[redacted]

Date Mailed: March 25, 2024
MOAHR Docket No.: 24-000181
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Steven Kibit

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) pursuant to MCL 400.9 and upon Petitioner's request for hearing.

After due notice, a telephone hearing began as scheduled on February 7, 2024. However, the hearing was not completed during the scheduled time and the undersigned Administrative Law Judge determined that it would be continued.

On February 28, 2024, the telephone hearing was continued and completed.

[redacted] Petitioner's mother/legal guardian, appeared and testified on Petitioner's behalf.

Jackie Bradley, Fair Hearings Officer, represented Respondent Lenawee Community Mental Health Authority (Respondent). Jearald Dudley, Intellectual and Developmental Disabilities Team (IDT) Program Director, and Niki Feller, Chief Clinical Officer, testified as witnesses for Respondent.

During the hearing, the following exhibits were admitted into the record without objection:

Petitioner's Exhibits

Exhibit #1: Request for Hearing, pages 1-3

Exhibit #2: Community Living Supports sheet, pages 1-2

Exhibit #3: Evidence Packet, pages 1-44[1]

Exhibit #4: Letter from Worker, pages 1-3

[1] Respondent objected to the admission of much of Exhibit #3 on the basis of relevancy, but the whole exhibit was subsequently admitted, with the undersigned Administrative Law Judge finding that Respondent's objections went to the weight that should be given to the evidence rather than its relevancy.

Exhibit #5: Screenshot, page 1

Respondent's Exhibits

Exhibit A: Notices, pages 1-17

Exhibit B: Policy, pages 1-5

Exhibit C: Assessments, pages 1-34

ISSUE

Did Respondent properly deny in part Petitioner's request for respite care services?

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 nineteen (19) year-old Medicaid beneficiary who has been diagnosed with attention-deficit/hyperactivity disorder, predominately hyperactive/impulsive presentation; autism spectrum disorder; and an intellectual disability. (Exhibit #3, page 1; Exhibit C, pages 1, 4 16).

2. He lives with his mother/legal guardian, who is his only natural support. (Exhibit C, pages 4-5).

3. He typically sleeps seven (7) hours a night. (Exhibit #2, pages 1-2)

4. Petitioner's mother attends all his medical appointments as Petitioner cannot communicate his needs. (Exhibit C, page 4).

5. He also relies on supports for transportation and assistance with personal care activities. (Exhibit C, page 4; Testimony of Petitioner's representative).

6. He further exhibits mood changes; he has difficulties with personal boundaries; he elopes and requires supervision while out in the community, with doors locked when he is at home; and he engages in aggressive behaviors and property destruction. (Exhibit C, page 4; Testimony of Petitioner's representative).

7. Petitioner attends school with supports. (Exhibit #3, pages 3-4; Exhibit C, page 4)

8. He is also approved for Home Help Services (HHS) through the Department of Health and Human Services, with Petitioner's mother as his paid home help provider. (Testimony of Petitioner's representative; Testimony of IDT Program Director).

9. Due to his diagnoses and need for assistance, Petitioner has also been approved for services with Respondent through Michigan's Habilitation Supports Waiver (HSW). (Exhibit C, pages 4, 16; Testimony of Petitioner's representative; Testimony of IDT Program Director).

10. Specific services have included psychiatric services; community living supports (CLS); respite care services; and case management. (Exhibit C, pages 4, 16).

11. Prior to the action at issue in this case, Petitioner was approved for seven (7) hours per day of CLS and fifteen (15) hours per week of respite care services. (Exhibit C, page 16).

12. On October 6, 2023, Respondent completed an Annual Bio/Psycho/Social Assessment with respect to Petitioner. (Exhibit C, pages 1-34).

13. In that assessment, it was noted that Petitioner had not had any major health issues or hospitalizations in the past year. (Exhibit C, page 4).

14. Petitioner's mother did report continuing incidences of mood changes, aggressive behaviors, property destruction, and elopement; that Petitioner does not understand personal boundaries; and that he requires around-the-clock supervision while out in the community. (Exhibit C, page 4).

15. The assessment also documented Petitioner's typical schedule, with Petitioner getting on the bus at 7:30 a.m. on days he has school; attending school from 8:00 a.m. to 3:00 p.m.; going to his CLS worker's house after school on Mondays through Thursdays until 8:00 p.m.; and then being at home with his mother for four hours until he goes to bed. (Exhibit C, page 4).

16. The assessment also documented that Petitioner spends Saturdays and Sundays: at his CLS worker's house from 7:00 a.m. to 8:00 p.m., with an occasional weekend there as well using respite care services. (Exhibit C, page 4).

17. On October 5, 2023, Respondent completed a Respite Assessment with respect to Petitioner. (Exhibit C, pages 19-22)

18. In that assessment, Petitioner's scored a 22, which indicated "up to 6 hours per week" of respite hours to authorize, which is the highest amount that can be recommended on the face of the assessment form. (Exhibit C, page 22).

19. On November 8, 2023, an Individual Plan of Service (IPOS) meeting was held with respect to Petitioner's IPOS for the upcoming plan year. (Exhibit C, pages 23-31).

20. The IPOS that was developed continued to have a goal of providing temporary relief to Petitioner's parents. (Exhibit C, page 29).

21. In support of that goal, Petitioner's guardian also requested the reauthorization of 15 hours per week of respite care services. (Testimony of Petitioner's representative; Testimony of IDT Program Director).

22. On November 16, 2023, Respondent sent Petitioner a written Adverse Benefit Determination stating that the request for 15 hours per week of respite care services had been denied, and that only 6 hours per week of such services would be approved, because the clinical documentation provided did not establish criteria for more services. (Exhibit A, pages 1-6).

23. On December 11, 2023, Petitioner filed an Internal Appeal with Respondent in response to that Notice of Adverse Benefit Determination. (Exhibit A, page 7).

24. On December 21, 2023, Respondent sent Petitioner a written Notice of Appeal Denial stating that the Internal Appeal had been denied and that the decision to only approve 6 hours per week of respite care services was being upheld. (Exhibit A, pages 12-17).

25. With respect to the reason for that decision, the Notice of Appeal Denial stated:

> we were not able to determine medical necessity for the additional Respite hours requested. The appeal review was completed by Chief Clinical Officer Niki Feller, LMSW on 12/14/2023. Ms. Feller met with you and Jackie Bradley, the CMH Appeals Coordinator. This conversation was held in person, by your request.
>
> Ms. Feller reviewed several documents related to your current request for Respite. This included [Petitioner's] most recent assessments, treatment plan, adverse benefit determination, and Medicaid Provider Manual (Habilitation Supports Waiver, Respite Care).
>
> During the appeal review, we talked about how you have always used the Respite hours previously authorized. You explained that you usually bank respite hours for when [Petitioner] is not in school. Together, we reviewed [Petitioner's] current Home Help hours, CLS authorization, school commitments, and sleep schedule.
>
> Based on this, we determined that the current authorized number of respite hours meet medical necessity. Therefore, we are upholding the partial denial of your request for 15 hours of respite services.
>
> *Exhibit A, page 12*

26. On January 10, 2024, MOAHR received the request for hearing filed in this matter with respect to Petitioner's respite care services. (Exhibit #1, pages 1-3).

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)) (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 respite care services from Respondent through the HSW, and, with respect to HSW services in general and respite care services specifically, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES [CHANGE MADE 7/1/23]**
>
> Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid covered state plan services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.
>
> HSW beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

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

The PIHP's enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, 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. (revised 7/1/23) (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 [CHANGES MADE 4/1/23 & 7/1/23]

* * *

Respite Care	Respite care services are provided to a waiver eligible beneficiary on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. ▪ "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations). ▪ "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with periods in between. ▪ "Primary" caregivers are typically the same people who provide at least some unpaid supports daily. ▪ "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school). Since adult beneficiaries living at

	home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service but may be available at other times throughout the day when the caregiver is not paid. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work full-time. In those cases, community living supports or other services of paid support or training staff should be used. The beneficiary's record must clearly differentiate respite hours from community living support services. Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver. Respite services may be provided in the following settings: ▪ Waiver beneficiary's home or place of residence. ▪ Licensed foster care home. ▪ Facility approved by the State that is not a private residence, such as: ▪ Group home; or ▪ Licensed respite care facility. ▪ Home of a friend or relative (not

	the parent of a minor beneficiary or the spouse of the beneficiary served or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with a respite worker training, if needed, by the beneficiary or family. These sites are approved by the beneficiary and identified in the IPOS. Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) **(text deleted 7/1/23)** is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from community living support services.

MPM, October 1, 2023 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 120-121, 136-137
(Internal highlighting omitted)

While respite care services are covered services, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services. *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.

Here, as discussed above, Petitioner requested a reauthorization of 15 hours per week of respite care services; Respondent denied that request and only approved 6 hours per week of respite care; and Petitioner appealed that reduced authorization.

In support of Respondent's decision, its IDT Program Director, who supervises Petitioner's case manager, testified regarding the basis for the change in level of care for Petitioner found in this case. In particular, he discussed that Petitioner is now approved for HHS through the Department of Health and Humans Services and, how between those services, Petitioner's paid supports through Respondent and his hours in school, Petitioner's total hours of supports has increased.

Respondent's Chief Clinical Officer testified regarding her review of Petitioner's Internal Appeal and the decision to uphold the partial denial based on the documentation in the record, including Petitioner's schedule and paid supports. She also testified as to what assessments were used in making the decision and why. She further testified that there is no set cap on the amount of respite care hours that a beneficiary may receive.

In response, Petitioner's representative/mother testified that Petitioner previously received services under the Children's Home and Community Based Services Waiver Program (CWP) and that how his respite care hours were calculated under that program was clearer than how they are calculated now under the HSW. She also testified that Petitioner started with the HSW in 2012, and that his services have never been so low as they are now.

She also testified that, as part of the hearing process in this case, she sent in letters regarding the medical necessity for more respite care from Petitioner's doctors, teachers, and staff; and that she does not know how Respondent could determine medical necessity without consulting them.

Petitioner's representative further testified that Respondent is wrong to just assume she will be a natural support, and that she wants to step into just a legal role as Petitioner's guardian and be able to hold a job. She also testified that she has been forced or guilted into being a full-time natural support with Petitioner 12-19 hours a day; she is always fighting for him and has given up her entire life; and that she has her own goals, including having a job. She did agree that she began working as Petitioner's paid home help provider when he was approved for such services in October of 2022.

Regarding Petitioner's services, she testified that there are no issues when Petitioner is in school and the problems arise in the summer, when Respondent will not adjust hours, despite Petitioner's representative begging and pleading for them to do so, and just telling Petitioner's representative to budget better. According to Petitioner's representative, she has raised concerns about Petitioner's CLS during the summer before too, but that no adverse benefit determination was sent and Petitioner has not appealed any denial of such services.

Petitioner's representative testified that Petitioner might look good on paper, but that the assessments are incomplete or inaccurate; too infrequent; just guidelines; and are not made available to her at the time they are completed. She further testified that it is hard for her to answer questions with Petitioner present, and that Petitioner functions better with his worker.

Regarding Petitioner's behaviors, she also testified regarding his attempts at elopement; his aggression; the fact that he does not always sleep eight hours at night; and his around-the-clock need for supervision and support.

Finally, Petitioner's representative testified that she has been told different things by the six case workers Petitioner has had in the last twelve years, and that she was told prior to the action in this case that Respondent was capping respite care services for all beneficiaries at 6 hours per week.

Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Respondent's decision in light of the information Respondent had at the time it made that decision.

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

Petitioner's representative undisputedly provides a significant amount of unpaid care to Petitioner, but Petitioner also continues to be authorized for a substantial amount of respite care, *i.e.,* 6 hours per week, and the authorization appears to be sufficient to provide Petitioner's representative with short-term, intermittent relief from the daily stress and care demands during times when she is providing unpaid care, especially given Petitioner's other services and circumstances, which include CLS through Respondent; HHS through the DHHS; Petitioner's attendance at school; and his typical sleeping schedule.

Moreover, the care Petitioner's representative's provides as Petitioner's home help provider cannot be grounds for additional respite as that is paid care, and, while Petitioner's representative credibly testified that she wants more respite to be able to hold down a job, the above policy expressly states that respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work full-time.

Petitioner was previously authorized for the amount of respite care services that Petitioner now seeks, and, other than Respondent taking into account Petitioner's HHS, the record does not reflect any improvement in Petitioner's conditions or significant needs that would necessitate a change in those services, but that alone does not warrant that the requested services be reauthorized as each assessment stands on its own and each new request must be reviewed on its own merits.

Additionally, while Petitioner's representative pointed out issues with the completed assessments, she did not describe anything that Respondent did not take into account when calculating Petitioner's respite care, with Petitioner's abilities largely undisputed.

Similarly, while Petitioner's representative testified that she was told that Petitioner's respite care services would be capped at 6 hours per week, which is what he was subsequently authorized for, and such a maximum would violate the above policies, the undersigned Administrative Law Judge does not find that testimony sufficient either. Even though the testimony is strongly supported by the fact that the assessment form seemingly identified a maximum recommendation of 6 hours per week of respite as well, Respondent's witnesses credibly testified that the assessment form just provides recommendations and guidelines, and the record as a whole demonstrates that Respondent completed an individualized assessment of Petitioner's needs and services as required, with the ultimate approval supported by the evidence.

Moreover, even Petitioner's representative's testimony conceded that Petitioner's services, including his respite care services, are currently sufficient while Petitioner is in school. And, while she also testified that the problem comes when the school year is over and that Petitioner therefore needs more services now, with his CLS and respite authorized for an entire year at a time, that testimony does not demonstrate a need for more respite. Petitioner's representative appears to be seeking respite care as a regular part of Petitioner's routine care during the summer when such continuous and long-term services are not the goal or role of respite, which is to provide his natural supports with short-term, intermittent relief from daily stress and care demands during times when they are providing unpaid care.

To the extent Petitioner's representative/guardian wants additional CLS for Petitioner in the summer, Petitioner's circumstances change, or his representative has additional or updated information to provide regarding his need for respite care, then Petitioner's representative can always request additional services in the future along with that information. With respect to the decision at issue in this case however, Respondent's decision must be affirmed given the available information and applicable policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied in part Petitioner's request for respite care services.

IT IS THEREFORE ORDERED that:

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

Steven Kibit

SK/sj

Steven Kibit
Administrative Law Judge

NOTICE OF APPEAL: Petitioner 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 25th day of March 2024.

S. James

S. James
Michigan Office of Administrative Hearings and Rules

Via Electronic Mail:

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