STATE OF MICHIGAN
GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

MARLON BROWN
DIRECTOR

[redacted]
[redacted] MI [redacted]

Date Mailed: July 23, 2024
MOAHR Docket No.: 24-004825
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 hearing was held on June 13, 2024. [redacted] Petitioner's mother and guardian, appeared and testified on Petitioner's behalf. [redacted] father and co-guardian; Haleigh Hardy, Case Manager, Summit Point; and Elizabeth Wygant, Director Community Living Services, Summit Point, appeared as witnesses.

Heather Woods, Member Services Specialist, appeared and testified on behalf of Respondent, Southwest Michigan Behavioral Health (SWMBH), the PIHP for Respondent Summit Point. (Respondent or CMH.) Ellie DeLeon, LLP, Strategic Initiatives Project Manager SWMBH; Mandi Quigley, Corporate Compliance Director, Summit Point; and Amy Vincent, Customer Service, Summit Point, appeared as witnesses for Respondent.

ISSUE

Did the CMH properly authorize Petitioner's Private Duty Nursing (PDN) 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 Medicaid beneficiary who has been receiving services through CMH. (Exhibit A; 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; Testimony)

3. Petitioner resides in a single-family home with his parents. (Exhibit A, p 13; Testimony)

4. Petitioner is diagnosed with a profound intellectual disability, seizure disorder, severe scoliosis, and cerebral palsy. (Exhibit A, p 14; Testimony)

5. In early 2024, Petitioner's guardian requested continued 24/7 PDN services for Petitioner under the Habilitation Supports Waiver (HSW). (Exhibit 1; Testimony.)

6. On March 27, 2024, CMH sent Petitioner an Adverse Benefit Determination indicating that Petitioner's PDN would be reduced from 24 to 16 hours per day. (Exhibit A, pp 3-5; Testimony.) Specifically, the notice indicated, in relevant part:

> [redacted] current Private Duty Nursing (PDN) services will be reduced. At this time, [redacted] is receiving 24 hours/day of PDN between two providers, Lakeshore Home Health and Maxim Healthcare Services. The Michigan Department of Health and Human Services (MDHHS) guidelines do not allow for more than 16 hours per day of PDN services.
>
> Because of these guidelines, [redacted] can not meet criteria to continue to receive 24 hours/day of PDN services as outlined in the Michigan Medicaid Provider Manual (Section 15: Habilitation Supports Waiver for Persons with Developmental Disabilities). The Code of Federal Regulations (42 CFR 440.230 (d)) provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or utilization control procedures.
>
> [redacted] current authorization(s) for PDN have been updated to state that PDN will not exceed 16 hours daily between both Lakeshore Home Health and Maxim Healthcare.
>
> You can share a copy of this decision with your provider so you and your provider can discuss next steps. If your Provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.
>
> (Exhibit A, p 3.)

7. Petitioner filed a local appeal. (Exhibit A, pp 6-7; Testimony.)

8. On April 26, 2024, following the internal appeal, CMH sent Petitioner a Notice of Appeal Denial, which upheld the original reduction in PDN. (Exhibit A, pp 6-8; Testimony.) Specifically, the notice indicated in relevant part:

> Your Internal Appeal was denied for the service/item listed above because:
>
> The account was reviewed by Elizabeth Philpott LMSW on 04/26/24, the original decision to reduce [redacted] Private Duty Nursing services to 16 hours per day split between the two providers (Lakeshore Home Health and Maxim Healthcare Services) is being upheld. The Department of Health and Human Services (MDH1-IS) guidelines do not allow for more than 16 hours per day of Private Duty Nursing (PDN) services. Summit Pointe is not able to authorize more hours per day than what is allowable in the Michigan Department of Health and Human Services guidelines.
>
> You should share a copy of this decision with your provider so you and your provider can discuss next steps. If your Provider requested coverage on your behalf, we have sent a copy of this decision to your provider.
>
> (Exhibit A, p 6.)

9. On May 7, 2024, Petitioner's request for hearing was received by the Michigan Office of Administrative Hearings and Rules. (Exhibit 1.)

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:

> **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 their 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, does not receive at least one HSW habilitative service per month, withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Division of Adult Home and 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

Private Duty Nursing (PDN)

Private Duty Nursing (PDN) services are skilled nursing interventions provided to individuals age 21 and older, up to a maximum of 16 hours per day, to meet an individual's health needs that are directly related to their developmental disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the written health care plan which is part of the beneficiary's individual plan of services (IPOS). PDN services are for beneficiaries who require more individual and continuous care than periodic or intermittent nursing available through state plan services, e.g., Home Health. The individual receiving PDN must also require at least one of the following habilitative services, whether being provided by natural supports or through the waiver.

- Community living supports
- Out-of-home non-vocational habilitation
- Prevocational or supported employment

To be determined eligible for PDN services, the PIHP must find that the beneficiary meets Medical Criteria I as well as Medical Criteria III, or meets Medical Criteria II as well as Medical Criteria III. Regardless of whether the beneficiary meets Medical Criteria I or II, the beneficiary must also meet Medical Criteria III.

Medical Criteria I – The beneficiary is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

- Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate-dependent respiration (e.g., some models of Bi-PAP); or
- Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or
- Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or

- Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or

- Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below.

Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments or interventions (as described in **III** below) due to a substantiated medical condition directly related to the developmental disability.

Definitions:

- "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months. "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.

- "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

- "Directly related to the developmental disability" means an illness, diagnosis, or syndrome occurred during the developmental period prior to age 22, is likely to continue indefinitely, and results in significant functional limitations in 3 or more areas of life activity. Illnesses or disability acquired after the developmental period, such

as stroke or heart conditions, would not be considered directly related to the developmental disability.

- "Substantiated" means documented in the clinical/medical record, including the nursing notes.

Medical Criteria III – The beneficiary requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

Definitions:

- "Continuous" means at least once every 3 hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.

- Equipment needs alone do not create the need for skilled nursing services.

- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:

  - performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;

  - managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the beneficiary four or more hours per day;

  - deep oral (past the tonsils) or tracheostomy suctioning;

  - injections when there is a regular or predicted schedule, or prn injections that are required at least once per month (insulin administration is not considered a skilled nursing intervention);

  - nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility;

  - total parenteral nutrition delivered via a central line and care of the central line;

- continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below;

- monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

Once the Medical Criteria eligibility for PDN has been established, and as part of determining the amount of PDN a beneficiary is eligible for, the Intensity of Care category must be determined. This is a clinical judgment based on the following factors:

- The beneficiary's medical condition;
- The type and frequency of needed nursing assessments, judgments and interventions; and
- The impact of delayed nursing interventions.

Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary but do not determine the amount of hours of nursing for which the beneficiary is eligible.

High Category

Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period when delayed nursing interventions could result in further deterioration of health status, in loss of function, death, or in acceleration of the chronic condition.

Medium Category

Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least one time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function, death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care.

Low Category

Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.

The amount of PDN hours authorized represents a monthly total determined by calculating an average amount of PDN per day multiplied by the number of days in the month. The beneficiary has the flexibility to use the hours as needed during the month, not to exceed the total monthly authorized amount.

The amount of PDN (i.e., the number of hours that can be authorized for a beneficiary) is determined through the person-centered planning process to address the individual's unique needs and circumstances. Factors to be considered should include the beneficiary's care needs which establish medical necessity for PDN; the beneficiary's and family's circumstances (e.g., the availability of natural supports); and other resources for daily care (e.g., private health insurance, trusts, bequests). Although the person-centered planning process is used to determine the exact amount of PDN specified in the IPOS, in general, a beneficiary who has Low Category PDN needs would require eight or fewer hours per day, a beneficiary who has Medium Category PDN needs would require 12 or fewer hours per day, and a beneficiary who has High Category PDN needs would require 16 or fewer hours per day.

The nurse may provide personal care only when incidental to the delivery of PDN, e.g., diaper changes, but may not provide routine personal care. The provision of personal care in unlicensed homes is through Home Help, a state plan service. If the beneficiary receiving PDN services demonstrates the need for Home Help services, the IPOS must document coordination of Home Help and PDN to assure no duplication of services.

Licensed nurses provide the nursing treatments, observation, and/or teaching as ordered by a physician, and that are consistent with the written individual plan of services.

These services should be provided to a beneficiary at home or in the community. A physician's prescription is required as defined in the General Information section of this chapter.

The PIHP must assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Champs, Worker's Compensation, an indemnity policy, automobile insurance) for private duty nursing and will assist the beneficiary in selecting a private duty nursing provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a beneficiary.

If a beneficiary is attending school and the Individualized Education Plan (IEP) identifies the need for PDN during transportation to and from school and/or in the classroom, the school is responsible for providing PDN during school hours. For adults up to age 26 who are enrolled in school, PDN services are not intended to supplant services provided in school or other settings or to be provided during the times when the beneficiary would typically be in school but for the parent's choice to home-school.

An exception process to ensure the beneficiary's health, safety and welfare is available if the beneficiary's needs exceed the 16-hours-per-day maximum for a time-limited period not to exceed six months. Factors underlying the need for additional PDN must be identified in the beneficiary's plan, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception; and
- Additional PDN services are essential to the successful implementation of the beneficiary's written plan of care and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to their condition.

Exceptions must be based on the increased identified medical needs of the beneficiary or the impact on the beneficiary's needs due to the unavailability of the primary unpaid caregiver. Consideration for an exception is limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

- A temporary alteration in the beneficiary's care needs, resulting in one or both of the following:

  - A temporary increase in the intensity of required assessments, judgments, and interventions.

  - A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs.

The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the beneficiary's increased medical needs for a maximum of six months.

- The temporary inability of the primary unpaid caregiver(s) to provide the required care, as the result of one of the following:

  - In the event the caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. Upon discharge from the hospital, or in the event of an acute illness or injury of the caregiver, the total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the caregiver's limitations and the needs of the beneficiary as it relates to those limitations, not to exceed six months.

  - The death of the primary caregiver. The initial amount of hours allowable under this exception is 24 hours per day for 14 days. Subsequent exceptions can be approved up to an additional 60 days, with monthly reviews thereafter by the PIHP/CMHSP.

  - The death of an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days.

"Inability" is defined as the caregiver is either unable to provide care or is prevented from providing care.

"Primary caregiver" is defined as the caregiver who provides the majority of unpaid care.

"Unpaid care" is defined as care provided by a caregiver where no reimbursement is received for those services, e.g., is not being paid as a Home Help provider or Community Living Supports staff.

> This exception is not available if the beneficiary resides in a licensed setting or in a home where all care is provided by paid caregivers.
>
> In the event that a transition plan has been developed wherein PDN services are to be reduced or eliminated based on a determination of medical necessity, the PIHP may provide PDN for a period of time (not to exceed three months) for the purpose of training the CLS or respite aides or family and assuring a smooth transition. In those cases, the transition plan, including amount, scope, frequency and duration of the training by nurses to aides, must be documented in the IPOS. A transition process is not intended to provide two-to-one (nurse and aide) staffing for any purpose other than for training (with limitations on duration and frequency noted in the IPOS) while the aide or family member becomes familiar with the beneficiary's care needs. This transition period is only permitted when it has been determined that PDN is not medically necessary and the beneficiary's care needs can be met by a trained CLS or respite aide.
>
> *Medicaid Provider Manual*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *January 1, 2024, pp 123, 133-139*
> *Emphasis added.*

CMH argued that policy limits the maximum amount of PDN a beneficiary can receive under the HSW to a maximum of 16 hours per day. CMH noted that Petitioner does have intense needs, requires 24/7 care, and would be at risk for out of home placement without that care. CMH argued that while Petitioner does not meet any of the exception criteria for a short-term authorization of more than 16 hours of PDN per day, there are alternatives available, including using CLS to make up the difference. CMH also noted that the MI Choice Waiver is another alternative for Petitioner because that program may not have the 16 hour per day cap on PDN.

Petitioner's mother noted that when she met with CMH, they discussed the possibility of transferring Petitioner to the MI Choice Waiver and CMH said the transition would be seamless. Petitioner's mother indicated that they have done an assessment with one of the MI Choice Waiver agencies in the area but were told Petitioner did not meet the requirements. Petitioner's mother inidcated that they were going to try the other MI Choice Waiver agency in the area. Petitioner's father noted that Petitioner does better at home and his quality of life is better. Petitioner's father indicated that Petitioner has not done well in out of home placement in the past.

Petitioner bears the burden of proving by a preponderance of the evidence that the CMH erred in authorizing Petitioner's PDN.

As CMH correctly points out, Medicaid policy limits PDN to 16 hours per day for beneficiaries receiving services under the HSW. Specifically, that policy indicates, "Although the person-centered planning process is used to determine the exact amount

of PDN specified in the IPOS, in general, . . . a beneficiary who has High Category PDN needs would require 16 or fewer hours per day." Here, Petitioner is in the "High" category of PDN, so his PDN is limited to a maximum of 16 hours per day. And, while there is an exception to the 16 PDN hour per day maximum, Petitioner does not meet the exception criteria here. The exception policy does, however, reiterate that the maximum amount of PDN per day that may be authorized is 16 hours: "An exception process to ensure the beneficiary's health, safety and welfare is available if the beneficiary's needs exceed the 16-hours-per-day maximum for a time-limited period not to exceed six months." (Emphasis added.)

Here, Petitioner requires 24/7 care but does not meet the exception requirements for a short term authorization of more PDN under the HSW. However, there are alternatives available to Petitioner to supplement the approved 16 hours per day of PDN, namely CLS services and/or Home Help Services (HHS). As indicated above, policy provides, "The nurse may provide personal care only when incidental to the delivery of PDN, e.g., diaper changes, but may not provide routine personal care." In other words, CLS and/or HHS workers may be able to assist Petitioner with routine personal care. Further, Petitioner may be able to obtain more than 16 hours of PDN per day through the MI Choice Waiver.

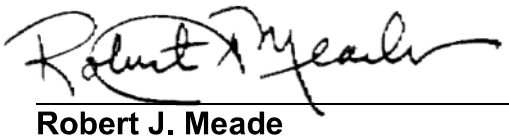
However, based on the evidence presented, the CMH's decision was proper and should be upheld. The policy here is clear and this ALJ has no authority to ignore clear policy or to grant any equitable relief. *Huron Behavioral Health v Department of Community Health*, 293 Mich App 491 (2011).

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that CMH properly authorized Petitioners' PDN according to policy.

IT IS THEREFORE ORDERED that:

The CMH decision is **AFFIRMED**.



RM/sj

Robert J. Meade
Administrative Law Judge

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

PROOF OF SERVICE

I certify that I served a copy of the foregoing document upon all parties, to their last known addresses in the manner specified below, this 23rd day of July 2024.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic Mail:

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