attend full school days plus ABA after school. Further, BABH cannot supplant the special education supports and services offered through his IEP at school. Thus the reduction in ABA hours is warranted.

Exhibit #4, pages 1-2

18. On December 2, 2025, MOAHR received the request for hearing filed in this matter regarding the decision to reduce Petitioner's ABA services. (Exhibit A, pages 1-4).

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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.

42 CFR 430.0

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.

42 CFR 430.10

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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...

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 Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA) services through Respondent. With respect to such services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

SECTION 18 – BEHAVIORAL HEALTH TREATMENT SERVICES/APPLIED BEHAVIOR ANALYSIS

The purpose of this policy is to provide for the coverage of Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for children under 21 years of age diagnosed with Autism Spectrum Disorder (ASD). All children, including children with ASD, must receive EPSDT services that are designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, to correct or ameliorate any physical or behavioral conditions so that health problems are averted or diagnosed and treated as early as possible.

BHT services prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the child. Medical necessity and recommendation for BHT services is determined by a physician, or other licensed practitioner working within their scope of practice under state law.

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Direct patient care services that treat or address ASD under the state plan are available to children under 21 years of age as required by the EPSDT benefit.

18.1 SCREENING

The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment. Early identification of a developmental disorder's underlying etiology may affect the medical treatment of the child and the parent's/guardian's intervention planning. Screening for ASD typically occurs during an EPSDT well child visit with the child's primary care provider (PCP). EPSDT well child visits may include a review of the child's overall medical and physical health, hearing, speech, vision, behavioral and developmental status, and screening for ASD with a validated and standardized screening tool. The EPSDT well child evaluation is also designed to rule out medical or behavioral conditions other than ASD, and include those conditions that may have behavioral implications and/or may co-occur with ASD. A full medical and physical examination must be performed before the child is referred for further evaluation.

18.2 REFERRAL

The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area for Medicaid beneficiaries. The PIHP will contact the child's parent(s)/guardian(s) to arrange a follow-up appointment for a comprehensive diagnostic evaluation and behavioral assessment. Each PIHP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation and behavioral assessment of ASD. If the PCP determines the child who screened positive for ASD is in need of occupational, physical, or speech therapy, the PCP will refer the child directly for the service(s) needed.

After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the PIHP is responsible for the comprehensive diagnostic evaluation, behavioral assessment, BHT services (including ABA) for eligible Medicaid beneficiaries, and for the related EPSDT medically necessary Mental Health Specialty Services. Occupational therapy, physical therapy, and speech therapy for children with ASD who do not meet the eligibility requirements for developmental disabilities by the PIHP are covered by the Medicaid Health Plan or by Medicaid Fee-for-Service.

18.3 COMPREHENSIVE DIAGNOSTIC EVALUATIONS

Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The comprehensive diagnostic evaluation must be performed before the child receives BHT services. The comprehensive diagnostic evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should include validated evaluation tools. Based on the evaluation, the practitioner determines the child's diagnosis, recommends general ASD treatment interventions, and refers the child for a behavior assessment which is provided or supervised by a board certified and licensed behavior analyst (BCBA/LBA) to recommend more specific ASD treatment interventions. The diagnostic evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A qualified licensed practitioner includes:

- a physician with a specialty in psychiatry or neurology;
- a physician with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline;
- a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health;
- a psychologist;

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- an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health;
 - a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or
 - a masters level, fully licensed clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD.

The determination of a diagnosis by a qualified licensed practitioner is accomplished by following best practice standards. The differential diagnosis of ASD and related conditions requires multimodal assessment and integration of clinical information. This is a complex assessment procedure in which clinicians must integrate data from caregiver reports, records (e.g., medical, school, other evaluations), collateral reports (e.g., teachers, other treatment providers), data gathered from utilization of standardized psychological tools (e.g., developmental, cognitive, adaptive assessment), and the observational assessment to determine diagnostic and clinical impressions. The utilization of multiple data modes and sources improves the reliability of ASD diagnosis. No one piece of data determines the ASD diagnosis, and evaluators should consider the accuracy of data and confounding factors that may impact data obtained (e.g., parent who seems to be overly negative about the child, child who was intensely shy during observational assessment).

18.4 MEDICAL NECESSITY CRITERIA

Medical necessity and recommendation for BHT services are determined by a physician or other licensed practitioner working within their scope of practice under state law. Comprehensive diagnostic reevaluations are required no more than once every three years, unless determined medically necessary more frequently by a physician or other licensed practitioner working within their scope of practice.

The recommended frequency should be based on the child's age and developmental level, the presence of comorbid disorders or complex medical conditions, the severity level of the child's ASD symptoms, and adaptive behavior deficits through a person-centered, family-driven youth-guided process involving the child, family, and treating behavioral health care providers.

The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B (listed below); and require BHT services to address the following areas:

- A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following:
 - 1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.
 - 2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.
 - 3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.
- B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least two of the following:

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1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).
 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day).
 3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest).
 4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, and/or visual fascination with lights or movement).

18.5 DETERMINATION OF ELIGIBILITY FOR BHT

The following is the process for determining eligibility for BHT services for a child with a confirmed diagnosis of ASD. Eligibility determination and recommendation for BHT must be performed by a qualified licensed practitioner through direct observation utilizing valid evaluation tools. BHT services are available for children under 21 years of age with a diagnosis of ASD from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and who have the developmental capacity to clinically participate in the available interventions covered by BHT services. A well-established DSM-IV diagnosis of Autistic Disorder, Asperger's Disorder or PDD-NOS should be given the diagnosis of ASD. Children who have marked deficits in social communication but whose symptoms do not otherwise meet criteria for ASD should be evaluated for social (pragmatic) communication disorder.

To be eligible for BHT, the following criteria must be met:

- Child is under 21 years of age.
- Child received a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.
- Child is medically able to benefit from the BHT treatment.
- Treatment outcomes are expected to develop, maintain, or restore, to the maximum extent practicable, the functioning of a child with ASD. Measurable variables may include increased social-communication skills, increased interactive play/age-appropriate leisure skills, increased reciprocal and functional communication, etc.
- Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e., Individualized Education Plan/Individualized Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.).
- Services are able to be provided in the child's home and community, including centers and clinics.
- Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities or may be masked by learned strategies later in life).
- Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence.
- Medical necessity and recommendation for BHT services are determined by a qualified licensed practitioner.

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- Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirements, and other daily activities as documented in the IPOS. Families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month.

18.6 PRIOR AUTHORIZATION

BHT services are authorized for a time period not to exceed 365 days. The 365-day authorization period for services may be re-authorized annually based on recommendation of medical necessity by a qualified licensed practitioner working within their scope of practice under state law.

18.7 RE-EVALUATION

Comprehensive diagnostic re-evaluations are required no more than once every three years, unless determined medically necessary more frequently by a physician or other licensed practitioner working within their scope of practice. The recommended frequency should be based on the child's age and developmental level, the presence of comorbid disorders or complex medical conditions, the severity level of the child's ASD symptoms and adaptive behavior deficits through a person-centered, family-driven youth-guided process involving the child, family, and treating behavioral health care providers.

18.8 TRANSITION AND DISCHARGE CRITERIA

The desired BHT goals and outcomes for discharge should be specified at the initiation of services, monitored throughout the duration of service implementation, and refined through the behavioral service level evaluation process. Transition and discharge from all BHT services should generally involve a gradual step-down model and require careful planning. Transition and discharge planning from BHT services should include transition goal(s) within the behavioral plan of care or plan, or written plan, that specifies details of monitoring and follow-up as is appropriate for the individual and the family or authorized representative(s) utilizing the PCP process.

Discharge from BHT services should be reviewed and evaluated by a qualified BHT professional for children who meet any of the following criteria:

- The individual has achieved treatment goals and less intensive modes of services are medically necessary and/or appropriate.
- The individual is either no longer eligible for Medicaid or is no longer a State of Michigan resident.
- The individual, family, or authorized representative(s) is interested in discontinuing services.
- The individual has not demonstrated measurable improvement and progress toward goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the BHT interventions are not able to be maintained or they are not replicable beyond the BHT treatment sessions through the successive authorization periods.
- Targeted behaviors and symptoms are becoming persistently worse with BHT treatment over time or with successive authorizations.
- The services are no longer medically necessary, as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner.
- The provider and/or individual/family/authorized representative(s) are unable to reconcile important issues in treatment planning and service delivery to a degree that compromises the potential effectiveness and outcome of the BHT service.

18.9 BHT SERVICES

18.9.A. BEHAVIORAL ASSESSMENT

A developmentally appropriate applied behavior analysis (ABA) assessment process must identify strengths and weaknesses across domains and potential barriers to progress.

The information from this process is the basis for developing the individualized behavioral plan of care with the individual, family, and treatment planning team. Behavioral assessments can include direct observational assessment, record review, rating scales, data collection, functional or adaptive assessments, structured interviews, and analysis by a board certified and licensed behavior analyst (BCBA/LBA). Behavioral assessment tools must describe specific levels of behavior at baseline to inform the individual's response to treatment through ongoing collection, quantification, and analysis of the individual's data on all goals as monitored by a BCBA/LBA.

18.9.B. BEHAVIORAL INTERVENTION

BHT services include a variety of behavioral interventions which have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence. BHT services are designed to be delivered primarily in the home and in other community settings.

BHT treatment services may also include any other intervention supported by credible scientific and/or clinical evidence, as appropriate for each individual. Based on the behavioral plan of care which is adjusted over time based on data collected by the qualified provider to maximize the effectiveness of BHT treatment services, the provider selects and adapts one or more of these services, as appropriate for each individual.

18.10 BHT SERVICE LEVEL

BHT services are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) within the individual's community for an appropriate period of time, depending on the needs of the individual and their family or authorized representative(s). Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the individual's goal attainment.

These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant responsibilities of educational or other authorities. Each individual's IPOS must specify how identified supports and services will be provided as part of an overall, comprehensive set of supports and services that does not duplicate services that are the responsibility of another entity, such as a private insurance or other funding authority, and do not include special education and related services defined in the Individuals with Disabilities Education Act (IDEA) that are available to the individual through a local education agency. The recommended service level, setting(s), and duration will be included in the individual's IPOS, with the planning team and the family or authorized representative(s) reviewing the IPOS no less than annually and, if indicated, adjusting the service level and setting(s) to meet the individual's changing needs. The service level includes the number of hours of intervention provided to the individual. The service level determination will be based on research-based interventions integrated into the behavioral plan of care with input from the planning team. Service intensity will vary with each individual and should reflect the goals of treatment, specific needs of the individual, and response to treatment.

The PIHP's Utilization Management will authorize the level of services prior to the delivery of services.

- **Focused Behavioral Intervention:** Focused behavioral intervention is provided an average of 5-15 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).
- **Comprehensive Behavioral Intervention:** Comprehensive behavioral intervention is provided an average of 16-25 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).

18.11 BHT SERVICE EVALUATION

As part of the IPOS, there is a comprehensive, individualized behavioral plan of care that includes specific targeted behaviors, along with measurable, achievable, and realistic goals for improvement.

BCBAs/LBAs and other qualified providers develop, monitor, and implement the behavioral plan of care. These providers are responsible for effectively evaluating the child's response to treatment and skill acquisition.

Ongoing determination of the level of service (minimally every six months) requires evidence of measurable and ongoing improvement in targeted behaviors that are demonstrated with the use of reliable and valid assessment instruments and other appropriate documentation of analysis (i.e., graphs, assessment reports, records of service, progress reports, etc.).

*MPM, October 1, 2025 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 165-171*

Here, as discussed above, Respondent decided to reduce Petitioner's ABA services pursuant to the above policies.

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 the Respondent's decision in light of the information it had at the time it made the decision.

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

As a preliminary matter, the undersigned ALJ would note that Petitioner's primary dispute is outside the scope of this case. Petitioner's parents strongly disagree with the school district's decision that Petitioner attend a full day of school and, while the ALJ appreciates their arguments, this case is limited to Respondent's decision to reduce Petitioner's ABA services and the ALJ lacks any authority to review or reverse the school district's decision. Accordingly, whatever avenues of relief may be available elsewhere for Petitioner, the undersigned ALJ will not be reviewing the school district's decision.

Similarly, the undersigned ALJ will not be reviewing Petitioner's parents' decision not to have Petitioner receive ABA services on the weekends, at night with a different provider, or at school. Petitioner's parents' explanation for their decision is clear and credible, but, even if it was not, it is their choice and the ALJ would not review it.

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However, with the parents' decision about when and where Petitioner can receive ABA services, in addition to the school district's decision, the reduction in this case was proper and must be affirmed. Petitioner is simply unavailable for more ABA services than what Respondent has now authorized and, while there was some discussion of a risk of Respondent duplicating or supplanting school-based services, the record makes clear that decision is based on logistics. Respondent was willing to continue to approve up to 15 hours per week of ABA services, but it could only approve the 7.5 hours per week OF services that could actually be provided given Petitioner's schedule, the choseN provider's business hours, and Petitioner's parents' preferences.

Petitioner's parents are essentially asking that Respondent ignore the school district's decision that Petitioner attend a full day of school, and, while it appears that Respondent may disagree with that decision as well, Respondent also properly found that it could not simply ignore it. In particular, Respondent relied upon a guidance document issued by the Michigan Department of Health and Human Services (MDHHS) that states in part:

Private ABA Therapy: Outside of the District

When an IEP Team has determined ABA therapy is not necessary for FAPE, a child's parent may pursue private ABA therapy that is not part of an IEP and not associated with school. When a physician or other provider has determined medical necessity for ABA therapy, there can and should be a coordination of therapy with the district so the child can access the ABA therapy they are entitled to and maximize the full school day they are also entitled to. *Private ABA therapy is funded through private insurance, the parents or other sources, but is not funded by the district.* Therefore, although districts have an obligation to provide a full school day, a district is not required to provide a place for an outside provider to provide private ABA therapy.

Typically, private ABA therapy does not address academic skills, but focuses on communication, independent living and challenging behaviors. In some instances, parents may schedule private ABA therapy outside of the school day. In other cases, parents have opted to remove students out of school to receive medically determined ABA therapy.

As a matter of civil rights, a student with a disability is entitled to a full school day, just like their nondisabled peers. A school district must never be expected to reduce a student's school day because of a physician statement, prescription or parent request so the student can attend private ABA therapy.

Doing so will result in a denial of FAPE and is a violation of the student's civil rights. Parents who choose to remove their child from school to attend private ABA therapy will need to excuse their child following a district's attendance procedure and should be aware that truancy laws may apply.

*Exhibit #28, page 16
MDHHS-Pub-2073 (1-25), page 15
(italics added for emphasis)*

Here, Petitioner's father testified that they will deal with any consequences that result from Respondent authorizing ABA services that would necessarily have to be provided during the school day, and that the school district has indicated that it will not report Petitioner for truancy. However, given the clear language of that guidance, Respondent cannot sanction what has been identified as a civil rights violation, even if that is Petitioner's parents' request.

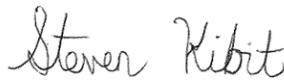
The record in this case reflects that Petitioner is to attend school for five full days per week; Respondent properly took that attendance into account; and that, for a combination for reasons, Petitioner is only available for 7.5 hours per week of ABA services at most. Respondent could therefore only approve that amount of services and its decision to reduce Petitioner's ABA services to 7.5 hours per week 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 reduced Petitioner's ABA services.

IT IS THEREFORE ORDERED that:

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



**STEVEN KIBIT
ADMINISTRATIVE LAW JUDGE**

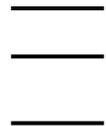
25-043393

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://rs.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 First Class & Electronic Mail:

Petitioner

[REDACTED]
[REDACTED]
MI [REDACTED]
[REDACTED]

Via Electronic Mail:

Authorized Hearing Representative

[REDACTED]
[REDACTED]
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Respondent

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