STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
Christopher Seppanen
Executive Director

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

Date Mailed: October 7, 2016
MAHS Docket No.: 16-009546
Agency No.: 0
Petitioner: n

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon Petitioner's request for a hearing.

After due notice, a telephone hearing was held on September 20, 2016. Petitioner's mother, appeared and testified on Petitioner's behalf. Petitioner; , one of Petitioner's care providers; and , Petitioner's case worker at ; also testified as witnesses for Petitioner. Attorney represented the Respondent . testified as a witness for Respondent.

Following the hearing, the record was left open for one week so that Respondent could have an opportunity to review the evidence Petitioner submitted at the hearing and file any objection it might have. Respondent subsequently sent in a Post-Hearing Supplement in which it indicated that it did not object to Petitioner's exhibits.

ISSUE

Did Respondent properly deny Petitioner's request for additional Community Living Supports (CLS)?

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 twenty-seven-year-old Medicaid beneficiary who has been diagnosed with major depressive disorder, bipolar disorder, Friedreich's Ataxia, cardiomyopathy, hypertension, obesity, asthma, gastroesophageal reflux disease; hearing impairments, and vision impairments. (Exhibit A, pages 11, 17-18, 30).

2. Petitioner also uses a wheelchair and has substantial functional limitations in self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency. (Exhibit A, pages 16, 18-19).

3. Due to his impairments and need for assistance, Petitioner receives Home Help Services (HHS) through the Department of Health and Human Services. (Exhibit A, page 19).

4. Specifically, he receives 92 hours and 48 minutes of services per month for assistance with bathing, grooming, dressing, toileting, transferring, eating, mobility, taking medications, housework, laundry, shopping, and meal preparation. (Exhibit A, page 40).

5. Petitioner also receives services through Petitioner, including supports coordination and CLS through the self-determination program. (Exhibit A, pages 19, 49).

6. On [redacted], an Annual Assessment was held with respect to Petitioner's needs and services. (Exhibit A, pages 11-33).

7. During that assessment, it was noted that Petitioner moved into his own place in 2013, but continues to require supervision or care 24 hours a day, 7 days a week. (Exhibit A, page 19).

8. The recommendation made during that assessment was that:

> [Petitioner] would benefit from a combination of CLS services and DHS Home Help services in order to maintain and increase personal self-sufficiency. Without this service, it suspected that [Petitioner's] level of self-sufficiency would decrease steadily over time. Due to his disability and medical diagnoses he requires 24 hour care and supervision to ensure health and safety.

Exhibit A, page 32

9. Following that assessment, Petitioner's Person-Centered Plan (PCP) was also developed for the time period of February 1, 2016 through January 31, 2017. (Exhibit A, page 49).

10. In that PCP, Petitioner was authorized for 21 hours per day of CLS for six months. (Exhibit A, page 49).

11. On [redacted], a PCP meeting/review was held. (Exhibit A, pages 42-55).

12. During that meeting, it was noted that Petitioner had lost a main caregiver and a couple of other staff members within the past six months, but that he was trying to replace them. (Exhibit A, page 42).

13. Petitioner's plan also continued to identify the same goals as six months earlier. (Exhibit A, page 49).

14. For example, Goal #4 provided: "Per [Petitioner], 'I can't do things on my own because of my disability and need staff to help me." (Exhibit A, page 47).

15. Objective B of Goal #4 also continued to refer to linking Petitioner with staff 24 hours a day, including 21 hours of CLS per day and 3 hours of HHS per day. (Exhibit A, page 47).

16. The CLS was to be provided for assistance with safely navigating the home, meal preparation, community integration at least 3-5 times per week, handling money, mobility, waking up in a timely manner, transferring, shopping, writing documents, and making phone calls. (Exhibit A, pages 47-48).

17. The CLS was also to be provided for supervision and monitoring at all times, whether Petitioner was awake or asleep. (Exhibit A, pages 47-48).

18. With respect to times when Petitioner is sleeping, the PCP stated:

> In the case of an emergency, [Petitioner] would not be able to safely leave his home without assistance. [Petitioner will require assistance if he needs to get up in the night to utilize the bathroom, get himself a snack, adjust his legs etc., 24 hour mounting and assistance to ensure health and safety is met with 1 or less verbal prompts and 100% success rate.

Exhibit A, page 47

19. During the meeting, a CLS staff worker also reported making sure Petitioner is safe and comfortable at night. (Exhibit A, page 49).

20. Overall, the amount of CLS that was requested was the same amount that had been approved before, *i.e.* 21 hours per day/588 units per week. (Exhibit A, page 49).

21. During the review of Petitioner's request, it was determined that only 13 hours per day/364 units per week of CLS should be approved because CLS is not intended to be provided during sleeping hours. (Exhibit A, page 7).

22. On July 19, 2016, Respondent sent Petitioner written notice that the request for 588 units per week of CLS had been denied and that only 364 units per week of such services would be approved. (Exhibit A, page 5).

23. The reason given for that decision was that the additional hours requested were not medically necessary. (Exhibit A, page 5).

24. On July 20, 2016, the Michigan Administrative Hearing System received the request for hearing filed in this matter regarding that decision. (Exhibit 1, page 22; Exhibit A, page 9).

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program:

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

42 CFR 430.0

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of

> its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

42 CFR 430.10

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

42 USC 1396n(b)

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915 (c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, Petitioner has been receiving CLS through Respondent. With respect to such services, the Medicaid Provider Manual (MPM) provides:

> **17.3.B. COMMUNITY LIVING SUPPORTS**
>
> NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.
>
> Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries,

city pools, camps, etc.).
Coverage includes:

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:

  - meal preparation
  - laundry
  - routine, seasonal, and heavy household care and maintenance
  - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
  - shopping for food and other necessities of daily living

  CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the DHS assessment.

- Staff assistance, support and/or training with activities such as:

    - money management

    - non-medical care (not requiring nurse or physician intervention)

    - socialization and relationship building

    - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)

    - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)

    - attendance at medical appointments

    - acquiring or procuring goods, other than those listed under shopping, and non-medical services

- Reminding, observing and/or monitoring of medication administration

- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

> CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.
>
> Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

MPM, July 1, 2016 version
Behavioral Health and Intellectual and Developmental Disability Supports and Services
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However, while CLS is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services and the Specialty Services and Support program waiver did not affect the federal Medicaid regulation that requires that authorized services be medically necessary. *See* 42 CFR 440.230.

Regarding medical necessity, the MPM also provides:

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;

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

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

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;

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

- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;

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

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

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:

  - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

  - that are experimental or investigational in nature; 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.

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Moreover, in addition to medical necessity, the MPM also identifies other criteria for B3 supports and services such as CLS:

> **SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3s)**
>
> PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning. NOTE: Certain services found in this section are State Plan EPSDT services when delivered to children birth-21 years, which include community living supports, family support and training (Parent-to-Parent/Parent Support Partner) peer-delivered services, prevention/direct models of parent education and services for children of adults with mental illness, skill building, supports coordination, and supported employment.
>
> **17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES**
>
> The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that

individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

Community Inclusion and Participation	The individual uses community services and participates in community activities in the same manner as the typical community citizen. Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with intellectual disability).
Independence	"Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996).

	Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning. For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.
Productivity	Engaged in activities that result in or lead to maintenance of or increased self-sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness. For example, a person who is 76 years old may choose to volunteer or participate in other community or senior

	center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and

> equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service . . .

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Here, Respondent denied Petitioner's request for reauthorization of the same amount of CLS that had been authorized in the first six months of his plan year, 21 hours per day of CLS, and instead only approved a reduced amount of services, 13 hours per day of CLS.

In support of that decision, [redacted] testified that 8 hours per day were not approved because they were hours when Petitioner was sleeping. She also testified that the documentation she reviewed did not identify any episodes or issues at night; there was nothing in Petitioner's PCP regarding what staff were specifically to do at night if an issue arose; and that there was no medical documentation that Petitioner requires overnight hours. She further testified that Petitioner lives with his cousin. [redacted] also asserted that the above policies regarding CLS imply that Petitioner must be an active participant in the services, which Petitioner could not do if he was sleeping.

In response, Petitioner testified that he wakes up during the night and needs someone to assist him and put him at ease. He also testified that he is not a well man, he needs assistance, and he does not want to live with his parents again.

Petitioner's representative/mother testified that Petitioner will never be self-sufficient and that it is necessary for him to have a staff worker at all times for his safety. She

also testified that Petitioner's staff have been trained extensively in CPR and first aid. Petitioner's representative/mother further testified that the cousin Petitioner lives with only does 1-2 shifts per week, she would not be able to sleep most of the time if the hours are removed; and she cannot provide services as natural supports during the night. Petitioner's representative/mother also testified that Petitioner never sleeps 8 hours per night and, when he does sleep, he has to be turned over for pressure relief multiple times and adjusted when he has coughing fits.

Ms. Ruggiero, one of Petitioner's care providers, testified that, while every day is different, Petitioner has an erratic sleep schedule and he is usually a night owl who is awake until 4:00 a.m. or 5:00 a.m. regularly. She also testified that, instead of sleeping regularly, Petitioner just takes little naps throughout the day. She further noted that they have gone out during the night at multiple times, including 2:00 a.m. or 3:00 a.m. trips to Walmart, and that her completed provider logs would reflect that.

█████████, ████████████████████, testified that Petitioner must be turned and repositioned while he is sleeping and that, when he wakes up, he needs assistance in both using a lift to transfer out of bed and getting to bathroom. She also testified that she reviews the time sheets for the CLS workers and that the paperwork indicates monitoring and turning while Petitioner is sleeping.

Petitioner bears the burden of proving by a preponderance of the evidence that the Respondent erred in denying his request for additional CLS hours. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Respondent's decision in light of the information that was available at the time the decision was made.

Given the available information and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has met his burden of proof and that Respondent's decision must therefore be reversed. Petitioner's approved person-centered plan continues to have the same goals and objectives as it did when the requested amount of CLS was approved in the past, including goals/objectives related to living in his own apartment with around-the-clock supports, and there do not appear to be any changes or new assessments that suggest a lessened need for services. Instead, Respondent's decision appears to be based on a broad finding that CLS is not available during sleeping hours and an assumption that Petitioner sleeps eight hours a night. However, the credible and uncontradicted testimony of Petitioner and his witnesses demonstrate that Petitioner does not sleep 8 hours a night, his sleep schedule is erratic, and that he needs the services he was receiving throughout the day and night. CLS may be provided for a number of purposes, including staff assistance with preserving the health and safety of the individual in order that he may reside or be supported in the most integrated, independent community setting, and Petitioner has met his burden of establishing medical necessity for additional CLS.

Given that medical necessity, and for the reasons discussed above, the undersigned Administrative Law Judge finds that Petitioner has met his burden of proving that

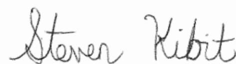
Respondent erred in denying his request to continue his CLS services at the same level and that its decision must, therefore, be reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent improperly denied Petitioner's request for additional CLS.

IT IS THEREFORE ORDERED that

> The Respondent's decision is **REVERSED** and it must initiate a reassessment of Petitioner's request for CLS.



SK/tm

Steven Kibit
Administrative Law Judge
for Nick Lyon, Director
Department of Health and Human Services

<u>NOTICE OF APPEAL</u>: 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 Administrative Hearing System (MAHS).

A party may request a rehearing or reconsideration of this Order if the request is received by MAHS 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. MAHS will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MAHS. If submitted by fax, the written request must be faxed to (517) 335-6088; Attention: MAHS Rehearing/Reconsideration Request.

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

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

Counsel for Respondent