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

Date Mailed: July 24, 2025
Docket No.: 25-016813
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
[redacted] MI [redacted]

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

هذه وثيقة قانونية مهمة. يرجى أن يكون هناك شخص ما يترجم المستند.

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

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这是一份重要的法律文件。请让别人翻译文件。

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

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Case No.: [redacted]
Petitioner: [redacted]

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 video hearing was held on July 16, 2025. Attorneys Matthew Nagai and Daniel R. Wojciak appeared on Petitioners' behalf. [redacted] and [redacted] Petitioner's parents and guardians, appeared as witnesses.

Attorneys Daniel J. Ferris and Kathleen A. Westfall appeared on behalf of the Department's Waiver Agency, Region 3 Area Agency on Aging, d/b/a CareWell Services. (Respondent or Waiver Agency). Amber Logsdon, MSN, BSN, RN, Chief Clinical Officer and Megan Bently, RN, Supports Coordinator, appeared as witnesses for Respondent.

EXHIBITS

Petitioner's Exhibits:

Exhibit 1: Person-centered Service Plan proposal from [redacted] and [redacted] (4/17/2025)

Exhibit 2: MDHHS letter to Stacy Wines, Chief Executive Officer Region 3B Area Agency on Aging (5/23/2025)

Exhibit 3: CareWell Adequate Action Notice (9/30/2024)

Exhibit 4: CareWell Person-Centered Service Plan (4/02/2025)

Exhibit 5: Letter from Dr. Eric J. Smith (5/19/2025)

Exhibit 6: Medicaid Provider Manual – MI Choice Chapter (select pages, 7/01/2025)

Exhibit 7: Federal Register / Vol. 79, No. 11 (1/16/2014)

Exhibit 8: Emails (various dates)

Respondent's Exhibits:

Exhibit A: March 20, 2025 Assessment

Exhibit B: April 10, 2024 Milestone Assessment

Exhibit C: August 20, 2024 Assessment

Exhibit D: Manual, MI Choice Waiver, July 1, 2025, § 4.1.M, p. 43

Exhibit E: Application for §1951(c) Home and Community Based Services Waiver, October 1, 2023

Exhibit F: Transcript of February 6, 2025 prehearing conference

Exhibit G: Petitioner [redacted] Hearing Brief

Exhibit H: Proposed Revisions to the Backup Plan and PCSP

Exhibit I: March 20, 2025 Person-Centered Service Plan

ISSUE

Did the Waiver Agency properly authorize Petitioner's Private Duty/Respiratory Care Nursing (PDN/RC)?

FINDINGS OF FACT

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

1. The Department contracts with the Waiver Agency to provide MI Choice Waiver services to eligible beneficiaries. (Exhibits D, E, Testimony.)

2. The Waiver Agency must implement the MI Choice Waiver program in accordance with Michigan's waiver agreement, Department policy and its contract with the Department. (Exhibits D, E; Testimony.)

3. Petitioner is diagnosed with cerebral palsy, spastic quadriplegia, arthritis, osteoporosis, and seizure disorder. (Exhibit A, p 9; Testimony.) Petitioner is bed/wheelchair-bound and dependent on others for all his needs. (*Id.*, p 17.) Petitioner has a tracheostomy and uses a ventilator, requires frequent suctioning, has contractures in his hands, has a feeding tube, and must be turned and repositioned every two hours. (*Id.*, pp 12, 17, 19, 20.)

4. Petitioner is non-verbal and his cognitive abilities have been described as similar to that of a one-year-old. (Exhibit A, p 16; Exhibit B, pp 5-6; Testimony.) Petitioner is unable to direct his own care or make decisions for himself without assistance. (Exhibit A, p 17; Testimony.)

5. Petitioner requires 24/7 supervision/support and cannot be left alone for any period of time. (Exhibit A, p 18; Testimony.) If Petitioner were left alone, there would be a risk of severe injury or death. (*Id.*, p 19.) Petitioner requires total assistance for all activities of daily living and instrumental activities of daily living. (*Id.*, p 17.)

6. Up until 2020, Petitioner was receiving 24/7 PDN coverage, with 8 hours being provided by his private insurance (Blue Cross Blue Shield) and 16 hours provided under the Habilitation Supports Waiver (HSW) through Summit Pointe, a provider in his local pre-paid inpatient health plan. (Petitioner's Brief, p 3; Testimony.)

7. In 2020, Summit Pointe began providing Petitioner 24/7 PDN under the HSW to make up for the PDN hours lost from BCBS. (*Id.*)

8. On March 27, 2024, Summit Pointe informed Petitioner that it would be reducing his PDN to 16 hours per day to comply with Medicaid policy. (*Id.*) Petitioner appealed this decision, but the decision was upheld following an administrative hearing in a decision dated July 23, 2024. (*Id.*)

9. Since July 23, 2024, Petitioner's parents have either been paying privately for 8 hours of PDN per day or providing the care themselves. (*Id.*)

10. At the hearing in 2024, Petitioner's parents were informed that they might want to seek services through their local MI Choice Waiver agency because MI Choice Waiver policy does not have the same 16-hour limit per day on PDN as the HSW. (*Id.*)

11. Petitioner's parents then contacted Respondent and applied for services in the hopes of having 24/7 PDN restored. (*Id.*)

12. On August 20, 2024, Respondent completed an assessment of Petitioner with his parents. (*Id.*)

13. On September 30, 2024, Respondent issued an Adequate Action Notice to Petitioner informing him that he was ineligible for the MI Choice Waiver program because he required 24/7 PDN. (Exhibit 3; Testimony.)

14. On December 27, 2024, Petitioner appealed Respondent's denial into the MI Choice program. (Petitioner's Brief, p 4; Testimony.)

15. On March 11, 2024, Respondent agreed to set aside its denial, dismiss

Petitioner's appeal, and reassess Petitioner. (*Id*.)

16. On March 20, 2025, Respondent performed another in-person assessment of Petitioner. (*Id*.)

17. On April 2, 2025, following a meeting with Petitioner's parents on March 28, 2025, Respondent sent Petitioner's parents a proposed Person Centered Plan (PCP) in which it authorized 16 hours of PDN/RC per day with Petitioner's parents providing the additional 8 hours of PDN/RC per day as informal supports. (Exhibit 4; Testimony.)

18. On April 17, 2025, Petitioner's parents sent Respondent a counter proposal of the PCP in which they agreed to provide 0.25 hours of PDN/RC per day with Respondent providing 23.75 hours of PDN/RC per day. (Exhibit 1; Testimony.) In the counter proposal, Petitioner's parents offered to continue as backup caregivers and cover any missed nursing shifts, provide gap coverage, and cover for any late arriving nurses. (*Id*.)

19. On April 22, 2025, Respondent acknowledged receipt of the counter PCP and promised to respond. (Petitioner's Brief, p 4; Testimony.)

20. On April 29, 2025, Respondent informed Petitioner's parents that a PCP must be approved within 30 days or the process needs to start over. (*Id*.)

21. On May 6, 2025, after being informed by MDHHS that there is no such 30-day requirement in policy, Respondent retracts the 30-day requirement and says it will send appeal paperwork to Petitioner. (Petitioner's Brief, p 5; Testimony.) Respondent never sent Petitioner's parents appeal paperwork or any notice supporting its denial of Petitioner's counter-proposal. (*Id*.)

22. On May 6, 2025, Petitioner's parents filed a request for a State Medicaid Fair Hearing. (*Id*.)

23. On May 19, 2025, Petitioner's treating physician provided updated medical support for Petitioner's need for 24/7 PDN/RC. (Exhibit 5; Testimony.)

24. On May 23, 2025, MDHHS sent a letter to Respondent instructing Respondent to approve the PCP modifications offered by Petitioner's parents and enroll Petitioner in the MI Choice program. (Exhibit 2; Testimony.)

25. Respondent ignored MDHHS' instructions and this matter proceeded to hearing. (Petitioner's Brief, p 5; Testimony.)

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.

Here, Petitioner is claiming services through the Department's Home and Community Based Services for Elderly and Disabled (HCBS/ED). The waiver is called MI Choice in Michigan. The program is funded through the federal Centers for Medicare and Medicaid (formerly HCFA) to the Michigan Department of Health and Human Services (MDHHS). Regional agencies function as the Department's administrative agency.

> Waivers are intended to provide the flexibility needed to enable States to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of recipients. Waivers allow exceptions to State plan requirements and permit a State to implement innovative programs or activities on a time-limited basis, and subject to specific safeguards for the protection of recipients and the program. Detailed rules for waivers are set forth in subpart B of part 431, subpart A of part 440 and subpart G of part 441 of this chapter. *42 CFR 430.25(b)*

A waiver under section 1915(c) of the [Social Security] Act allows a State to include as "medical assistance" under its plan, home and community based services furnished to recipients who would otherwise need inpatient care that is furnished in a hospital, SNF [Skilled Nursing Facility], ICF [Intermediate Care Facility], or ICF/MR [Intermediate Care Facility/Mentally Retarded], and is reimbursable under the State Plan. 42 CFR 430.25(c)(2).

Home and community based services means services not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this subchapter. 42 CFR 440.180(a).

According to 42 CFR 440.180(b), home or community-based services may include the following services, as they are defined by the agency and approved by CMS:

- Case management services.
- Homemaker services.
- Home health aide services.

- Personal care services.
- Adult day health services
- Habilitation services.
- Respite care services.
- Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.
- Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization.

Medicaid policy in Michigan is contained in the Medicaid Provider Manual (MPM). With regard to the issues in this appeal, the MPM provides:

4.1.M. PRIVATE DUTY NURSING/RESPIRATORY CARE

Definition

Private Duty Nursing/Respiratory Care (PDN/RC) services are skilled nursing or respiratory care interventions provided to a participant age 21 and older on an individual and continuous basis to meet health needs directly related to the participant's physical disorder. PDN/RC includes the provision of skilled 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 participant's person-centered service plan. RC may be provided by a licensed respiratory therapist to a participant who is ventilator dependent. To be eligible for PDN/RC services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III.

The participant's PCSP must provide reasonable assurance of participant safety. This includes a strategy for effective backup in the event of an absence of providers. The backup strategy must include informal supports or the participant's capacity to manage their care and summon assistance.

PDN/RC for a participant between the ages of 18-21 is covered under the State Plan.

Requirements

Through a person-centered planning process, the waiver agency must determine the length and duration of services provided.

The direct service provider must maintain close contact with the authorizing waiver agency to promptly report changes in each participant's condition and/or treatment needs upon observation of such changes.

The direct service provider must send case notes to the supports coordinator on a regular basis, preferably monthly, but no less than quarterly, to update the supports coordinator on the condition of the participant.

This service may include medication administration as defined under Michigan law.

The waiver agency is responsible for assuring there is a physician order for the PDN services authorized. The physician may issue this order directly to the provider furnishing PDN/RC services. However, the waiver agency is responsible for assuring the PDN/RC provider has a copy of these orders and delivers PDN/RC services according to the orders.

The waiver agency must maintain a copy of the physician orders in the case record.

Medical Criteria

To be eligible for PDN/RC services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III.

Medical Criteria I – The participant 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-level positive airway pressure [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 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 P02 level is 55 mm HG or below.

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

Definitions of Medical Criteria II:

- "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 who is qualified to furnish such services and that 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 that 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 physical disorder" means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in three or more ADL.

- "Substantiated" means documented in the clinical or medical record, including the progress notes.

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

Definitions of Medical Criteria III:

- "Continuous" means at least once every three hours throughout a 24-hour period, and 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 services.

- "Skilled" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse or respiratory therapist. Skilled 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 participant 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 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 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 P02 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.

Limitations

Participants receiving MI Choice Nursing Services are not eligible to receive PDN/RC services.

All PDN/RC services authorized must be medically necessary as indicated through the MI Choice assessment and meet the medical criteria described above.

The participant's physician, physician assistant, or nurse practitioner must order PDN/RC services and work in conjunction with the waiver agency and provider agency to ensure services are delivered according to that order. Orders should be updated on an annual basis unless the order

states otherwise due to ongoing medical need that is unlikely to improve over time.

PDN is limited to persons age 21 or older. PDN is a State Plan benefit for persons under the age of 21 who qualify for the service.

It is not the intent of the MI Choice program to provide PDN/RC services on a continual 24-hours-per-day/7-days-per-week basis. MI Choice services are intended to supplement informal support services available to the participant. Only under extreme circumstances should 24/7 PDN/RC be authorized for a participant. These circumstances must be clearly described on the person-centered service plan and approved by MDHHS.

PDN/RC services provided 24/7 cannot be authorized for participants who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency backup plan without assistance.

These participants must have informal caregivers actively involved in providing some level of direct services to them on a routine basis.

Providers of PDN/RC must be licensed by the State of Michigan.

Medicaid Provider Manual
MI Choice Waiver Section
April 1, 2025, pp 40-43
Emphasis added

The MI Choice Waiver Program is a Medicaid-funded program and its Medicaid funding is a payor of last resort. In addition, Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services. *42 CFR 440.230.* To assess what MI Choice Waiver Program services are medically necessary, and therefore Medicaid-covered, the Waiver Agency performs periodic assessments.

Petitioner bears the burden of proving, by a preponderance of evidence, that the Waiver Agency erred in authorizing and/or delivering their medically necessary services.

Here, Petitioner argues that his parents already provide significant informal supports and services to Petitioner outside of PDN/RC so their offer to provide 0.25 hours of PDN/RC per day is entirely reasonable and supported by policy. Petitioner also argues that Respondent cannot compel Petitioner's parents to provide informal support and, since all agree Petitioner requires 24/7 PDN/RC, Respondent must provide the medically necessary services.

Respondent argues that Petitioner is only entitled to 16 hours of PDN/RC per day

because MI Choice services are only available to supplement informal supports and Petitioner's parents have been voluntarily providing 8 hours of PDN/RC per day for the past year. Respondent also argues that MDHHS' interpretation of law and policy is incorrect and conflicts with the spirit and purpose of the MI Choice program.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent improperly authorized his PDN/RC Based on the evidence presented, Petitioner has proven by a preponderance of the evidence that the Waiver Agency erred in denying Petitioner's requests.

Ultimately, what this case comes down to is the interpretation of two paragraphs of policy in the MPM. Specifically, Section 4.1.M., Private Duty Nursing/Respiratory Care, of the MI Choice Chapter in the MPM provides, under the heading "Limitations" the following:

> It is not the intent of the MI Choice program to provide PDN/RC services on a continual 24-hours-per-day/7-days-per-week basis. MI Choice services are intended to supplement informal support services available to the participant. Only under extreme circumstances should 24/7 PDN/RC be authorized for a participant. These circumstances must be clearly described on the person-centered service plan and approved by MDHHS.
>
> PDN/RC services provided 24/7 cannot be authorized for participants who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency backup plan without assistance. These participants must have informal caregivers actively involved in providing some level of direct services to them on a routine basis.

When construing the meaning of statutory language, this ALJ's goal is to discern the [drafter's] intent. *TMW Enters v Dep't of Treasury*, 285 Mich App 167, 172; 775 NW2d 342 (2009). The best and most reliable indicator of that intent is the plain language used and therefore the starting point for analysis is the language of the text itself. *Id*. This ALJ must view the statutory language in context, considering "both the plain meaning of the critical word or phrase as well as its placement and purpose in the statutory scheme." *Sun Valley Foods Co v Ward*, 460 Mich 230, 237; 596 NW2d 119 (1999).

So, under the plain language used in the above policy, the MI Choice Program is not intended to provide 24/7 PDN/RC, except in extreme circumstances. Also, participants who cannot direct their own services, such as Petitioner, must have informal caregivers actively involved in providing "some" level of services on a routine basis.

Here, the parties agree on the first provision but disagree as to what constitutes "some" level of services to be provided by Petitioner's parents.

Petitioner argues that since his parents cannot be compelled to provide informal supports, 15 minutes per day of PDN/RC, plus all the other informal support they

provide, is sufficient to meet the requirements of policy. Respondent does not recognize the other informal supports Petitioner's parents provide, and argues that 15 minutes of PDN/RC per day is inadequate to meet the definition of "some" level of services in policy.

Based on the evidence presented, it is more likely that Petitioner's interpretation of law and policy is correct. First, this is an extreme circumstance because, as the parties agree, Petitioner would likely die without 24/7 skilled care. And, while Respondent seems to argue that some of that "care" only consists of monitoring, which is not skilled, the point is that skilled care needs to be available 24/7 to respond to Petitioner's particular needs as they arise.

So, given that this is an emergency situation, the provision of 24/7 PDN must be approved by MDHHS per policy. Here, MDHHS has not only approved Petitioner's request for PDN in this case, but it also directly ordered Respondent to provide that care. (Exhibit 2.)

Furthermore, Respondent should keep in mind that the care they are requesting Petitioner's parents to provide is every day – 7 days per week, 365 day per year. So, if Petitioner's parents are to provide 8 hours of PDN/RC per day, that equals 56 hours of PDN per week, 224 hours per month, and 2,912 hours per year.

And, while Respondent offers respite services to provide Petitioner's parents a break, respite care specifically does not include skilled nursing care. In other words, Petitioner's parents would never get a break unless they pay out of pocket for skilled care, which they have done in the past year.

In addition, Petitioner's parents provide more care for Petitioner than just PDN/RC. Petitioner's parents also provide tracheostomy care, suctioning, and tube changes; daily range of motion and motor skills exercises; repositioning Petitioner in his wheelchair and bed in order to massage cramps; repositioning Petitioner in bed to avoid skin breakdown; ordering medical supplies and prescriptions; scheduling equipment maintenance and traveling to the medical equipment supplier; scheduling doctor appointments; and charting all the tasks they've performed for Petitioner so nursing staff know what has or has not been completed that day. Petitioner's parents also serve, and will continue to serve, as unpaid backup providers for when Petitioner's nurses miss a shift due to illness, medical appointments, dangerous weather, etc. Petitioner's parents testified credibly that the need for backup care comes up on a regular basis.

Respondent also argues that their proposal is reasonable because Petitioner's parents have voluntarily been providing 8 hours of PDN/RC per day for the past year. However,

the fact that Petitioner's love their son and want to keep him alive should not be confused with them providing "voluntary" care. As indicated, for many years, Petitioner's parents received 24/7 PDN care for Petitioner and they sought services through the MI Choice Waiver because the Waiver does not have the same hard cap of 16 hours as the HSW. All parties are aware of these facts so for Respondent to argue that Petitioner's parents have been voluntarily providing 8 hours of PDN/RC per day for the past year is disingenuous at best.

And, as Petitioner points out, Respondent cannot compel Petitioner's parents to provide informal supports. While the PCP must identify individuals, both paid and unpaid, who will provide a beneficiary support, and any informal supports must be provided on a voluntary basis. (See 42 CFR 441.301(c)(2)(v)).

The MPM also supports that informal supports must be voluntary, stating that informal supports are "unpaid supports that choose to volunteer their time to assist participants in lieu of MI Choice services and supports." (Exhibit 6, p 62.) Furthermore, comments from CMS on the federal regulation indicate that the "planning process must not compel unpaid services." (Exhibit 7.) Having established that Petitioner's parents, who are now in their 70's, are no longer willing or able to provide as much support as they have in the past, Respondent cannot compel them to do so.

Therefore, based on the evidence presented, Petitioners have proven by a preponderance of the evidence that the Waiver Agency's actions were improper. The Waiver Agency must enroll Petitioner in the MI Choice Waiver program and approve the modifications in the PCP Petitioner's parents submitted, which includes the approval of 23.75 hours of PDN/RC per day.

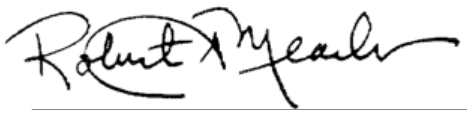
DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Waiver Agency's actions were improper.

IT IS THEREFORE ORDERED that:

The Waiver Agency's decision is **REVERSED**.

Within 10 days of the issuance of this Decision and Order, the Waiver Agency must certify that it has taken steps to enroll Petitioner in the MI Choice Waiver program and approve the modifications in the PCP Petitioner's parents submitted, which includes the approval of 23.75 hours of PDN/RC per day.



ROBERT J. MEADE
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to 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.

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