[redacted]
MI [redacted]

Date Mailed: November 15, 2021
MOAHR Docket No.: 21-004462
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Robert J. Meade

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 November 10, 2021. [redacted] and [redacted], Petitioner's parents, appeared and testified on behalf of Petitioner, [redacted]. Stacy Coleman, Chief Privacy and Compliance Officer, appeared and testified on behalf of Respondent, Macomb County Community Mental Health (CMH).

EXHIBITS

Petitioner's Exhibits:

Exhibit 1: Michigan Provider Manual (MPM) Excerpt Re: Respite

Exhibit 2: MPM Excerpt Re: Community Living Supports (CLS)

Exhibit 3: MPM Excerpt Re: Overnight Health and Safety Support (OHSS)

Exhibit 4: Decision and Order by ALJ Meade, dated October 20, 2020

Exhibit 5: Decision and Order by ALJ Arendt, dated March 22, 2021

Exhibit 6: Notice of Adverse Benefit Determination, dated April 18, 2021

Respondent's Exhibits:

Exhibit A: Hearing Summary, pp 1-36

ISSUE

Did the CMH properly authorize Petitioner's respite hours?

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 [redacted]-year-old Medicaid beneficiary, born [redacted] 1991, receiving services through Macomb County Community Mental Health (CMH). (Exhibit 4; Testimony)

2. CMH is under contract with the Michigan Department of Health and Human Services (MDHHS) to provide Medicaid covered services to people who reside in the CMH service area. (Exhibit A)

3. Petitioner resides in single family home with his parents and brother. (Exhibit 4; Testimony)

4. Petitioner is diagnosed with autism spectrum disorder, intellectual disability, obsessive-compulsive disorder, posttraumatic stress disorder, attention-deficit/hyperactivity disorder, unspecified anxiety disorder, and other specified disorders involving the immune mechanism. (Exhibit 4; Testimony)

5. Petitioner participates in the HAB Waiver and receives CLS, Respite, Supports Coordination, Enhanced Pharmacy, Goods and Services, Speech Therapy, Massage Therapy (private), Self-Determination, and Behavioral Services. (Exhibit 4, Testimony)

6. Petitioner is a high school graduate and has obtained an Associates Degree from Macomb Community College. Petitioner participated in special education programs in elementary and high school and required extensive one on one assistance to attend community college. (Exhibit 4; Testimony)

7. Petitioner has substantial functional limitations in the areas of self-care, receptive and expressive language, learning, self-direction, capacity for independent living, and economic self-sufficiency. (Exhibit 4; Testimony)

8. On July 23, 2021, Petitioner's supports coordinator submitted a request for 5 hours of respite care per day for Petitioner for the period of August 1, 2021 to July 31, 2022. (Exhibit A, p 2; Testimony)

9. Petitioner is also authorized to receive 14 hours of Community Living Supports (CLS) per day, 6 hours of Overnight Health and Safety Support (OHSS) per day and an average of 2.3[1] hours of Adult Home Help per

[1] The parties disagree on the amount of AHH authorized. Petitioner's parents claim it averages out to about 1.25 hours per day, Respondent claims it averages out to 2.3 hours per day. This discrepancy does not effect the decision in this case.

day. (Exhibit A, p 1; Testimony)

10. On July 30, 2021, CMH issued a Notice of Adverse Benefit Determination, effective August 1, 2021, denying Petitioner's request. The Notice indicated, in relevant part:

> Your clinician requested 5 hours per day of Respite Care Services for the date range of 8/1/2021 - 1/31/2022. Based on a review of the documentation in the medical record in conjunction with the Medicaid Provider Manual it was determined that the provision of this service does not align with the MPM therefore it has been denied. The MPM states that respite care services are to be provided on a short-term, intermittent basis to relieve the unpaid primary caregiver(s) from care demands. The documentation in this case does not support that respite services are being provided in a manner consistent with this definition.
>
> A MFH was held on 7/28/2021 regarding the authorization of respite in this case. The authorization for respite will be continued through 8/30/2021 to allow time for this decision and order to be received. (Exhibit A, p 2; Testimony)

11. On August 4, 2021, ALJ Steven Kibit issued a Decision and Order in MOAHR docket number 21-002583 which also addressed the issue of five hours per day of respite for Petitioner. (Exhibit A, pp 11-36). ALJ Kibit concluded, in part:

> Petitioner was approved for approximately 8 hours per week of respite care services following the Internal Appeal and given Petitioner's other, substantial paid services, that significant amount of respite care services appears sufficient to meet Petitioner's needs and provide his natural supports with short-term, intermittent relief from the daily stress and care demands during times when they are providing unpaid care. Petitioner has been authorized for a combination of 20 hours per day of CLS and OHSS, in addition to his daily HHS, and, while Petitioner's family provides those services and they demand a lot of time, by policy respite care cannot be provided for relief for providing that *paid* care. Moreover, even if Petitioner requires two caregivers at unspecified times, one of whom would be unpaid, and

> there are unspecified times where CLS and HHS are being provided at the same time without overlapping, which would discount simply adding up his HHS, CLS, OHSS and respite to determining Petitioner's daily paid care, the record fails to reflect that Petitioner's parents are providing unpaid care in such an amount that 5 hours per day of respite care is medically necessary. Petitioner undisputedly requires around-the-clock care, but there are only so many hours in the day; Petitioner is receiving so much paid care; and Petitioner's representatives failed to sufficiently detail what specific unpaid care they are providing, in what specific amount, and why they need intermittent relief from it, as opposed to relief from the demands of providing paid care. Instead, Petitioner and his representatives appear to be seeking respite care as a regular part of daily care when such continuous and long-term services are not the goal or role of respite.
>
> Petitioner also argues that Respondent was previously reversed for reducing Petitioner's respite care authorization from 5 hours per day and that nothing has changed since that reversal with respect to Petitioner's need for respite care, with Respondent also failing to conduct any subsequent evaluation that would support a reduction in respite care. However, Petitioner's argument ignores one distinct change in his circumstances that would clearly warrant a change in his respite care services. Specifically, at the time of its initial decision in this case, Respondent also approved 6 hours per day of OHSS for the first time and such paid services would clearly lessen the need for unpaid care; any stress on Petitioner's natural supports for providing such unpaid care; and, consequently, the need for respite care services. With the approval of 6 hours per day of OHSS, in addition to the reauthorization of 14 hours per day of CLS, Petitioner's paid supports actually increased overall and Petitioner's argument that nothing has changed and that 5 hours per day of respite care remains necessary is unpersuasive. (Exhibit A, p 35)

12. On September 17, 2021, following an internal appeal, CMH issued a Notice of Appeal Denial Partial, which authorized 10 hours of respite per week for the period of August 1, 2021 through February 1, 2021. The Notice indicates, in relevant part:

> We partially **denied** your internal appeal for the service/item listed above because:
>
> You had requested five hours per day of Respite services. The Medicaid Provider Manual (7/1/21) defines Respite as: "Respite care services are provided to a waiver beneficiary on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands when they are providing unpaid care."
>
> Five hours per day is neither a temporary or intermittent basis. This request was made for a consistent authorization for the service on a daily basis. [redacted] is currently authorized to receive paid services and supports daily in the amount of 22.3 hours. 260 hours for a six-month period would allow the authorization to be utilized to relieve unpaid caregivers on a temporary, intermittent basis. In the event that there is a change in his needs, please consult with your Supports Coordinator to request additional units. (Exhibit A, pp 1, 7-10; Testimony)

13. On September 28, 2021, Petitioner filed a request for hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR). (Exhibit 7)

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.

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

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…

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 (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. *See 42 CFR 440.230.*

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
- 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; and

- Made within federal and state standards for timeliness; and

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

- 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; and

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and

- 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;
    - 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.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
July 1, 2021, pp 14-16

SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

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

in his individual plan of services developed through the person-centered planning process.

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

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

The PIHP's enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW habilitative service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Bureau of Community Based Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

****

15.1 WAIVER SUPPORTS AND SERVICES

****

Respite Care Respite care services are provided to a waiver eligible beneficiary 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. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

- "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 periods 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).

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 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 full-time. In those cases,

community living supports or other services of paid support or training staff should be used. The beneficiary's record must clearly differentiate respite hours from community living support services. Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver.

Respite services may be provided in the following settings:

- Waiver beneficiary's home or place of residence.
- Licensed foster care home.
- Facility approved by the State that is not a private residence, such as:
- Group home; or
- Licensed respite care facility.
- Home of a friend or relative (not the parent of a minor beneficiary or the spouse of the beneficiary served or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with a respite worker training, if needed, by the beneficiary or family. These sites are approved by the beneficiary and identified in the IPOS.

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. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) or MDHHS approved day program site is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from community living support services.

Medicaid Provider Manual
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
July 1, 2021, pp 108, 124-125
Emphasis added.

CMH argues that five hours per day of respite does not fit into the MPM definition of respite as being short-term and intermittent. CMH points out that Petitioner receives 14 hours of CLS per day, 6 hours of OHSS per day, and 2.25 hours per day of AHH, for a

total of 22.25 hours of paid support per day. As such, CMH argues that if Petitioner were authorized to receive 5 respite hours per day, the paid care authorized for Petitioner would exceed the number of hours in a day and services cannot overlap. CMH argues that because Petitioner's family also normally serves as Petitioner's paid caregivers, they are not entitled to respite for relief from that paid caregiving. CMH argues that the 260 hours of respite authorized for a six-month period is more than sufficient to provide Petitioner's family intermittent and short-term breaks from the unpaid care they provide to Petitioner.

Petitioner argues that he was not provided the required 10-day notice when the Adverse Benefit Determination was issued on July 30, 2021 because the effective date of the Notice was August 1, 2021. Petitioner then argues that CMH violated federal guidelines by indicating that the actual effective date would be on hold pending a decision in a prior case on the same issue. Petitioner argues that even with the extended effective date, it made it difficult to hire staff because the family did not know what the authorization would be as of September 1, 2021.

Petitioner argues that the definition of respite in the MPM places no limit on the amount of respite that can be authorized per day and CMH's interpretation of this definition does not meet Petitioner's needs. Petitioner argues that the need should be established with each individual case and here, Petitioner needs these services, which have been authorized for several years. Petitioner points out that his needs have not decreased over the years but rather have increased, as have the needs of his natural supports. Petitioner also argues that due to COVID-19, it has been difficult or impossible to hire qualified staff, so Petitioner's unpaid, natural supports are under even more pressure.

Petitioner also argues that while he may be authorized to receive 22 hours of paid support per day, he is unable to utilize this amount due to the staffing crisis in Michigan. As such, Petitioner argues that his unpaid, natural supports must pick up the slack and, therefore, need additional respite. Petitioner argues that natural supports provide anywhere from 14-24 hours of support per day due to Petitioner's high needs, as indicated in his PCP/IPOS. Petitioner argues that due to Petitioner's diet, he needs special meals prepared as well as personal hygiene, supports for medical and sensory needs throughout the day, as well as behavioral interventions.

Petitioner also argues that since the change in Supports Coordination agencies, he has not received needed supports coordination services, which has led to more support having to be done by unpaid, natural supports. Petitioner also argues that the fact that Petitioner was awarded some respite hours at the local appeal means that the original determination was faulty and should be overturned in its entirety.

Petitioner bears the burden of proving by a preponderance of the evidence that the CMH erred in authorizing his respite services. Based on the evidence presented, Petitioner has failed to meet that burden.

First, as indicated above, ALJ Steven Kibit considered the same issue of Petitioner's request for five hours per day of respite and concluded in a Decision and Order issued

August 4, 2021 that CMH's denial of that request was proper. Nothing much has changed with Petitioner's circumstances since that decision and it is still applicable to the facts of the present case. As such, that Decision and Order is adopted in its entirety and incorporated into this decision. Petitioner's parents made many of the same arguments in that case as in the present case and ALJ Kibit's findings are amply supported in the record here as well.

Furthermore, as indicated above, respite services may be 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." According to policy, short term means, ". . . 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 periods in between." Primary caregivers "are typically the same people who provide at least some unpaid supports daily." And, unpaid means "that respite may only be provided during those portions of the day when no one is being paid to provide the care."

Here, Petitioner is requesting 35 hours of respite per week, or an average of five hours of respite every day, 365 days per year. While one could argue that five hours is "short-term", as in a "limited period of time" when compared to the 24 hours of care per day Petitioner requires, five hours per day, every day can in no way be considered intermittent. Clearly, five hours of respite per day, every day, is regular and continuous. And, while there is a break of 19 hours in between each respite service, the fact that the same pattern repeats itself every day is regular and continuous. Furthermore, the 260 hours of respite authorized for a six-month period following the local appeal seems a more reasonable amount to give Petitioner's unpaid, natural supports short, intermittent breaks during the week.

Again, Petitioner's arguments to the contrary are not persuasive and many of the arguments were addressed by ALJ Kibit in his decision. First, while the Adequate Benefit Determination should have provided a 10-day notice given that the authorization request amounted to the continuation of a previously authorized service, the Notice went on to indicate that the benefits would be continued for 30 days while waiting on the decision from the case in front of ALJ Kibit, as discussed above. In addition, as ALJ Kibit pointed out in his Decision and Order, the remedy for failure to follow the notice requirements is not a reversal of the action.

Second, while the undersigned agrees with Petitioner that respite should be determined individually for each beneficiary, the amount requested here seems excessive given the amount of paid supports Petitioner receives. Again, 260 hours of respite authorized for a six-month period seems like a more reasonable authorization for Petitioner, even given his high needs.

In addition, while the undersigned is aware of the staffing shortage in Michigan and the effect that has on unpaid, natural supports like Petitioner's parents and brothers, here Petitioner has three family members caring for him in both a paid and unpaid capacity.

Surely, even if Petitioner sometimes requires two persons to care for him, 260 hours of respite authorized for a six-month period should be sufficient to meet Petitioner's needs.

Also, the fact that CMH authorized some respite at the internal appeal does not mean, as Petitioner argues, that the original decision needs to be reversed. Such a finding would be contrary to the internal appeal procedure as outlined in 42 CFR 438.402 and 42 CFR 438.408.

Other issues raised by Petitioner were addressed in ALJ Kibit's Decision and Order, as previously mentioned.

Finally, it must be mentioned that it appears part of CMH's issue with Petitioner's respite request was the way it was worded, i.e., requesting five hours per day. In the future, Petitioner's supports coordinator may want to request a six-month total of respite hours at once, like CMH's authorization of 260 respite hours. That way, the respite hours can be used as needed over the six-month period and will better fit respite's definition of short-term and intermittent.

However, based on the evidence presented, CMH's decision was proper and must be upheld.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly authorized Petitioner's respite.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

RM/dh

Robert J. Meade
Administrative Law Judge
for Elizabeth Hertel, Director
Department of Health and Human Services

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30763
Lansing, Michigan 48909-8139

DHHS -Dept Contact	Belinda Hawks 320 S. Walnut St. 5th Floor Lansing, MI 48913
Authorized Hearing Rep.	[redacted] MI [redacted]
DHHS-Location Contact	David Pankotai Macomb County CMHSP 22550 Hall Road Clinton Township, MI 48036
Petitioner	[redacted] MI [redacted]
Agency Representative	Stacy E. Coleman 22550 Hall Road Clinton Township, MI 48036