UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

DEREK WASKUL, by his guardian, Cynthia Waskul;
CORY SCHNEIDER, by his guardians, Martha and Wendy Schneider;
KEVIN WIESNER, by his guardian, Kerry Kafafian;
ROGER ERLANDSON, by his guardian, Maureen Forrest;
LINDSAY TRABUE, by her guardian, Kristin Kill;
HANNAH ERNST, by her guardians, Susan and Robert Ernst;
and WASHTENAW ASSOCIATION FOR COMMUNITY ADVOCACY,

Plaintiffs,

v.

No. 2:16-cv-10936-AJT-EAS

Hon. Arthur J. Tarnow

Hon. Elizabeth A. Stafford

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH; TRISH CORTES, in her official capacity as Director of Washtenaw County Community Mental Health; MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT GORDON, in his official capacity as Director of Michigan Department of Health and Human Services; JANE TERWILLIGER in her official capacity as Director of Community Mental Health Partnership of Southeast Michigan; and COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN,

Defendants.
_____/

PLAINTIFFS' FIRST AMENDED AND SUPPLEMENTAL COMPLAINT

Table of Contents

This First Amended and Supplemental Complaint is identical to the document annexed to the motion for leave to file, except for (a) updating the signature block and the filing and service dates, (b) substituting Director Gordon for former Director Lyon, pursuant to Fed. R. Civ. P. 25(d), and (c) correction of the citation error in paragraph 466(b), as noted in open court on February 6, 2019.

Plaintiffs allege:

PRELIMINARY STATEMENT

1. This is an action to restore services and supports Defendants are obligated to provide to the individual Plaintiffs and those similarly situated to enable them to avoid institutionalization.

2. Plaintiffs are (a) six severely developmentally-disabled adults receiving medically necessary Community Living Support (CLS) services through Washtenaw County Community Mental Health (WCCMH), which allow them to avoid institutionalization, and (b) the Washtenaw Association for Community Advocacy (WACA), a non-profit organization that, among other things, advocates for persons with developmental disabilities and their families in order to help them obtain and maintain services.

3. Prior to May 2015, Plaintiffs and the members of WACA received medically necessary CLS services and supports in accordance with their individual plans of service (IPOSs), pursuant to budgets that properly provided for the cost of obtaining those services and supports.

4. In May 2015, however, Defendants changed the budgeting methodology and improperly imposed top-down caps on the amounts that

Plaintiffs could pay for their medically necessary services and supports. Instead of determining what services and supports were necessary and budgeting for them, Defendants now imposed an artificial cap on a medically irrelevant "rate" that they used for their own internal accounting and statistical reporting purposes, and they required all aspects of Plaintiffs' budgets to be included within that single "rate."

5. Defendants effected this change simply to save money, without regard for the impact on those they were duty-bound to serve and without providing proper notice or a truthful description of what it was they were doing.

6. As a result of the budgeting change, Plaintiffs have faced severe cutbacks in services and are at risk of institutionalization.

7. Plaintiffs bring this action pursuant to 42 U.S.C. § 1983, 42 U.S.C. § 12133, and 29 U.S.C. § 794a based on violations of their rights expressly conferred by the Social Security Act, the Americans with Disabilities Act, the Rehabilitation Act, and the United States Constitution. Plaintiffs bring additional state claims pursuant to Michigan's Mental Health Code and as third-party beneficiaries of the contract whereby Defendant Michigan Department of Health and Human Services (MDHHS) delegated certain implementation of the Medicaid

program at issue to Defendant Community Mental Health Partnership of Southeast Michigan (CMHPSM).

JURISDICTION AND VENUE

8. This Court has jurisdiction over Plaintiffs' federal and constitutional claims under 28 U.S.C. § 1331.

9. This Court has supplemental jurisdiction over Plaintiffs' state law claims under 28 U.S.C. § 1367(a).

10. Venue in the Eastern District is proper because Plaintiffs reside in Washtenaw County, Michigan, and because all the events complained of herein occurred in Washtenaw County, Michigan. Washtenaw County is in the Eastern District of Michigan.

PARTIES

11. Individual plaintiffs, Derek Waskul (guardian Cynthia Waskul), Cory Schneider (guardians Martha Schneider and Wendy Schneider), Kevin Wiesner (guardian Kerry Kafafian), Roger Erlandson (guardian Maureen Forrest), Lindsay Trabue (guardian Kristin Kill), and Hannah Ernst (guardians Susan and Robert Ernst) are residents of Washtenaw County, Michigan and Medicaid recipients. All are participants in the CLS program offered under Michigan's Medicaid Habili-

tation Supports Waiver (HSW) and administered by WCCMH and its predecessor, the Washtenaw Community Health Organization.

12. Guardians for the individual Plaintiffs are suing on Plaintiffs' behalf pursuant to Fed. R. Civ. P. 17(c)(1)(A).

13. WACA brings this action on behalf of its members who have been directly affected by Defendants' unlawful policies and practices.

14. Defendant WCCMH is a community mental health authority created pursuant to MCL 330.1205. It provides mental health services to Washtenaw County adults with a severe and persistent mental illness, children with a severe emotional disturbance, and individuals with a developmental disability.

15. Trish Cortes is the Director of WCCMH and is being sued in her official capacity.

16. Robert Gordon is the Director of Michigan's Department of Health and Human Services (MDHHS, or the Department) and is being sued in his official capacity. Mr. Gordon is the successor in office to Nick Lyon and is substituted pursuant to Fed.R.Civ.P. 25(d). The Department itself is also made a defendant herein, but solely on Count VI.

17. The Department is the single state agency responsible for administering Medicaid in Michigan. 42 U.S.C. § 1396a(a)(5).

18. Jane Terwilliger is the Executive Director of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) and is being sued in her official capacity.

19. The CMHPSM is a specialty prepaid inpatient health plan (PIHP) and is considered a Medicaid managed care organization under MCL 400.109f.

20. Medicaid managed care organizations are responsible for making medical assistance available and accessible to Medicaid beneficiaries within their region. 42 U.S.C. § 1396b(m).

FACTS

A. The Medicaid Program and the Habilitation Supports Waiver

21. The Medicaid program is jointly funded and administered by the state and federal governments under Title XIX of the Social Security Act.

22. The Medicaid program provides medical assistance for certain low income children, families, pregnant women, disabled adults, and elderly people.

23. The Medicaid Act creates a "cooperative federal-state program" through which states that elect to participate receive federal financial assistance to pay for the medical treatment of specific groups of needy individuals.

24. Michigan must operate its Medicaid program in compliance with federal Medicaid statutes and regulations and other federal laws, including the Americans with Disabilities Act and the Rehabilitation Act.

25. To receive federal funding, states, including Michigan, are required first to formulate a plan that meets federal requirements.

26. Michigan must submit its plan to the federal Centers for Medicare and Medicaid Services (CMS), specifying how the Medicaid program will be administered in the State. This is called the State Plan. 42 U.S.C. § 1396a(a). The State Plan contains and describes the nature and scope of the State's Medicaid program. 42 C.F.R. § 430.10.

27. Federal law requires that each State Plan "provide for the establishment or designation of a single State agency to administer or to supervise the administration of" the Plan. 42 U.S.C. § 1396a(a)(5); *see* 42 C.F.R. § 431.10(b)(1). In Michigan, as alleged above, MDHHS is that "single state agency," and Defendant Gordon is its administrator.

28. The designated agency may not delegate to others its "authority to supervise the plan or to develop or issue policies, rules, and regulations or program matter." 42 C.F.R. § 431.10(e).

29. The State must ensure, through its contracts, that each MCO (Managed Care Organization), PIHP (Prepaid Inpatient Health Plan), and

PAHP (Prepaid Ambulatory Health Plan) oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor. 42 C.F.R. § 438.230. As alleged below, MDHHS, through Defendant Gordon, has implemented this obligation in its contract with Defendant CMHPSM but has failed to ensure Defendant CMHPSM's compliance with that contract.

30. A state's plan must provide coverage to seven designated classes of needy individuals, termed "categorically needy," for at least seven specific kinds of medical care or services. *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i), 1396d(a).

31. A state may, if it chooses, extend this coverage to other designated populations, termed "medically needy." *See* 42 U.S.C. § 1396a(a)(10)(C).

32. Additionally, the state may choose to expand the care and services available under its plan beyond the seven mandated categories. *See id*. §§ 1396a(a)(10)(A), 1396d(a) (defining "medical assistance" by enumerating twenty-eight types of care and services).

33. CMS grants waivers to "permit states to offer, under a waiver of statutory requirements, an array of home and community-based services

that an individual needs to avoid institutionalization." 42 C.F.R. § 441.300.

34. Michigan's State Plan includes the provision of home and community-based services to approved Medicaid beneficiaries under a waiver, "granted under 42 C.F.R. Part 441, subpart G," who would otherwise require services in an institution. Attachment 2.2-A to the Michigan State Plan. This waiver is called the Habilitation Supports Waiver (HSW) in Michigan.

35. Michigan elected, applied, and was approved to receive funding under the HSW to furnish waiver services to assist individuals with developmental disabilities with activities of daily living necessary to permit them to live in their own home or rental unit in a community-supported living arrangement setting.

36. Waivers granted pursuant to 42 U.S.C. § 1396n(c) allow the state to include as "medical assistance" under such plan "payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a

nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan." 42 U.S.C. § 1396n(c).

37. Under such a waiver, the state may forgo compliance with statewide, comparability, and certain community income and resource rules, but must otherwise comply with all other federal Medicaid requirements. *See* 42 U.S.C. § 1396n(c)(3).

38. Federal law lists the type of services which may be offered under Michigan's HSW waiver. 42 U.S.C. § 1396u; *see also* 42 C.F.R. § 440.180.

39. Michigan elected to make all Medicaid home and community-based living arrangement services under 42 U.S.C. § 1396u and 42 C.F.R. § 440.180 available to individuals on the HSW. *See* MCL § 400.109c.

40. The federal statute defines "community supported living arrangement services" as assistance to developmentally disabled individuals in activities of daily living necessary to permit them to live in their own home or apartment, in a community supported living arrangement setting. 42 U.S.C. § 1396u. It also includes personal assistance and "support services necessary to aid an individual to participate in community activities." *Id.* § 1396u(a)(7).

41. Michigan has included within its HSW services "Community Living Supports" (CLS), which "facilitate an individual's independence, productivity, and promote inclusion and participation." Michigan Medicaid Provider Manual (MPM) § 15.1.

42. An individual receives services under the HSW when, "if not for the availability of the home and community-based services, [he or she would] require the level of care provided in an intermediate care facility for the mentally retarded (ICF/MR)." HSW Eligibility Certification, available at http://www.michigan.gov/documents/mdhhs/MI_Choice_Waiver_1915-b_537092_7.pdf. In other words, but for the provision of CLS services, eligible individuals would require the level of care provided in an institution.

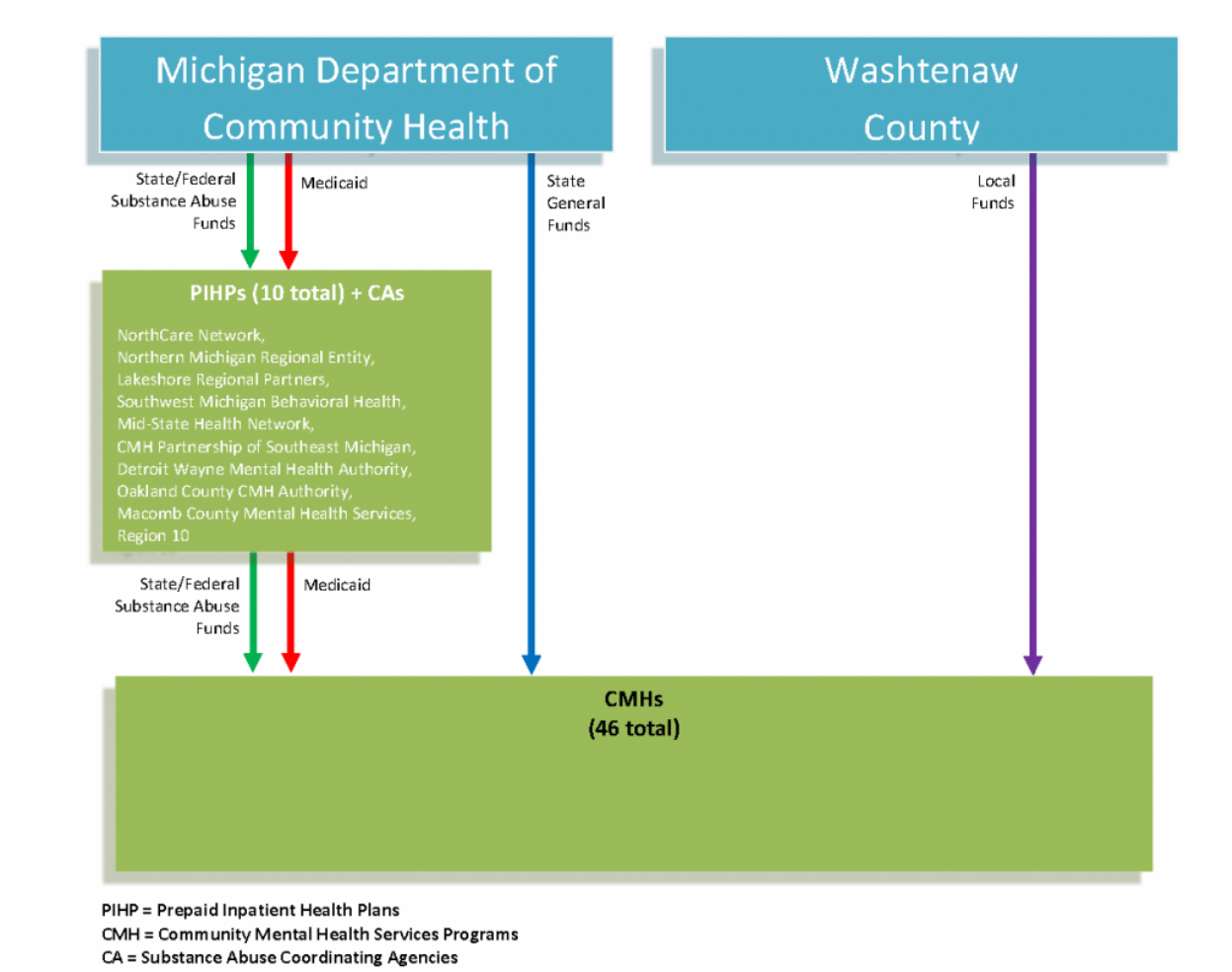
43. MDHHS contracts with CMHPSM, a PIHP and a Medicaid managed care organization, to provide or arrange for services for enrollees in its region. *See* 42 U.S.C. § 1396u-2(a)(1)(B); MCL 400.109f.

44. CMHPSM, in turn, contracts with WCCMH, an organization statutorily required to provide and arrange for mental health services to individuals with developmental disabilities in Washtenaw County, to provide or arrange services for Medicaid enrollees.

45. CMHPSM, as a Medicaid managed care organization, is responsible for "providing defined inpatient services, outpatient hospital services, physician services, other specified Medicaid state plan services, and additional services approved by the centers for Medicare and Medicaid services under section 1915(b)(3) of title XIX of the social security act, 42 U.S.C. § 1396n." MCL 400.109f(2)(A).

46. The relationship between MDHHS, CMHPSM, and WCCMH is represented in the following graphic published by the University of Michigan and Blue Cross Blue Shield of Michigan's Center for Healthcare Research & Transformation:[1]

[1] The Michigan Department of Community Health is now part of MDHHS.



47. Michigan has a long history of authorizing CLS services under the HSW (the provision authorizing the HSW was first added to the Social Security Act in 1981), which are seen as a humane and cost-effective alternative to institutionalization.

B. Right to Self-Determination Under the Habilitation Supports Waiver

48. The core of the CLS program is the participant's right to self-determination. Exhibit A, HSW, Appendix E-2. This means both that the participant structures his or her own plan of service according to

medical need and that the participant has a significant degree of flexibility in implementing the plan.

49. States decide whether to allow participant-directed services. If so, the state must complete Appendix E of the HSW and specify which aspects of the services are participant-directed. *See* CMS Instructions, Technical Guide, and Review Criteria, page 213 *et seq*.

50. Michigan has elected to allow participant-directed services in connection with the HSW. Participant direction fosters the overall goals of HSW services, which are to preserve the independence of the client, avoid institutionalization, and assist in the integration of the client into the community. Participant direction also assists in setting up realistic costing to achieve this, avoiding arbitrary limits that will defeat these purposes.

51. In accordance with 42 C.F.R. § 441.301(b)(1)(i), a participant-centered service plan of care, known in Michigan as an Individual Plan of Service (IPOS), is developed for each participant employing the person-centered planning procedures specified in Appendix D of the HSW.

52. Central to developing a client's IPOS is identification of the services and supports that are medically necessary for that client.

53. Medical necessity criteria is defined in Michigan's Medicaid Provider Manual as supports, services, and treatment "intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability, or substance use disorder." MPM § 2.5.A.

54. Medical necessity criteria also includes supports, services, and treatment "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." *Id*.

55. The determination of a medically necessary support, service, or treatment must be based on information provided by the beneficiary and/or his family and clinical information from the beneficiary's primary care physician or other qualified health care professionals who have evaluated the beneficiary. MPM § 2.5.B. It must be "[s]ufficient in amount, scope, and duration . . . to reasonably achieve its purpose," and it must be "[d]ocumented in the individual plan of service." *Id*.

56. The IPOS thus embodies the medical necessity determination as to each individual participant.

57. The IPOS is implemented through a budget that is developed with the participant using the person-centered planning process. The IPOS and

its implementing budget are interdependent and developed in conjunction with one another. Only after the participant's medical needs have been determined can the plan of service be budgeted. HSW Appendix E-2(b)(ii).

58. "An individual budget includes the expected or estimated costs of a concrete approach of obtaining the mental health services and supports included in the [IPOS]" (Self Determination Guideline II.C.).

59. "The amount of the individual budget is determined by costing out the services and supports in the IPOS, after a IPOS that meets the participant's needs and goals has been developed. In the IPOS, each service or support is identified in amount, scope and duration (such as hours per week or month). The individual budget should be developed for a reasonable period of time that allows the participant to exercise flexibility (usually one year)." HSW Appendix E-2(b)(ii) (emphasis added).

60. As set forth in the Behavioral Health chapter of the Michigan Medicaid Provider Manual (MPM), services cannot be denied "based solely on preset cost limits on the amount, scope, and duration of services." MPM § 2.5.C., pg. 14. "Instead, determination of the need for services shall be conducted on an individualized basis." *Id*.

61. These provisions of the Michigan Manual implement the requirement of the Social Security Act and federal regulations that "lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan." 42 U.S.C. § 1396a(a)(2); 42 C.F.R. § 433.53(c)(2).

62. Also, in accordance with 42 C.F.R. § 431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan. The participant (most often his or her guardian) selects and hires service providers who fit the participant's individual needs, assuming the role of a traditional provider agency. The participant can hire and fire staff, schedule staff, and "determine staff wages and benefits subject to State limits." HSW, Appendix E-2(a)(ii).

63. There are no state limits for staff wages under the HSW.

64. In the HSW application, the state has the option to check this box: "There is a limit on the maximum dollar amount of waiver services authorized for each specific participant." Michigan's application provides: "Not applicable- The State does not impose a limit on the amount of waiver services…" HSW Appendix C-4(a). This is in accordance with state policy, which prohibits services from being denied

based "solely on preset limits of the cost, amount, scope, and duration of services." MPM § 2.5.C., pg. 14.

65. Michigan specifically gives participants the right to reallocate funds among services included in the budget, as well as to determine the amount paid for services. HSW, Appendix E-2(b)(i).

66. "Both the participant and the PIHP must agree to the amounts in the individual budget before it is authorized for use by the participant. This agreement is based not only on the amount, scope and duration of the services and supports in the IPOS, but also on the type of arrangements that the participant is using to obtain the services and supports. Those arrangements are also determined primarily through the PCP [person-centered planning] process." HSW Appendix E-2(b)(ii); *see also* 42 C.F.R. § 441.301(c)(2)(ix).

67. The participant must have the authority through the person-centered planning process to budget for services that fall within the amount, scope, and duration of his or her IPOS.

68. Finally, "[t]he mental health agency (PIHP or designee) must provide the participant with information on how to request a Medicaid Fair Hearing when the participant's Medicaid-funded services are changed, reduced or terminated as a result of a reduction in the individual

budget or denial of the budget adjustment." HSW Appendix E-2(b)(iv). This requirement is also found in the Medicaid Act and its implementing regulations. 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 431.205.

C. Financing the HSW in Michigan

69. Financing for the Habilitation Supports Waiver in Michigan is effected through managed care/capitation procedures. The central characteristic of those procedures is that the State and its Medicaid agencies are not reimbursed on a fee-for-services basis by the federal government for services provided under the Waiver. Instead, reimbursement occurs on a "capitation" basis, under which the relevant operating unit receives a fixed amount for each person enrolled in the program, regardless of how much (or how little) in the way of services the operating unit actually provides to that person.

70. In this case, the relevant operating unit is the PIHP — which, as alleged in more detail below, was originally the Washtenaw Community Health Organization (WCHO) and then became Defendant CMHPSM. As the acronym PIHP indicates, these were ***prepaid*** health plans. The word "prepaid" refers to funding on a capitation basis: the PIHP receives payment in advance of the same fixed amount for each enrolled

client, regardless (to repeat) of the amount of services any given client ends up needing.

71. On the expenditure side, the PIHP uses the aggregate of the capitation funds it has received to pay for the services it provides.

72. There is no direct relationship between funding and expenditures. Neither the amount of services provided to any one client nor the cost of providing those services bears any relation to the capitation amount the PIHP received for enrolling that client.

73. Accordingly, with respect to their HSW operations, PIHPs are not pass-through entities, in which some other entity bears the risk that needed services during the course of a year will exceed the expected amount. Rather, they use their own funds, received through the capitation process, to pay for whatever services turn out to be required. PIHPs are thus risk-bearing entities exactly like insurance companies,

74. Also exactly like insurance companies, PIHPs can make money or lose money depending on whether the "premiums" (here, the capitation payments) are, in the aggregate, greater or less than the "losses" (payments for needed services).

75. Because they are risk-bearing entities that can in fact lose money, PIHPs have a financial incentive to provide as little in the way of ser-

vices as they can. The Medicaid statute and regulations and the Michigan Habilitation Waiver recognize this incentive and contain specific provisions to prevent PIHPs' financial incentives from operating to the detriment of their clients, specifically including the beneficiary protection, service, and quality assurance provisions of 42 U.S.C. § 1396u-2(b), (c), and the MPM provision, cited above, that services cannot be denied based on preset cost limits on the amount, scope, and duration of services.

D. WCHO's Reformation and Budget Crisis

76. Prior to 2014, WCHO was the PIHP for Washtenaw County, as well as for three other counties — Lenawee, Livingston, and Monroe.

77. Until about December 10, 2013, Defendant CMHPSM was simply a coordinating organization for the four counties that were served by WCHO as PIHP.

78. During this timeframe, WCHO was also a Community Mental Health Service Provider (CMHSP), although it mostly contracted with Community Support and Treatment Services (CSTS) to provide those services. Until 2002, CSTS had been called Washtenaw County Community Mental Health (WCCMH).

79. One of the services CSTS provided was to oversee the development of participants' IPOSs and associated budgets. Once the budget was developed, it was managed and implemented for the participants by a fiscal intermediary.

a. The use of a fiscal intermediary allows participants to employ their own staff directly without having to manage administrative details such as payroll, taxes, and W2s, which are handled by the fiscal intermediary.

b. The fiscal intermediary for the majority of Plaintiffs is the Community Living Network (CLN), which operates under the d/b/a of Community Alliance of Southeastern Michigan. Other plaintiffs use GI Independence.

80. In 2013, the State of Michigan issued new regulations that a CMHSP could not also be a PIHP — that is, that an entity providing direct mental health services to the community (a CMHSP) could not also be the prepaid inpatient health plan that received Medicaid capitation funding. Since WCHO was both, organizational changes became necessary.

81. As of approximately December 10, 2013 (the date of Defendant CMHPSM's "enumeration" in the National Provider Index operated

by CMS), Defendant CMHPSM, which had up to that point been merely an umbrella coordinating organization for the mental health services of the four counties including Washtenaw, started the process of becoming an operating PIHP. The goal was to move WCHO's PIHP operations to CMHPSM and have WCHO continue simply as a service provider.

82. As of January 2014, WCHO's PIHP operations and staff were transitioned to CMHPSM.

83. There was never more than one actual operating PIHP for Washtenaw and its three sister counties. Before January 2014, the PIHP was WCHO; thereafter, it was CMHPSM.

84. In summer 2014, WCHO informed Washtenaw County that it was facing a shortfall of several million dollars.

85. A Behavioral Health Task Force issued a report in February 2015, in which it recommended dissolving WCHO and creating a new Community Mental Health Agency. Exhibit B, Behavioral Health Task Force, Final Report.

86. The Behavioral Health Task Force also specifically recommended targeting Community Living Support services in order to reduce the deficit. Exhibit B.

87. In October 2015, WCHO was dissolved and CSTS changed its name back to WCCMH, the defendant in the present case.

88. CSTS and WCCMH are and always have been the same organization, having merely gone through a name change in 2002 and a reversal of that name change in 2015.

89. CSTS/WCCMH was and always has been the party responsible for servicing the Medicaid contract for the waiver services at issue in this action. It has at all times operated as a contractor to the PIHP, either directly (before 2014 and after October 2015) or as a subcontractor to WCHO when WCHO was a CMHSP but no longer the PIHP.

90. There was no cessation of operations as WCHO dissolved and CSTS changed its name back to WCCMH. As WCHO dissolved and WCCMH became the county mental health agency, the same service population continued to receive the same services from the same service provider in the same geographic area with no interruption.

91. In general terms, service personnel in the WCHO/CSTS operation remained at CSTS as it changed its name to WCCMH, whereas personnel on the PIHP side of the operation moved to CMHPSM.

92. Because the operative events alleged in Sections E and F below overlapped with these transitions, keeping track of the players can become difficult, and the following timeline is thus provided for convenience:

Time Period	Who Was Doing What
December 2013 and earlier	• WCHO was the PIHP for Washtenaw County (and Livingston, Lenawee, and Monroe Counties). It received Medicaid capitation funds and disbursed those funds (and other funds it received) to pay for mental health services in the four counties. • WCHO was also a Community Mental Health Service Provider, but it subcontracted most of those functions to CSTS. • CSTS was the operating service provider, under contract to WCHO. CSTS was the entity that interacted with self-determination clients and developed their IPOSs and budgets. • CMHPSM was an umbrella coordinating organization for the mental health operations of the four counties.

Time Period	Who Was Doing What
January 2014 to October 2015	• WHCO was no longer a PIHP. It was solely a service provider (CMHSP), and it continued to sub-contract most of those functions to CSTS. • CSTS remained the operating service provider, under contract to WCHO. It continued to be the entity that interacted directly with clients. • CMHPSM became an operating PIHP and thus was the entity that received Medicaid capitation funds and disbursed those funds to pay for mental health services in the four-county area.
October 2015 to present	• WCHO is dissolved. • CSTS changes its name to Washtenaw County Community Mental Health (WCCMH) and continues as the service provider that interacts directly with clients on IPOSs and budgets. • CMHPSM continues as the PIHP.

E. The April 2015 Letter and the May 2015 Cuts

The Budget Process for CLS Services Participants Prior to May 15, 2015

93. Prior to May 15, 2015, and from at least April 2012, the IPOS budget for CLS services participants was built up from the individual service and support components of the IPOS. The services and supports include both staff, who assist participants in the activities of daily liv-

ing, and other items specified in the IPOS, such as transportation and community activities.

94. The build-up of the budget started with an hourly pay rate for each of the paid CLS providers, which was multiplied by the number of hours specified for that provider (or type of provider) in the IPOS to establish the services component of the budget.

95. To this services component were added additional line items, such as workers compensation, staff training, and transportation. The CLS participant's final annual CLS budget consisted of the sum of all of these items, plus the fee of the "fiscal intermediary" that handled paying staff and monitoring the participant's ongoing usage of services.

96. Thus, Plaintiff Waskul's budget for the period March 16, 2015 to March 11, 2016, which was approved by WCHO on March 16, 2015 (Exhibit C) was for a total of $29,182.56 and was derived as follows:

a. 32.5 weekly hours (1690 annual hours) of CLS personnel, at $13.88 per hour, for a total of $23,457.20 in "Personnel Hours," *plus*

b. 74 annual hours of Staff Training, at $13.88, for a total of $1,027,32, *making*

c. a "Direct Care Costs to be paid by WCHO" subtotal of $24,482.32, *to which were added*

d. "Community Supports" of $3,498.24, consisting of

   i. Transportation of $175/month, or $2,100 for the year, *and*

   ii. Workers compensation expense for two staff members of $398.16 for the year, *and*

   iii. "Community Participation" expenses of $60/month, *and*

   iv. $280.08 for an Annual Recreation Pass, *making*

e. a "Subtotal WCHO Obligation" of $27,982.56, *to which was added*

f. the Fiscal Intermediary Administrative Fee of $100/month, or $1,200 for the year, *making*, finally,

g. "Total Costs" for the 360-day budget period of $29,182.56.

97. For its own statistical reporting purposes, WCHO then separated this amount into two components, reporting the $27,982.56 "WCHO Obligation" under code H2015 (Comprehensive Community Support Services, per 15 minutes) of the Healthcare Common Procedure Coding System (HCPCS) and the Fiscal Intermediary fee under code T2025 (Waiver services, not otherwise specified). It also divided the WCHO obligation by 6,760, the number of 15-minute segments in the

1690-hour annual CLS personnel authorization, to obtain a "15 Minute H2015 Variable Rate" of $4.14 (*i.e.*, $16.56 per hour).

98. None of the calculations described in the preceding paragraph, however, affected either Plaintiff Waskul or the amounts the fiscal intermediary paid out on his behalf — for CLS personnel, for transportation, for the recreation pass, or for anything else.

99. Nor did WCHO's coding affect the amounts CMHPSM received as reimbursement from State or Federal Medicaid funds on account of services and supports supplied to Plaintiff Waskul, because WCHO received no such reimbursement. CMHPSM was a PIHP: it had already been paid to provide these services and supports by receiving its fixed capitation amount when it reported Plaintiff Waskul as an enrollee.

100. The only relevance of WCHO's statistical coding for Medicaid reimbursement purposes was that CMHPSM's 2015 expenses would be included in its actuarial calculations to support its 2016 capitation rate (and/or future rates). That is, if CMHPSM spent more than it had anticipated on H2015 services in 2015, it could — like any insurance company — ask for a (prospective) rate increase for the following year. None of that, however, affected either the services WCHO on

behalf of CMHPSM had agreed were medically necessary in Plaintiff Waskul's 2015 IPOS or the amounts CMHPSM had agreed to pay — in 2015, from its own funds, obtained from its aggregate 2015 capitation payments — in the budget CMHPSM (through its contracting service provider) and Plaintiff Waskul jointly developed from the IPOS.

101. Prior to January 2014, WCHO was itself the funding PIHP. Thereafter, the funding PIHP became CHMPSM, with first WCHO and then WCCMH administering the CLS program in Washtenaw County on CHMPSM's behalf. Both before and after January 2014, it remained true that (a) the PIHP (now CHMPSM) paid for CLS services out of its own aggregate capitation funds, and (b) the coding of payments was solely for the purpose of the PIHP's statistical reporting for its future ratemaking purposes.

102. Prior to May 15, 2015, all plaintiffs' budgeting processes were substantially as described above with respect to Plaintiff Waskul. There were, of course, individual variations in amounts of services and support received, but in all cases the service component of the budget was built up by applying an agreed rate (hourly in most cases; *per diem* in the case of recipients receiving 24/7 care (like Plaintiff Schneider)) to

the amount of services provided for in the IPOS, and then adding amounts for other services and supports such as staff training, workers compensation, and transportation.

103. There were likewise minor variations as among the individual plaintiffs in the PIHP's statistical reporting as to them — *per diem* services were reported under HCPCS code H0043 instead of H2015, for example — but in each instance the budgeted services were provided by the PIHP from its own capitation funds, and the statistical reporting was solely for future ratemaking purposes.

The April 2015 Letter and the Inversion of the Budget Process

104. All this changed dramatically — and very much for the worse — on April 9, 2015. On that date WCHO sent a letter to all participants receiving CLS services, stating that what the letter called "our Community Living Support (CLS) rate" would be "reduc[ed]" to $13.88 per hour, effective May 15, 2015. Exhibit D, Letter to CLS Participants from Sally Amos O'Neal. The letter further stated that "[t]he new rate . . . includes worker's compensation, transportation, community participation, taxes, and training." It then claimed, contradictorily, that "[w]hile this is not a reduction in your current level of services, it may reduce the amount you can pay your staff." *Id*.

105. What the letter described as WCHO's "CLS rate," however, was not a rate to be paid to providers at all but a pure artifact of WCHO's statistical reporting. Previously, the rate reported by WCHO under code H2015 (or H0043 for *per diem* participants) could vary from participant to participant, depending on the level of non-staff services required by that participant's IPOS. If, for example, Plaintiff Waskul had not required a town recreation pass, at an annual cost of $280, the amount WCHO would have reported under code H2015 as to him would have decreased slightly, from $4.14 per 15-minute segment to $4.10. Nothing else — including the amounts he paid his staff — would have changed.

106. Now, however, the entire budgetary process was reversed. Instead of costing out necessary services and supports and then reporting the results for statistical purposes, WCHO now required that participants start with a fixed H2015 rate of $13.88 per hour ($3.47 per 15-minute segment) and work backwards to an amount that could be paid for staff by subtracting out the cost of all the non-staff services and supports.

107. WCHO's change in the budgeting process was continued by WCCMH on WCHO's dissolution in October 2015. The change continues to this day and, unless enjoined, will continue in the future.

108. The change in budgeting violates the requirement of HSW Appendix E-2(b)(ii) that "[t]he amount of the individual budget is determined by costing out the services and supports in the IPOS."

109. As a result of WCHO's illicit change in budgeting procedure, participants' IPOS budgets were instantly and drastically reduced. To continue with the example of Plaintiff Waskul, the new, uniform $3.47 H2015 rate was a 16.2% reduction from the previous $4.14 WCHO had been reporting statistically in his case. That meant that, if nothing else changed in his budget for non-staff services and supports, the amount he could pay his staff would be reduced by 18.5%. In fact, WCHO made other changes at the same time — such as taking the fiscal intermediary fee out of the H2015 amount even though it was reported separately for statistical purposes — so that the amount Plaintiff Waskul could pay staff went from $13.88 per hour to $9.63.

110. Each of the other named plaintiffs (except, as alleged below, Plaintiff Trabue, who was at that time under the age of 18 and thus not a CLS participant) suffered similar reductions.

111. Numerous members of WACA have suffered similar reductions.

112. Rather than developing an individual plan and then budgeting for it, participants were now forced to fit their plans within a budget that was capped at a specific rate times the number of staff hours in the IPOS, regardless of the extent of non-staff services and supports provided for in the IPOS and regardless of the actual rates that WCHO had previously approved paying individual staffers. For all participants for whom WCHO had been reporting an H2015 rate of more than $13.88 before May 15, 2015, the amount that could be paid for services was reduced, and the rate that could be paid to CLS staff was likewise reduced from the amounts previously authorized.

113. Moreover, participants' budgets were effectively capped, because budgeting for additional medically necessary services, such as additional community activities, would further reduce the CLS providers' pay, making it difficult to find and maintain paid CLS providers at such a low rate. Adding money for a line item like transportation must now come out of some other part of the budget, usually the provider hourly rate.

114. Ms. Amos O'Neal acknowledged in her April 2015 letter that the change would (she said "may") reduce the amount that participants could pay staff.

115. Each paid staff person of each of the named plaintiffs in this action was approved by WCHO to be a CLS provider. So, too, were many paid staff persons of the members of WACA.

116. The amounts those approved staff members were being paid were set forth in the participants' budgets, which WCHO had likewise approved.

117. At no point in connection with the April 2015 letter did WCHO, either directly or through its contractor, CSTS/WCCMH, determine that these approved staff personnel should no longer be approved.

Comparison Between What WCHO Did and What the State Had Told the Federal Government It Would Do

118. In 2010, when it obtained its most recent Habilitation Supports Waiver, the State of Michigan told the federal government what it expected to pay for CLS services during the course of the waiver. (The HSW expired at the end of 2014, but it has been extended since that time by a succession of 90-day extensions.)

119. The $3.47 "CLS rate" imposed by WCHO in the April 2015 letter is significantly less than the average rates the State had told the federal government it expected to pay.

120. Thus, when Michigan applied for the HSW in 2010, it told the federal government that it expected that the average CLS rates (per 15-minute segment) it would pay in the course of the five years (2010-2014) of the HSW would be:

Waiver Year	Average CLS Rate
2010	$4.20
2011	$4.38
2012	$4.57
2013	$4.77
2014	$4.98

121. Accordingly, when WCHO arbitrarily imposed a $3.47 cap on "CLS rates" in the April 2015 letter, it was setting a rate 17.4% lower than the *lowest* average rate the State had told the federal government it expected to pay, and fully ***31.3% lower*** than the rate the State had said it expected to pay in 2014, the then-most-recent year of the Habilitation Supports Waiver.

122. This effort of the WCHO bureaucrats to balance their budget on the backs of those they were duty-bound to serve is all the more disgraceful when one considers that Washtenaw County is a high-cost county

relative to most of the rest of the State of Michigan (indeed, in most years it is the *highest* cost county in the State), so that one would expect the cost of services and supports in Washtenaw to be *higher* than the statewide average, not lower.

Failure To Provide Adequate Notice

123. The April 2015 letter from Ms. Amos O'Neal failed to give notice to participants of their right to request a Medicaid fair hearing. The April 2015 letter did not give any reason for the intended action or cite any specific regulation supporting the action. The April 2015 letter was not based on medical necessity criteria, and did not provide an explanation of the circumstances under which benefits would be maintained should a hearing be requested.

WCCMH's "Double Counting" Explanation

124. Subsequent to the commencement of this action, WCCMH has asserted that the budgeting change was necessary to avoid "double billing," and that the manner in which budgets were being calculated prior to May 2015 was tantamount to Medicaid fraud.

125. Those assertions are not correct.

126. WCCMH has asserted that, from 2008 to 2012, WCHO's CLS rates were calculated on an "all inclusive" basis (*i.e.*, on a basis that included transportation and other non-staff services).

127. Even if that assertion is true, and even if the 2008 memorandum that WCCMH says implemented the practice survived the subsequent representation by the State of Michigan to CMS in Appendix E-2(b)(ii) of the 2010 HSW Application as to the manner in which budgets would be costed out, WCHO made the affirmative choice in 2012 to go to the build-up budgeting method described herein, specifically telling CLS participants that it was doing so in order to increase the services and supports available to them. See Exhibit E.

128. WCHO's decision to increase services and supports was within its powers as a PIHP to make and affected only WCHO's expenditure of its own capitation funds.

129. There was no "double counting." Both before and after the 2012 budgeting change, the CLS rates WCHO reported under line H2015 would properly have included additional expenses, services, and supports such as workers compensation, transportation, and the like. Even assuming WCCMH's current description of the pre-2012 process is

correct, the reported rates were simply higher after 2012 than they were before.

130. Neither the Habilitation Supports Waiver nor any other aspect of Michigan or Federal Medicaid law requires working backwards from a single, fixed H2015 statistical reporting rate to participants' budgets under this self-determination program.

131. Indeed, as alleged above, the backwards budgeting currently being imposed by Defendants WCCMH and CMHPSM (and Defendants Cortes and Terwilliger as their Directors), and being acquiesced in by Defendant Gordon as director of MDHHS, is expressly *contrary* to HSW Appendix E-2(b)(ii).

The Post-May 2015 Process and Its Effect on CLS Participants

132. The effect of the illicit budgeting change in 2015 is illustrated by Plaintiff Waskul, who is severely autistic. The effect of the April 9, 2015 letter was to immediately reduce the amount he could pay his providers from approximately $12.00 an hour ($13.88 an hour gross of employment taxes) to $9.63. The change was implemented by transmogrifying Waskul's CLS provider rate into an overall, all-inclusive CLS reimbursement rate. Previously, items that had been budgeted separately from the provider rate were used to build up the

Medicaid reimbursement rate. Now, they all had to be shoehorned into a single fixed rate.

133. Thus, as alleged above, at the end of the new process, Waskul was told he could pay at most $9.63 per hour to his providers, the "max rate for employee wage." Exhibit C, Waskul Post-May 15, 2015 Budget.

134. This was a reduction of 20% in the amount Waskul could pay for the care he needed — care that was certified as medically necessary in his approved IPOS.

135. This budget reduction and new calculation method affected all CLS participants in Washtenaw County.

F. Post-June 4, 2015 Notice of Hearing Rights

136. MDHHS sent notice to Defendant WCCMH's predecessor on June 4, 2015, warning it that its decision to reduce CLS participants' budgets did not conform to the approved budget authority process in the Habilitation Supports Waiver application. Exhibit F, Letter from Jeffrey Wieferich to Sally Amos O'Neal.

137. MDHHS noted that "Medicaid-funded services are changed, reduced, or terminated as a result of a reduction in the individual budget." *Id*.

138. In response to MDHHS's letter, Defendant WCCMH's predecessor claimed that it was "collaborating with the individual and/or guardian to review the Individual Plan of Service (IPOS) and the Self Determination budget. Upon review with all parties, the IPOS will be reviewed and signed off on by the individual and/or guardian and the CMHSP . . . Through the completion and signature on the updated IPOS, each individual and/or guardian will be provided Adequate Notice of Rights." Exhibit G, WCHO Response to MDHHS.

139. Starting in late June 2015, Defendant WCCMH's predecessor began reopening participants' IPOS to incorporate the budget reductions.

140. Upon information and belief, contrary to MDHHS's demand that Defendant WCCMH's predecessor comply with the person-centered planning process when reopening the IPOS, Defendant WCCMH's predecessor often simply had clinical staff call participants and notify them that their IPOS would be redone.

141. Upon information and belief, the clinical staff of Defendant WCCMH's predecessor usually showed up at participants' homes with an IPOS reflecting the reduction already incorporated and asked them to sign it.

142. When Defendant WCCMH's predecessor incorporated the CLS budget reduction into participants' IPOS, it provided a notice of hearing rights with the new IPOS.

143. These later notices of hearing rights described the action taken as "adequate," and were not negative advance action notices. Exhibit H, Post-June 4, 2015 Notice of Hearing Rights (for Plaintiff Schneider).

144. These later notices did not cite any statute or policy authorizing the reduction in services.

145. These notices did not state what was reduced or why.

146. Because these later notices did not acknowledge the reduction in services, no reason for the reduction was given in the notices.

147. Upon information and belief, Defendant WCCMH's predecessor told participants at the time the hearing notice was provided that the CLS budget reduction was not appealable and that they should not bother requesting a hearing.

148. A number of recipients, including Plaintiff Erlandson, did not request hearings because of these representations.

149. Defendant WCCMH's predecessor did not even provide these post-June 4 notices to all recipients. Plaintiffs Erlandson and Ernst did not receive these notices.

150. Upon information and belief, the majority of recipients did not receive even this deficient notice.

151. At two local dispute meetings held in late summer and early fall 2015 (just about the time WCHO was dissolving and CSTS was changing its name to WCCMH), Defendant WCCMH continued to argue that the budget reduction was not an appealable issue. Defendant WCCMH also argued that the Michigan Administrative Hearing System (MAHS) did not have jurisdiction to hear the named Plaintiffs' cases.

152. Defendant WCCMH continued to assert that MAHS did not have jurisdiction to hear CLS budget reduction appeals through February 2016.

153. Per testimony from Sally Amos O'Neal at the September 20, 2016 evidentiary hearing held in this matter, only about 19 of around 170 CLS participants in Washtenaw County reached administrative hearings by an appeal based on this later notice of hearing rights.

154. Although Defendant WCCMH also assured MDHHS that it had "reversed the CLS rate retroactive to May 15, 2015 pending results of the Medicaid Fair Hearings Process scheduled for July 1, 2015," it did not do so for every individual.

155. For the few CLS participants who requested a hearing notwithstanding the defective notice, Defendant WCCMH did not immediately restore the rate to the pre-May 15, 2015 amount; instead, it sought to impose a rate of $14.48, which it borrowed from Michigan's Children's Waiver.

156. Defendants later postured the $14.48 rate as "negotiated." Upon information and belief, however, this rate was never "negotiated"; rather, participants were told they could have the $14.48 rate or the $13.88 rate.

157. Due to, among other things, differences in the service populations and waiver structures, the Children's Waiver rates are not a valid basis of comparison to rates for HSW CLS services.

158. Both the $14.48 rate and $13.88 rate were inputs to the illicit post-May 15, 2015 budgeting method, which inappropriately ignores non-staff services and supports in setting the overall amount available under the budget.

159. Since this lawsuit was filed, Defendants have slightly raised the CLS rate several times, but all participants' budgets are still set without any reference to non-staff services and supports.

160. The harm to Plaintiffs is irreparable. Plaintiffs have no adequate remedy at law to prevent the continuing wrong and irreparable injury caused by Defendants' acts.

WCCMH's Knowledge of Illegality

161. Due to the WCHO/WCCMH budget crisis, an outside consultant, Health Management Associates (HMA), was brought in around the time of the merger to review WCCMH's budget.

162. In a draft report dated December 17, 2015, HMA wrote: "The Community Living Supports program area is another with cost metrics that bear scrutiny. WCCMH leadership has indicated to HMA that they already have made changes that will reduce costs in this area and that they will continue to evaluate and explore options for improved cost effectiveness while maintaining quality. We encourage these continuing efforts." Exhibit I, HMA Draft Report, page 12.

163. In a letter sent to PIHP executive directors on October 22, 2015, MDHHS had notified Defendants CMHPSM and WCCMH that the "changes that will reduce costs" mentioned in the HMA letter were illegal. Exhibit J, Letter from Thomas Renwick to PIHP Executive Directors.

164. Specifically, MDHHS condemned "PIHPs and/or their provider networks [implementing] a practice of using assessments or screening tools to determine, limit or restrict the amount, scope, or duration of a service." *Id*.

165. The letter states that "it is the person-centered planning process and medical necessity criteria that determine the amount, scope and duration of services." *Id*.

166. Moreover, MDHHS stated that "it also bears reminding that the PIHP is obligated to ensure that medically necessary supports, services or treatments or treatment are sufficient in amount, scope and duration to reasonably achieve their purpose." *Id*.

167. The "changes that will reduce costs," criticized by MDHHS in the letter and affecting the named Plaintiffs' CLS services, went into effect in May 2015, and have not been reversed despite several individual administrative law decisions reversing the reductions.

PLAINTIFFS' FACTS

DEREK WASKUL

168. Plaintiff Waskul incorporates all paragraphs above.

A. Mr. Waskul's Disabilities; Effect of the May 15, 2015 Cuts.

169. Plaintiff Derek Waskul (Mr. Waskul) suffers from a severe cognitive impairment and autism.

170. He is in his mid-thirties, but cannot function independently and requires 24/7 supervision.

171. Both Mr. Waskul and his guardian are members of WACA.

172. Mr. Waskul receives Home Help Services through MDHHS, and Cynthia Waskul, his mother and legal guardian, provides about ten hours of unpaid natural support per day, but Mr. Waskul depends on two paid CLS providers seventy hours per week.

173. Mr. Waskul receives CLS services under the HSW.

174. Through his guardian, Mr. Waskul participates in the CLS self-determination process.

175. Prior to May 15, 2015, Mr. Waskul's CLS providers were paid $13.88 an hour before taxes.

176. Mr. Waskul's budget included separate items for training, transportation, community activities, and worker's compensation.

177. Mr. Waskul's pre-May 15, 2015 IPOS budget was developed based on the medically necessary services authorized by his IPOS.

178. Mr. Waskul received the April 9, 2015 letter from Sally Amos O'Neal, described above and attached as Exhibit D, and his budget was reduced and entirely recalculated effective May 15, 2015, as alleged above.

179. The result of this unilateral interference with Mr. Waskul's budget was that Mr. Waskul was forced to lower the hourly rate he could pay his CLS staff from $12.00 per hour after taxes ($13.88 per hour gross) to around $9.50 per hour after taxes.

180. Prior to May 15, 2015, Mr. Waskul's total yearly budget amount was $29,182.56. Exhibit C, Budget Created February 12, 2015.

181. After the May 15, 2015 reduction, Mr. Waskul's total budget amount was only $26,957.20. Exhibit K, Budget Created May 18, 2015.

182. Defendant WCCMH has never offered any justification based on medical need for the reduction of Mr. Waskul's budget, and no such justification exists.

183. Prior to May 15, 2015, Defendant WCCMH's predecessor (WCHO) had reduced the staff hours specified in Mr. Waskul's IPOS, and Mr. Waskul had a pending fair hearing request related to that reduction.

184. At a meeting on June 12, 2015, counsel for Mr. Waskul stated that the pending fair hearing request would be amended to include the

May 15, 2015 budget reduction. In response, representatives of WCHO said they would reverse the budget reduction and asked Mr. Waskul to withdraw his hearing request.

185. Katie Snay, Fair Hearings Officer for Defendant WCCMH and its predecessor, confirmed around June 30, 2015 that the reduction in the amount Mr. Waskul could pay his CLS providers had been reversed.

186. With that assurance, Mr. Waskul withdrew his pending request for a Medicaid fair hearing.

187. By notice dated July 20, 2015, however, WCHO unilaterally reduced Mr. Waskul's budget and imposed a budget based solely on staff hours and using an overall rate of $14.48 per hour. It did so notwithstanding its assurances at the June 12 meeting and notwithstanding that Michigan policy allows the IPOS and budget to be developed only through the person-centered planning process, MPM, § 15, page 975.

188. That is, WCHO started with an overall amount based on staff hours (staff hours times the unilaterally determined "CLS rate" of $14.48 per hour) and then proceeded to *subtract* from that overall amount the cost of the non-staff services and supports specified in the IPOS in order to obtain an amount that could be paid to staff.

189. The notice of action sent to Mr. Waskul stated that the reduction would be imposed unilaterally, explicitly acknowledging that Mr. Waskul did not agree to the reduction. Exhibit L, Notice of Hearing Rights, July 20, 2015.

190. This time, WCCMH's predecessor admitted that the change was a "reduction in services" and correctly characterized the July 20 notice as a negative advance action notice. *Id*. At the subsequent administrative law hearing, however, Defendant WCCMH claimed that this notice was a mistake, and that no notice with hearing rights (or an adequate action notice) should have been given on the basis that there was no reduction in services.

191. Upon information and belief, this was the only negative advance action notice subsequently sent to CLS participants who had received the April letter.

192. The only justification provided in the July notice was that the new imposed rate of $14.48 was the maximum state rate allowed under the Children's Waiver. *Id*.

193. The Children's Waiver, however, is a separate waiver program that is not relevant to Mr. Waskul. Although there is a maximum rate set by

the state under the Children's Waiver, there is no such rate under the HSW.

194. After receiving the July 20 notice, Mr. Waskul requested a local dispute hearing and a Medicaid fair hearing.

195. After a local dispute resolution meeting, Defendant WCCMH issued a decision affirming the reduction in services, citing its need "to be good stewards of Medicaid dollars." Exhibit M, August 24, 2015 Local Dispute Resolution Committee Report of Findings.

196. Although Mr. Waskul's primary care provider wrote a letter stating that "a lowering of Derek's self-determination budget would be devastating to Derek," Exhibit N, Letter from Maria Heck, DO, Defendant WCCMH did not take this into account.

197. Doctor Heck also wrote, "[a]s a young man with severe cognitive impairment and autism, Derek needs stability, consistency and dependability. With the proposed changes, which would lower the staff wage, Derek will lose his current staff whom he has developed relationships with. Derek's current staff have facilitated and helped Derek to develop meaningful relationships in the community. Social interaction with others is a very important piece in the purpose of the self-determination arrangement." *Id.*

198. "Without constancy, Derek will inevitably have increased anxiety, increased behavior problems, and increased autism symptoms. Autism is a disorder that requires a need for sameness. As his doctor, I ask that you consider Derek's specific medical needs when making this decision." *Id*.

199. Despite Doctor Heck's clear direction, Defendant WCCMH nevertheless ignored Mr. Waskul's medical needs and reduced his CLS budget.

B. Administrative Law Hearing and Subsequent Developments.

200. Mr. Waskul requested a Medicaid Fair Hearing shortly after receiving the July 20, 2015 notice of hearing rights.

201. When Mr. Waskul requested the Medicaid hearing, the rate that Defendants used to calculate his budget was restored to its full pre-May 15, 2015 amount, but the manner of the budget calculation — *i.e.*, starting with a single, overall amount based on staff hours and then subtracting out non-staff services and supports — was not changed.

202. A Medicaid Fair Hearing was held by the Michigan Administrative Hearing System (MAHS) on October 14, 2015.

203. Mr. Waskul's two paid CLS providers both testified under oath that they could not continue to work at the reduced rate.

204. Medical evidence was admitted stating that losing any of his current CLS providers would be detrimental to Mr. Waskul's health.

205. Despite Mr. Waskul's evidence that the rate reduction would force his CLS staff to quit and lead to harm, at the urging of Defendant WCCMH ALJ Steven Kibit issued a dismissal order asserting that he had no jurisdiction on the basis that there had been no reduction in the amount, scope, and duration of Mr. Waskul's services. Exhibit O, Order of Dismissal.

206. For unknown reasons, the overall rate Defendants used to calculate Mr. Waskul's budget was not reduced again after the dismissal, but stayed at the pre-May 15, 2015 rate.

207. On November 25, 2015, ALJ Kibit *sua sponte* issued an Order Vacating Dismissal, ruling that MAHS did in fact have jurisdiction to hear the case. Exhibit P.

208. Specifically, ALJ Kibit ruled that MAHS had jurisdiction because the reduction in Mr. Waskul's CLS budget did confer the right to a Medicaid Fair Hearing, and ordered a new hearing.

209. After ALJ Kibit had dismissed the case for lack of jurisdiction, Mr. Waskul's provider Christina Pulcifer quit, and Mr. Waskul did not

have enough staff to provide the medically necessary services required by his IPOS.

210. It generally takes significant time to find a suitable replacement for Mr. Waskul's CLS providers, because Mr. Waskul must be familiar with the provider and have established a certain level of trust.

211. Given the nature of their disabilities, the same is true of many of the other individual Plaintiffs and many members of WACA.

212. Mr. Waskul was at risk of losing his other paid CLS provider as well because of the uncertainty surrounding her job.

213. On February 18, 2016, ALJ Kibit granted Mr. Waskul's Motion for Summary Disposition and ordered Defendant WCCMH to reverse the budget reduction.

214. On February 29, 2016, Defendant WCCMH sent Mr. Waskul an Order Certification, certifying that ALJ Kibit's Order had been implemented.

215. Despite its representations in the Order Certification, Defendant WCCMH did not reverse the new budget calculation method, and it purported to appeal ALJ Kibit's decision.

216. Mr. Waskul currently cannot budget for any additional needs without reducing the amount he can pay his CLS providers.

217. Defendant WCCMH denied Mr. Waskul's requests for additional CLS hours on the sole basis that he was not using his full allotted hours.

218. Mr. Waskul was unable to use his full hours because he was unable to fill Ms. Pulcifer's position due to the inadequately low provider rate.

219. Mr. Waskul's guardian was eventually forced to hire her husband to fill Ms. Pulcifer's hours, at which time Defendant WCCMH approved the request for additional hours, increasing Mr. Waskul's hours from 37.5 to 70 hours per week.

220. Mr. Waskul is currently unable to find suitable CLS providers willing to work at the current rate, but he cannot increase the provider rate without decreasing some other part of his budget.

221. Ms. Waskul's husband can provide the bulk of the paid CLS services only on weekends and in the evening, leaving Mr. Waskul short-staffed during the week.

222. As a result of this short-staffing, Mr. Waskul goes three weekdays (Monday through Wednesday) without his normal community routine and is confined to his home on those days.

223. This serious reduction in community involvement has had a serious deleterious effect on Mr. Waskul's health.

a. Without the necessary amount of community involvement and social interaction, Mr. Waskul becomes lethargic and depressed, often refusing to eat. The resultant excess sitting has worsened Mr. Waskul's scoliosis.

b. Certain relationships that Mr. Waskul had developed in the community are deteriorating. For example, Mr. Waskul is no longer able to go to the farmer's market in Ann Arbor on Wednesday, where he had developed special relationships with certain vendors, because he has no CLS providers during the day on Wednesday.

c. Currently, Mr. Waskul frequently refuses to get out of the car when taken into the community, and his CLS provider has been forced to turn around and go home. Mr. Waskul has refused to get out of the car even when accompanied by his mother. In the community, he now becomes angry and potentially poses a danger to himself and others.

CORY SCHNEIDER

224. Plaintiff Schneider incorporates all paragraphs above.

A. Mr. Schneider's Disabilities and Staffing Before the May 15, 2015 Cuts.

225. Mr. Schneider has been diagnosed with autism and a developmental disability, and he suffers from an undiagnosed behavior disorder.

226. Mr. Schneider is twenty-one years old but cannot function independently. He has received CLS services under the HSW since he turned eighteen.

227. Both Mr. Schneider and his guardian are members of WACA.

228. Due to his extremely limited speech and the likelihood of self-inflicted harm, Mr. Schneider requires 24/7 care.

229. Mr. Schneider's CLS providers are necessary to help Mr. Schneider lead as normal a life as possible and avoid institutionalization.

230. Among other things, the CLS providers help Mr. Schneider to cross the street, engage in basic social interactions, remind him to use the bathroom, and monitor his aggression.

231. Caring for Mr. Schneider is a strenuous job involving constant monitoring. Mr. Schneider is over six feet tall and has aggressive tendencies resulting from his behavioral disorder, which CLS staff need to control to prevent him from hurting others or himself.

232. Mr. Schneider's IPOS provides for 168 hours of CLS services per week (24/7).

233. Prior to May 15, 2015, just as in the case of Plaintiff Waskul, Mr. Schneider's IPOS budget was calculated by applying the actual hourly pay rates for his paid CLS providers to the number of hours they

worked and then adding in additional line items for non-staff services and supports.

234. Mr. Schneider had around four paid CLS providers prior to May 15, 2015. His lead CLS provider, Stacey Rozsa, who has been with him for at least six years, was paid around $13.50 per hour, and his other three CLS providers were paid around $10.00 per hour.

B. Effect of the May 15, 2015 Cuts.

235. Mr. Schneider received the April 9, 2015 letter informing him that his budget would be changed as described above with respect to Plaintiff Waskul.

236. The letter did not give notice to Mr. Schneider of his right to a Medicaid Fair Hearing. Only much later, on November 18, 2015, did Defendant give Mr. Schneider a notice of hearing rights and permit him to request an administrative hearing.

237. The notice was not the required advance adverse action notice. It was given well after the budget reduction was implemented and incorrectly stated that the action taken was "adequate."

238. Because the notice described the action taken as "adequate," the notice on its face did not provide Mr. Schneider an opportunity to request a timely hearing and receive benefits pending, because pending

benefits require "a termination, reduction, or suspension of a service that was previously authorized."

239. The specific regulation cited in the notice simply stated that the amount, scope, and duration of an IPOS must be sufficient, and that the Medicaid agency "may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition." *Id*.

240. For the reasons outlined above, the rate reduction was not simply a new set rate for paid CLS providers. Rather, the budget was reduced, and amounts that previously had their own line items now had to be taken from a single amount calculated based solely on Mr. Schneider's staff hours.

241. As a consequence, the take-home pay both of Ms. Rozsa and of the other three CLS providers was reduced from the amounts that WCCMH and/or its predecessor had previously approved.

242. Defendant WCCMH reduced Ms. Rozsa's pay rate, which then fluctuated for no apparent reason in subsequent months between $11.50 and $12.00 per hour.

243. After the May 15, 2015 budget recalculation, the pay rate for Mr. Schneider's CLS providers was frozen at around $10 per hour for new providers.

244. Because of the budget imposed by Defendant WCCMH, Mr. Schneider is unable to maintain his current paid CLS providers or find suitable replacement providers, and consequently is not receiving the medically necessary services required by his IPOS.

245. After May 15, 2015, Mr. Schneider's grandmother, Martha Schneider, made numerous attempts to find replacement CLS providers, posting at Eastern Michigan University and on care.com.

246. Due to the low pay rate and the difficult nature of the work involved, Mr. Schneider was unable to find suitable replacement CLS staff.

247. Between May 2015 and April 2016, Mr. Schneider could only employ two paid CLS providers for about sixty-five of his ninety-three then-scheduled hours a week. Mr. Schneider's grandmother provided unpaid care for Mr. Schneider the remaining 103 hours of the week.

248. Ms. Schneider is seventy-five years old and underwent heart surgery within the last year.

249. On February 18, 2016, ALJ Kibit granted Mr. Schneider's Motion for Summary Disposition and ordered Defendant WCCMH to reverse the budget reduction.

250. On March 4, 2016, Defendant WCCMH sent Mr. Schneider an Order Certification, certifying that ALJ Kibit's Order had been implemented.

251. However, Defendant WCCMH has not reversed the budget calculation method.

252. Although Mr. Schneider's IPOS specifically requires him to have five days out in the community, Mr. Schneider is now unable to budget for additional medically necessary items like transportation and community activities without further reducing his CLS providers' pay.

253. Mr. Schneider's grandmother has paid, and continues to pay, out of pocket for transportation and community activity expenses.

254. On December 4, 2015, Mr. Schneider requested $400 monthly for transportation and $200 monthly for community activities. Mr. Schneider's amended IPOS from December 4, 2015 states that "these costs are above what the current self-determination budget covers."

255. Defendant WCCMH did not provide Mr. Schneider notice of his hearing rights when it denied this request for medically necessary services.

256. Ms. Schneider was recently forced to hire her 77-year-old husband, Dick Schneider, to provide paid CLS services due to her inability to find providers willing to work at the low rate available under Defendants' budget method.

257. Over the 2016 Christmas holiday, Mr. Schneider's grandfather provided nearly 150 hours of paid CLS services.

258. Mr. Schneider is receiving regular treatment for kidney failure.

259. Another CLS provider recently quit, and Ms. Schneider is still unable to hire sufficient staff at the current rate.

260. Mr. Schneider's grandfather and grandmother are now providing around 75 hours of CLS services per week, nearly 50% of the CLS support required by Mr. Schneider's IPOS, because Mr. Schneider is still short-staffed and cannot find CLS providers to work at the current rate.

KEVIN WIESNER

261. Plaintiff Wiesner incorporates all paragraphs above.

A. <u>Mr. Wiesner's Disabilities; Background.</u>

262. Plaintiff Kevin Wiesner (Mr. Wiesner) is twenty years old. He has severe developmental disabilities and suffers from seizures.

263. Mr. Wiesner collapses during seizures and risks striking his head on objects while falling. In addition to preventing him from collapsing during seizures, his paid CLS providers must also pass a magnet over his Vagus Nerve Stimulator, which sends an electric charge to his brain. CLS staff must also ensure that Mr. Wiesner coughs up food to prevent blockage of his airways during seizures.

264. Both Mr. Wiesner and his guardian are members of WACA.

265. Mr. Wiesner receives about 85 hours of care per week in his IPOS.

266. Mr. Wiesner requires at least two CLS staff with him at all times in public.

267. Mr. Wiesner has been receiving CLS services under the HSW since he turned eighteen.

268. Mr. Wiesner's pre-May 15, 2015 hourly CLS provider rate of $12.00 per hour allowed for transportation and community activities to be budgeted outside of the caregiver rate, although he did not have a written budget between the time he transitioned from the Children's Waiver and the May 15, 2015 cuts.

B. Effect of the May 15, 2015 Cuts.

269. Mr. Wiesner's IPOS requires medically necessary community activities.

270. Mr. Wiesner's guardian was prepared to ask that medically necessary transportation and community activity expenses be budgeted when she received the April 9, 2015 letter from Sally Amos O'Neal.

271. The April 2015 letter and subsequent discussions with WCHO, Defendant WCCMH's predecessor, convinced Mr. Wiesner's guardian that she could not budget for those medically necessary services without reducing Mr. Wiesner's CLS providers' pay rate to an unlivable wage.

272. On May 15, 2015, Mr. Wiesner's CLS budget was reduced and recalculated as described above with respect to Plaintiffs Waskul and Schneider, so that the amount Mr. Wiesner could pay his CLS providers was lowered to $11.50 per hour.

273. The result was that Mr. Wiesner's overall CLS budget was reduced, and the amount of services he could obtain was likewise reduced.

274. This reduction caused Mr. Wiesner to breach his employment contracts with his CLS staff.

C. Improper Notice of Hearing Rights and Lack of Benefits Pending.

275. Mr. Wiesner received no notice of hearing rights either in April 2015, when the letter was sent, or on May 15, 2015, when the budget reduction was instituted.

276. Mr. Wiesner refused to sign an amended IPOS in July 2015, which would have implemented the reduced budget in his IPOS.

277. At that time, Mr. Wiesner received a notice of his hearing rights, dated July 7, 2015 (a notice of "adequate action"), and requested a hearing.

278. Defendant WCCMH reduced Mr. Wiesner's services before providing the July 7, 2015 notice, which was not a negative advance action notice.

279. Because the July 7th notice described the action taken as "adequate," the notice on its face did not provide Mr. Wiesner an opportunity to request a timely hearing and receive benefits pending, because pending benefits require a termination, reduction, or suspension of a service that was previously authorized.

280. Mr. Wiesner was forced to pay his CLS providers reduced wages for two months.

281. When Mr. Wiesner requested the hearing in August 2015, Defendant WCCMH raised his CLS rate, but not to the full prior amount.

282. Instead, this was a "compromised" rate of $14.48, which WCCMH borrowed from the Children's Waiver.

283. Mr. Wiesner received no retroactive benefits for his CLS providers.

284. An administrative mix-up concerning Mr. Wiesner's guardian paperwork prevented his hearing request from being properly processed until December 2015.

285. Upon information and belief, it was only in December 2015 that Mr. Wiesner was told by Katie Snay, Fair Hearings Officer for WCCMH, that Defendant WCCMH had restored his CLS provider rate to the full $12.00.2

286. Moreover, the pre-May 15, 2015 method of calculating the budget was not reinstated pending the Medicaid fair hearing.

287. Mr. Wiesner's guardian paid out of pocket for community activity and transportation expenses.

288. When Mr. Wiesner's guardian requested reimbursement for these expenses, she was told that additional line items would need to be added to his IPOS.

289. Adding these additional budget line items would only continue to reduce Mr. Wiesner's CLS provider pay rate.

[2] Although under the HSW a self-determination participant has the right to hire staff, the fiscal intermediary handles all administrative work pertaining to the CLS providers' wages. The participant therefore would not know what the providers' rate is without looking at the providers' pay stubs or asking the fiscal intermediary directly.

290. Since the budget reduction was imposed, Mr. Wiesner has lost one CLS provider due to the inability to pay sufficient wages.

291. Over the past year, because of her inability to budget for additional services without reducing Mr. Wiesner's hourly provider rate, Mr. Wiesner's guardian had to pay for the majority of Mr. Wiesner's community activity and transportation needs out of pocket.

292. These expenses contributed to causing Mr. Wiesner's guardian to fall behind on her property taxes, putting her at risk of foreclosure.

293. Mr. Wiesner has suffered harm as a result of the illegal reduction in his CLS budget, and as a result of WCCMH's refusal to budget for transportation and community activities.

294. A state ALJ again ruled that WCCMH had inappropriately denied Kevin Wiesner medically necessary services (MAHS Docket No. 16-008576). ALJ Kibit found that WCCMH had both failed to comply with his March 16, 2016 Decision and Order and had improperly denied Ms. Kafafian's new request for an increase in funding for Kevin's approved CLS budget.

295. Defendant WCCMH appealed this decision, but reconsideration was denied.

296. Although Mr. Wiesner's IPOS currently requires him to have 3 CLS providers, Mr. Wiesner's guardian has been able to hire only two since January 2017 because the rate that she can offer is too low.

297. Mr. Wiesner is currently receiving only about 80 of the 120 CLS hours per week required by his IPOS.

298. Mr. Wiesner's guardian is unable to work during the time she has to stay home with Mr. Wiesner, which has taken a financial toll on her.

299. Mr. Wiesner's behavioral issues have also become worse in the last few months due to being stuck at home more.

300. Because Mr. Wiesner requires two-on-one staffing in the community, the inability to hire a third CLS provider has also negatively impacted Mr. Wiesner's ability to get into the community during the hours that are currently provided. This is because Mr. Wiesner's guardian now cannot balance her work schedule in such a way as to be home at the same time as the two CLS providers and accompany them into the community, due to the fact that she must stay home at other times to cover the hours that the third CLS staff would provide.

ROGER ERLANDSON

301. Plaintiff Erlandson incorporates all paragraphs above.

302. Mr. Erlandson suffers from severe autism and cognitive impairments. Although he is 37 years old, he requires 24/7 care and supervision.

303. Both Mr. Erlandson and his guardian are members of WACA.

304. Mr. Erlandson began receiving CLS services under the Habilitation Supports Waiver using a self-determination arrangement around four years ago.

305. Because he receives 24/7 care, the costs WCCMH and CMHPSM incur with respect to his CLS services are coded H0043 for statistical reporting purposes. His actual staff budget, however, consists of a combination of *per diem* and hourly charges, depending on the provider.

306. In his pre-May 15, 2015 budgets, Mr. Erlandson had the ability to increase his spending for additional line item costs like transportation without reducing his hourly provider rate.

307. Mr. Erlandson received the April 9, 2015 letter, attached as Exhibit D. The letter was sent only to Mr. Erlandson, not to his guardian, and did not give Mr. Erlandson notice of his right to a hearing.

308. On May 15, 2015, Mr. Erlandson's budget was reduced and recalculated.

309. Mr. Erlandson's guardian, desiring to request a Medicaid fair hearing, consulted with WCHO staff and a private attorney.

310. Mr. Erlandson's guardian was advised by WCHO staff that she did not have the right to request a hearing because there had been no reduction in the amount, scope, or duration of services.

311. Relying on the April 9, 2015 letter and the statements of WCHO, the private attorney advised that Mr. Erlandson's guardian did not have the right to pursue a Medicaid fair hearing.

312. Mr. Erlandson never received a post-June 4, 2015 notice of hearing rights.

313. On the advice of a friend and fellow CLS self-determination guardian, Mr. Erlandson's guardian stated her intention to file a grievance against WCHO, at which point she was offered, and accepted, the $14.48 "compromise" rate.

314. Since the post-May 15, 2015 budget calculation method went into effect, Mr. Erlandson has been unable to budget for the medically necessary services in his IPOS.

315. Mr. Erlandson's guardian expends significant out-of-pocket costs — well over $3,000 per year — for the medically necessary services and

supports in Mr. Erlandson's IPOS that cannot be paid for under the post-May 2015 budget methodology.

316. Most recently, Mr. Erlandson attempted to budget for a CLS staff supervisor, as explicitly provided for in his IPOS. The supervisor is necessary to train staff on Mr. Erlandson's unique needs, and is specifically included in Mr. Erlandson's IPOS.

317. The request was initially denied on the basis that it was not medically necessary, but *all* services described in the IPOS are medically necessary. In reality, under the new budget calculation method, WCCMH simply *cannot* budget for the supervisor without reducing another part of the budget.

318. WCCMH was eventually forced to concede that hiring a supervisor was appropriate, but it continued to make no provision in the budget for doing so. In order to avoid reducing the wages of CLS staff to untenably low levels, Mr. Erlandson's guardian has been forced to pay out of pocket for a significant portion of the cost of the supervisor.

319. Mr. Erlandson continues to suffer harm each day that his pre-May 15, 2015 CLS service levels and budget calculation method are not reinstated.

LINDSAY TRABUE

320. Plaintiff Trabue incorporates all paragraphs above.

321. Ms. Trabue has been diagnosed with Down syndrome, and her IQ is 38.

322. Both she and her guardian are members of WACA.

323. Ms. Trabue is non-verbal and possesses only the most basic functional skills. She requires 24/7 care.

324. Ms. Trabue has received CLS services under a self-determination arrangement only since December 2015. Therefore, unlike the other named plaintiffs, she did not receive the April 2015 letter and experience a budget reduction on May 15, 2015.

325. However, Ms. Trabue has always been subject to the post-May 15, 2015 budget calculation method, and has consequently suffered from a CLS budget in which the cost of non-staff services and supports is subtracted from an overall amount based on staff hours and a single, overall rate, thereby reducing the amount that can be paid to staff.

326. Ms. Trabue's overall rate started at $13.88, but was almost immediately increased to $14.48 at the request of her guardian.

327. From the beginning of her self-determination arrangement, Ms. Trabue's budget has not included separate a line item for transportation

expenses, but requires transportation to be taken out of the overall amount calculated by applying the $14.48 rate to the approved staff hours in her IPOS.

328. Because Ms. Trabue travels around 600 miles per month to meet her medically necessary community involvement needs, and the cost of that transportation reduces her providers' hourly wages.

329. From the beginning of her self-determination arrangement, Ms. Trabue's budget has not included a separate a line item for community activity expenses, but would require such expenses, if paid for by Defendant CMHPSM, to be taken out of the overall amount calculated by applying the $14.48 rate to the approved staff hours in Ms. Trabue's IPOS.

330. For example, Ms. Trabue has been diagnosed with non-alcoholic fatty liver disease, requiring significant physical activity each week.

331. Pursuant to her IPOS, Ms. Trabue participates in disabled bowling, yoga, dance, and gym activities, in part for her physical needs and in part to further her community integration.

332. The expense of these activities is and should be the obligation of Defendant CMHPSM, but Ms. Trabue's guardian has been forced to pay for all of these expenses out of pocket. She cannot take these expenses

out of the providers' pay, as she did with transportation, because doing so would reduce the providers' hourly rate to an untenable level.

333. Because of Defendants' budgeting method and the capping of Ms. Trabue's budget at $14.48 times the IPOS staff hours, Ms. Trabue cannot add additional money for transportation or community activities without losing other medically necessary services and supports.

HANNAH ERNST

334. Plaintiff Ernst incorporates all paragraphs above.

335. Ms. Ernst has been diagnosed with Angelman Syndrome, a seizure disorder, and a moderate cognitive impairment.

336. She is 20 years old, but cannot function independently.

337. Both she and her guardians are members of WACA.

338. Ms. Ernst was living at her guardians' home in May 2015 and employing one CLS provider during the week.

339. When the May 15, 2015 reduction went into effect, the provider's pay rate suddenly decreased from about $16 per hour to about $11.88 per hour.

340. This provider subsequently quit due to the reduced rate.

341. Due to her difficulty finding staff at the reduced rate, Ms. Ernst's guardians tried using a provider agency to receive services.

342. The provider agencies were not suitable for many reasons, and Ms. Ernst resumed a self-determination arrangement in July 2016.

343. In July 2016, Ms. Ernst was no longer living with her guardians and required additional staff.

344. Ms. Ernst's guardians hired four CLS providers, but were only able to do so because they had resolved to pay for all transportation and community activities themselves in order to offer a living wage.

345. To this day, Ms. Ernst's guardians pay out of pocket for *all* community activity and transportation expenses.

346. This is because, should Ms. Ernst budget for transportation and community activities in her individual budget, her provider rate would be reduced to an untenable level.

347. All of the transportation and community activities for which she is paying out of pocket are provided for in Ms. Ernst's IPOS.

348. Ms. Ernst's guardians pay about $1,000 out of pocket per month for these activities and transportation costs.

WASHTENAW ASSOCIATION FOR COMMUNITY ADVOCACY (WACA)

349. Plaintiff WACA incorporates all paragraphs above.

350. WACA is a non-profit organization, established in 1949.

351. Its mission and purpose include advocating for persons with developmental disabilities and their families in order to help them obtain and maintain services.

352. WACA frequently advocates for self-determination recipients, often through participation in the person-centered planning process, and it regularly fields calls regarding CLS self-determination from participants and their guardians, providing information and answers to client questions.

353. In addition to helping its members obtain services, WACA often provides representation to individuals whose services are reduced or terminated in administrative law hearings.

354. Its service population is comprised mainly of persons with disabilities and their families.

355. Its members include recipients of CLS services and their providers.

356. All HSW CLS services recipients in Washtenaw County qualify for WACA's services.

357. All named individual Plaintiffs are members of WACA.

358. Many of WACA's clients, including the named individual Plaintiffs in this case, have been directly harmed by Defendants' practices.

359. WACA has an interest in protecting the interests of its developmentally disabled members.

360. The relief sought in this lawsuit would directly benefit WACA and its developmentally disabled members.

361. WACA has seen an increase in the number of advocacy requests from individuals with developmental disabilities who receive self-determination CLS services from Defendant WCCMH in 2015 and 2016, due to the reductions at issue in this case.

CLAIMS FOR RELIEF

COUNT I – FAILURE TO PROVIDE CONSTITUTIONALLY ADEQUATE NOTICE AND RIGHT TO BE HEARD (All Plaintiffs Against Defendants Cortes, Terwilliger, and Gordon)

362. Plaintiffs incorporate all paragraphs above.

363. The right to procedural due process is secured by the 14th Amendment, and public benefits are a constitutionally-protected property interest. *See Goldberg v Kelly*, 397 U.S. 254, 262 (1970).

364. Medicaid participants' hearing and notice rights under *Goldberg* are codified at 42 C.F.R. § 431.205(d): "The hearing system must meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and any additional standards specified in this subpart."

365. Under *Goldberg,* the state must provide a meaningful notice stating the basis for the action and, when coverage is to be reduced or terminated, a pre-termination notice informing the claimant of the right to continue benefits pending a final administrative decision.

366. "The notice must comprise (1) a detailed statement of the intended action . . . (2) the reason for the change in status . . . (3) citation to the specific statutory section requiring reduction or termination; and (4) specific notice of the recipient's right to appeal." *Barry v. Lyon*, 834 F.3d 706, 719 (6th Cir. 2016).

367. In this case, Defendant WCCMH simply sent the April 2015 letter to all CLS participants in the county notifying them that the reduced rate/budget would be unilaterally imposed effective May 15, 2015.

368. Plaintiffs and the members of WACA were not advised in the letter of their right to appeal the rate and budget reduction, how to appeal, or how to obtain continued services pending the outcome of a hearing.

369. Defendant WCCMH reduced Plaintiffs' services, and those of the members of WACA, on May 15, 2015, well before providing the post-June 4, 2015 notices, which were not negative advance action notices.

370. Because the post-June 4th notices described the action taken as "adequate," the notices on their face did not provide participants an oppor-

tunity to request a timely hearing and receive benefits pending, because pending benefits require a termination, reduction, or suspension of a service that was previously authorized.

371. The specific regulation cited in the post-June 4, 2015 notices states only that the amount, scope, and duration of an IPOS must be sufficient, and that the Medicaid agency "may not arbitrarily deny or reduce the amount, duration, or scope of a required service under [42 C.F.R.] §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition."

372. Not all recipients, including two of the named plaintiffs, even received this post-June 4, 2015 notice.

373. Defendants violated Plaintiffs' constitutional rights to due process, rights secured by the 5th and 14th Amendments and enforceable by Plaintiffs pursuant to 42 U.S.C. § 1983, when they did not allow Plaintiffs an opportunity to be heard and contest the reduction of their CLS services.

374. Defendants violated the constitutional rights of the members of WACA to due process, rights secured by the 5th and 14th Amendments and enforceable by the members of WACA pursuant to 42 U.S.C. § 1983, when they did not allow the members of WACA an

opportunity to be heard and contest the reduction of their CLS services.

375. Defendants' actions, under color of state law, have harmed Plaintiffs and the members of WACA by depriving them, and continuing to deprive them, of medically necessary care, disrupting and diminishing their development and mental health.

COUNT II – VIOLATION OF STATUTORY RIGHT TO NOTICE AND AN OPPORTUNITY TO BE HEARD (All Plaintiffs Against Defendants Cortes, Terwilliger, and Gordon)

376. Plaintiffs incorporate all paragraphs above.

377. The Medicaid Act requires that a "State plan for medical assistance must . . . provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3).

378. 42 C.F.R. 431.200 "[i]mplements section 1902(a)(3) [1396a(a)(3)] of the Act, which requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly."

379. 42 C.F.R. § 431.206 provides that the state must provide notice of a beneficiary's right to a hearing and instructions on how to request it "[a]t the time of any action affecting his or her claim."

380. Notice given under 42 C.F.R § 431.210 must "contain (a) A statement of what action the State … intends to take; (b) The reasons for the intended action; (c) The specific regulations that support, or the change in Federal or State law that requires, the action; (d) An explanation of— (1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested."

381. If a beneficiary requests a hearing before the date of action, the State may not terminate or reduce services until a decision is rendered after the hearing, unless it is determined at the hearing that the sole issue is one of Federal or State law or policy, and the agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision. 42 C.F.R § 431.230(a)(1) and (2).

382. The budget reductions imposed by Defendant WCCMH were and are a reduction of a previously authorized service.

383. Defendant WCCMH simply sent out a letter in April 2015 stating that participants' CLS rates would be reduced and additional budget items included in (i.e. subtracted from) that rate.

384. Defendant WCCMH did not provide HSW participants adequate notice of hearing rights when it reduced their budgets on May 15, 2015.

385. Plaintiffs and the members of WACA were and are entitled to continued services under 42 C.F.R § 431.230 and 42 C.F.R § 431.210.

386. The post-June 4, 2015 notices did not provide HSW participants adequate notice of their hearing rights pursuant to 42 C.F.R § 431.210.

387. Defendant WCCMH reduced Plaintiffs' services, and those of the members of WACA, before providing the post-June 4, 2015 notices, which were not negative advance action notices.

388. Because the post-June 4th notices described the action taken as "adequate," the notices on their face did not provide participants an opportunity to request a timely hearing and receive benefits pending, because pending benefits require "a termination, reduction, or suspension of a service that was previously authorized."

389. The specific regulation cited in the post-June 4, 2015 notices simply states that the amount, scope, and duration of an IPOS must be sufficient, and that the Medicaid agency "may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition."

390. Not all recipients, including two of the named plaintiffs, even received this post-June 4, 2015 notice.

391. Defendant WCCMH violated Plaintiffs' right, and the rights of the members of WACA, to statutory due process by failing to provide proper notice.

392. Defendants have violated Plaintiffs' clearly established rights under 42 U.S.C. § 1396a(a)(3), rights enforceable by Plaintiffs pursuant to 42 U.S.C. § 1983. *See Gean v. Hattaway*, 330 F.3d 758 (6th Cir. 2003).

393. Defendants' actions, under color of state law, have harmed Plaintiffs and the members of WACA by depriving them, and continuing to deprive them, of medically necessary care, disrupting and diminishing their development and mental health.

COUNT III – VIOLATION OF SOCIAL SECURITY ACT – FAILURE TO AUTHORIZE SERVICES IN THE AMOUNT, SCOPE, OR DURATION TO REASONABLY ACHIEVE THEIR PURPOSE (All Plaintiffs Against Defendants Cortes, Terwilliger, and Gordon)

394. Plaintiffs incorporate all paragraphs above.

395. Under 42 U.S.C. § 1396a(a)(10)(B), the individual Plaintiffs and the members of WACA have the right to services in the amount, scope, and duration akin to those of any other such individual under Medicaid.

396. Under 42 C.F.R. § 440.230(b), "[e]ach service must be sufficient in amount, duration, and scope to reasonably achieve its purpose."

397. The individual Plaintiffs and the members of WACA receive home and community based services to assist them with participating in community activities and to prevent institutionalization.

398. CMS waived MDHHS's obligation to comply with the comparability requirements of § 1396a(a)(10)(B) in the HSW (implemented by 42 C.F.R. § 440.230(a)), but not the sufficiency requirements set forth in 42 C.F.R. § 440.230(b).

399. The service group specified in the State's HSW must still receive services sufficient in amount, duration, and scope to reasonably achieve their purpose.

400. Defendants' reduction of the individual Plaintiffs' IPOS budgets, and those of the members of WACA, has frustrated the purpose of the medically necessary services set forth in the IPOSs.

401. The individual Plaintiffs have not received, and are currently not receiving, services sufficient in scope to achieve the services' purpose, in violation of their established rights under 42 U.S.C. § 1396a(a)(10)(B) and 42 C.F.R. § 440.230(b), rights enforceable by Plaintiffs pursuant to 42 U.S.C. § 1983.

402. Defendants' budgeting methodology systematically creates an unacceptable risk that each of the members of WACA will not receive services sufficient in scope to achieve the services' purpose, in violation of their established rights under 42 U.S.C. § 1396a(a)(10)(B) and 42 C.F.R. § 440.230(b), rights enforceable by the individual Plaintiffs, and by WACA on behalf of its members, pursuant to 42 U.S.C. § 1983.

403. Defendants' actions, under color of state law, have harmed the individual Plaintiffs and the members of WACA by depriving them of medically necessary care and disrupting their development and mental health.

COUNT IV – VIOLATION OF SOCIAL SECURITY ACT – RIGHT TO RECEIVE SERVICES WITH REASONABLE PROMPTNESS (All Plaintiffs Against Defendants Cortes, Terwilliger, and Gordon)

404. Plaintiffs incorporate all paragraphs above.

405. The Social Security Act, 42 U.S.C. § 1396a(a)(8) and (a)(10), requires the State to furnish medical assistance with reasonable promptness to all eligible individuals.

406. Medical assistance includes "community supported living arrangement services" as defined in 42 U.S.C. §§ 1396u(a) and1396d(a)(23).

407. "Community supported living arrangement services" is defined as approved services which assist a developmentally disabled individual "in activities of daily living necessary to permit such individual to live in the individual's own home, apartment, family home, or rental unit furnished in a community supported living arrangement setting." 42 U.S.C. § 1396u.

408. It also includes "[s]upport services necessary to aid an individual to participate in community activities." 42 U.S.C. § 1396u(a)(7).

409. The individual Plaintiffs' support services, which allowed them to participate in the community, have been curtailed because their CLS budgets have been reduced and have been capped by application of a

fixed rate to staff hours in the IPOS, regardless of the extent of non-staff services and supports specified in their IPOSs.

410. In numerous cases, paid CLS providers cannot be readily found to work at the low rates available in such Plaintiffs' budgets under the new budgeting method.

411. Several of such Plaintiffs' CLS providers have quit as a result of reductions and uncertainty in their pay. For the same reasons, replacements are generally unavailable, or are available only with significant delays.

412. Defendants have failed to make services available to the individual Plaintiffs by imposing low reimbursement rates and refusing services based on cost.

413. Defendants have failed to make services available to the individual Plaintiffs by capping their budgets without regard to the extent of non-staff services and supports specified in their IPOSs and in not allowing them to budget for additional medically necessary services and supports.

414. This makes it impossible for participants to obtain adequate medically necessary services with reasonable promptness, in violation of 42 U.S.C. §§ 1396a(a)(8) and 1396 a(a)(10)(A).

415. Defendants have also violated state policy prohibiting services from being denied "solely on preset limits of the cost, amount, scope, and duration of services." MPM, § 2.5.C., pg. 14.

416. The post-May 15, 2015 budget calculation method and consequent inadequate provider reimbursement rates have effectively denied Plaintiffs the right to medical assistance in violation of 42 U.S.C. §§ 1396a(a)(8) and (10)(A).

417. Defendants' budgeting methodology systematically creates an unacceptable risk that each of the members of WACA will not receive adequate medically necessary services with reasonable promptness, in violation of 42 U.S.C. §§ 1396a(a)(8) and 1396 a(a)(10)(A).

418. Defendants have violated the individual Plaintiffs' clearly established rights, and those of the members of WACA, under 42 U.S.C. §§ 1396a(a)(8) and (10)(A), rights enforceable by the individual Plaintiffs, and by WACA on behalf of its members, pursuant to 42 U.S.C. § 1983.

419. Defendants' actions, under color of state law, have harmed the individual Plaintiffs and the members of WACA by depriving them of medically necessary care and disrupting and diminishing their development and mental health.

COUNT V – VIOLATION OF ADA, TITLE II, 42 U.S.C. § 12131 *ET SEQ*.
(All Plaintiffs Against Defendants Gordon, Terwilliger, Cortes, CMHPSM, and WCCMH)

420. Plaintiffs incorporate all paragraphs above.

421. Title II of the Americans with Disabilities Act (ADA) of 1990 (Title II), 42 U.S.C. § 12131 *et seq*., provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the service, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. Rights of action with respect to violations of Title II are expressly conferred by 42 U.S.C. § 12133.

422. A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. 28 C.F.R. § 35.130(d).

423. "[T]he most integrated setting appropriate to the needs of qualified individuals with disabilities mean[s] a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 591 (1999) (quoting 28 C.F.R. pt. 35, App. A, p. 450 (1998)) (internal quotation marks omitted).

424. The ADA prohibits both outright discrimination and "identified unjustified 'segregation' of persons with disabilities." *Olmstead*, 527 U.S. at 600 (quoting § 12101(a)(2)). "Unjustified isolation" is therefore "properly regarded as discrimination based on disability." *Id*. at 597.

425. "Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id*. at 600.

426. Isolation in a home can just as "severely diminish[] the everyday life activities" of people with disabilities. *Id.* at 601. *See Steimel v. Wernert*, 823 F.3d 902 (7th Cir. 2016).

427. MDHHS, CMHPSM, and WCCMH are public entities receiving federal funds to administer the Medicaid program in Michigan. 42 U.S.C. § 12131(1).

428. The individual Plaintiffs and the members of WACA are individuals with a disability within the meaning of the ADA. 42 U.S.C. § 12102(1). Specifically, they are individuals whose impairment substantially limits one or more of their major life activities, who have a record of the impairment, and who are regarded by Defendants as having the impairment.

429. The individual Plaintiffs and the members of WACA are qualified individuals, as that term is defined in the ADA. 42 U.S.C. § 12131(2). With or without reasonable modifications to the Defendants' rules, policies, or practices, Plaintiffs meet the essential eligibility requirements to receive Medicaid.

430. Defendants have violated the ADA and have injured the individual Plaintiffs and the members of WACA by failing to provide them with CLS services for which they are eligible, thereby failing to provide services in the most integrated setting appropriate to their needs, depriving them of medical and related services, increasing the risk of institutionalization, and disrupting and diminishing their development and mental health.

431. Defendants have further violated the ADA because the top-down budgeting practice that they have imposed creates a systematic risk that any CLS recipient with a significant amount of non-staff services in his or her IPOS, including all of the individual Plaintiffs and many members of WACA, will be unable to obtain CLS services for which s/he is eligible, will not receive services in the most integrated setting appropriate to his or her needs, will be deprived of medical and relat-

ed services, will face increased risk of institutionalization, and will be disrupted and diminished in his or her development and mental health.

432. Defendants have further caused Plaintiffs Waskul and Wiesner to be confined to their homes for substantial and unjustifiable periods of time, due to the inability to hire sufficient and appropriate CLS staff to take them into the community. This does not merely place these Plaintiffs at risk of institutionalization; it is effectively equivalent to actual institutionalization.

433. Defendants can avoid continuing these discriminatory activities through reasonable modifications of their programs and services. 28 C.F.R. § 35.130(b)(7).

434. Defendants have violated Plaintiffs' clearly established rights under 42 U.S.C. § 12132, rights enforceable by Plaintiffs pursuant to 42 U.S.C. §§ 1983, 12133.

COUNT VI – VIOLATION OF REHABILITATION ACT, 29 U.S.C. § 794
(All Plaintiffs Against All Defendants)

435. Plaintiffs incorporate all paragraphs above and specifically refer to the allegations of Count V.

436. Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, together with its implementing regulations, including 28 C.F.R. § 41.51(d) and 45 C.F.R. § 84.4(b)(vii)(2), and the right of action granted by 29 U.S.C.

§ 794a, are all construed *in pari materia* with the ADA with respect to *Olmstead*/"most integrated setting" claims.

437. By continuing to participate in the Medicaid program, and continuing to accept federal funding therefor, after enactment of 42 U.S.C. § 2000d-7, the State of Michigan has waived its Eleventh Amendment immunity for claims under the Rehabilitation Act related to its conduct of the Medicaid program.

438. Plaintiffs therefore have a right to relief under 29 U.S.C. § 794a against all Defendants for violation of Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, to the same extent they have a right to relief against Defendants Gordon, Cortes, and Terwilliger as alleged in Count V.

COUNT VII – VIOLATION OF 42 U.S.C. § 1396n(c)(2)(A) — FAILURE TO TAKE NECESSARY SAFEGUARDS TO PROTECT THE HEALTH AND WELFARE OF WAIVER SERVICES RECIPIENTS (All Plaintiffs Against Defendant Gordon)

439. Plaintiffs incorporate all of the paragraphs above.

440. Pursuant to 42 U.S.C. § 1396n(c)(2)(A), "[a] waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that . . . necessary safeguards (including adequate standards for provider participation) have been taken to protect

the health and welfare of individuals provided services under the waiver." *See also* 42 C.F.R. § 441.302(a).

441. These necessary safeguards include "adequate standards for all types of providers that provide services under the waiver," 42 C.F.R. § 441.302(a)(1); and "assurance that services are provided in home and community based settings, as specified in § 441.301(c)(4)," 42 C.F.R. § 441.302(a)(5).

442. These "home and community based settings" must support "full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS," 42 C.F.R. § 441.301(c)(4)(i); must optimize, "but . . . not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact," 42 C.F.R. § 441.301(c)(4)(iv); and must facilitate "individual choice regarding services and supports, and who provides them," 42 C.F.R. § 441.301(c)(4)(v).

443. Defendants WCCMH and CMHPSM's new budgeting method, which imposes a cap on the amount of CLS services self-determination recipients can receive, is not based on any sort of evaluation of the medical needs of the individual waiver program recipients, therefore putting recipients subject to the cap at risk.

444. In allowing MDHHS's contractual agents to impose such a cap, Defendant Gordon (director of the single state agency responsible for administering the Medicaid program) has failed to take necessary safeguards to protect the health and welfare of individuals provided services under the HSW waiver.

445. By allowing MDHHS's contractual agents to require that participants start with a fixed H2015 or H0043 rate and work backwards to an amount that can be paid for staff by subtracting out the cost of all the non-staff services and supports, Defendant Gordon has failed to ensure adequate standards for the self-determination providers who provide services under the waiver, because recipients are often left with inadequate funds to pay staff.

446. By allowing MDHHS's contractual agents to cap CLS self-determination recipients' budgets without consideration of individual medical needs or goals, Defendant Gordon has failed to ensure that

services are provided in the home and community based settings specified in 42 C.F.R. § 441.301(c)(4), because recipients are no longer able to access and participate in the community to the extent and in the manner necessitated by their individual plans of service; because recipients are unable to optimize individual initiative, autonomy, and independence in making life choices; and because recipients' choices regarding services, supports, and providers are limited rather than facilitated.

447. The requirements of 1396n(c)(2)(A) are clearly intended to protect the health and welfare of Medicaid recipients receiving services under the HSW waiver, to confer rights on such recipients, and to impose a mandatory duty on the State. This mandatory duty is neither vague nor amorphous; rather, it is an unambiguous directive.

448. Defendant Gordon has violated the rights of the individual Plaintiffs and the members of WACA under 42 U.S.C. § 1396n(c)(2)(A), rights enforceable by Plaintiffs and the members of WACA pursuant to 42 U.S.C. § 1983.

COUNT VIII – VIOLATION OF 42 U.S.C. § 1396n(c)(2)(C) — FAILURE TO PROVIDE A MEANINGFUL CHOICE BETWEEN INSTITUTIONALIZATION AND HOME AND COMMUNITY BASED SERVICES (All Plaintiffs Against Defendant Gordon)

449. Plaintiffs incorporate all of the paragraphs above.

450. Pursuant to 42 U.S.C. § 1396n(c)(2)(C), "[a] waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that . . . such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded." *See also* 42 C.F.R. § 441.302(d).

451. By allowing MDHHS's contractual agents to require that participants start with a fixed H2015 or H0043 rate and work backwards to an amount that can be paid for staff by subtracting out the cost of all the non-staff services and supports, Defendant Gordon has failed to ensure that waiver participants have a meaningful choice between home-and-community-based services and institutionalization, because the participants' consequent inability to pay adequate staff wages (or, under Hobson's Choice, to pay adequate staff wages only by forgoing vital non-staff services) leaves the participants at risk of — and, in many cases, in fact — being effectively homebound, unable to get out

into the community and unable to receive necessary care, services, and support.

452. The "choice" between such a home-based existence and actual institutionalization is in fact no choice at all, and putting participants to such a "choice" violates the express assurances required under 42 U.S.C. § 1396n(c)(2)(C).

453. The requirements of 1396n(c)(2)(C) are clearly intended to protect the health and welfare of Medicaid recipients receiving services under the HSW waiver, to confer rights on such recipients, and to impose a mandatory duty on the State. This mandatory duty is neither vague nor amorphous; rather, it is an unambiguous directive.

454. Defendant Gordon has violated the rights of the individual Plaintiffs and the members of WACA under 42 U.S.C. § 1396n(c)(2)(C), rights enforceable by Plaintiffs and the members of WACA pursuant to 42 U.S.C. § 1983.

COUNT IX – THIRD-PARTY BENEFICIARY CLAIM FOR VIOLATION OF ASSURANCES GIVEN IN THE HSW WAIVER APPLICATION AND IMPLEMENTED IN THE MDHHS/PIHP CONTRACTS (All Plaintiffs Against Defendants Gordon, Terwilliger, and CMHPSM)

455. This Count arises under 42 U.S.C. § 1983 against Defendants Gordon and Terwilliger by reason of (a) Defendant Gordon's failure to enforce MDHHS's responsibilities as the single state agency responsible

for administering Michigan's Medicaid program, and (b) Defendant Terwilliger's failure to ensure that Defendant CMHPSM complies with the PIHP Contract described below.

456. This Count also arises under the common law of Michigan and/or federal common law against Defendant CMHPSM. To the extent the claim arises under Michigan law, this Court has supplemental jurisdiction under 28 U.S.C. § 1367.

457. As the single state agency responsible for administering Michigan's Medicaid program, MDHHS has a non-delegable duty to ensure compliance by its contractors and subcontractors with all requirements of the program, including such policies, rules, or regulations as it issues or undertakes in connection with the program. That duty arises under federal law (specifically 42 U.S.C. § 1396a(a)(5) and 42 C.F.R § 431.10).

458. MDHHS has the right to, and does, subcontract for the performance of certain of those duties, but MDHHS remains responsible for its subcontractors' performance.

459. MDHHS has implemented its responsibilities through, in part, a Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Contract (the PIHP Contract) with

CMHPSM. The terms quoted herein are taken from the form PIHP Contract for Fiscal Year 2017, but on information and belief the actual contracts executed by MDHHS and CMHPSM throughout the relevant period contained materially identical terms.

460. In the PIHP Contract, Defendant CMHPSM agreed with MDHHS, among other things, as follows:

a. "Operation of the Concurrent 1915(b)/(c) Program must conform to . . . each . . . Waiver." (Section 7.0, "PIHP Responsibilities"; the Habilitation Supports Waiver at issue in this action is expressly included in that agreement).

b. The provisions of each Waiver were expressly incorporated into the PIHP Contract (Section 13.0F, "Entire Agreement," expressly incorporating "Approved Medicaid Waivers and corresponding CMS conditions").

c. In Section 3.0 (Service Requirements) in the Statement of Work in the PIHP Contract, CMHPSM obligated itself as follows:

> The PIHP shall provide covered state plan or 1915(c) services (for beneficiaries enrolled in the 1915(c) Habilitation Supports Waiver) in sufficient amount, duration and scope to reasonably achieve the purpose of the service. Consistent with 42 CFR 440.210 and 42 CFR 440.220, services to recipients shall not be reduced arbitrarily. Criteria for medical necessity and utilization control procedures that are consistent with the medical necessity criteria/service selection

> guidelines specified by MDHHS and based on practice standards may be used to place appropriate limits on a service (CFR 42 sec.440.230).

461. Plaintiffs and the members of WACA are third-party beneficiaries of the PIHP Contract, because the agreement was made for their benefit and was intended by the parties thereto to be enforceable by the recipients against Defendant CMHPSM. In particular (and without limitation):

a. The PIHP Contract does not contain any provisions disclaiming third-party beneficiary rights.

b. Parallel MDHHS contracts (those for General State Fund Services) state that they do not create rights in recipients to certain services that are funded solely by the State, since those services are dependent on State appropriations and thus are not "entitlements." The services at issue in this action, however, are Medicaid services that ***are*** entitlements, and the contracts therefore do create rights in recipients with respect to those services.

462. In applying for the Habilitation Supports Waiver, the State of Michigan was required to, and did, give certain assurances to CMS about how activities under the waiver (if granted) would be conducted and how the rights of participants such as these Plaintiffs and the members

of WACA would be protected. Upon CMS's granting of the waiver, the assurances became binding contractual obligations of the MDHSS to CMS.

463. Under the PIHP Contract, Defendant CMHPSM is obligated to carry through MDHSS's obligations, and Plaintiffs and the members of WACA, as third-party beneficiaries, have the right to enforce CMHPSM's obligations.

464. Certain of the HSW assurances are as alleged in Counts VI and VII hereof. Also as alleged therein, violations of those assurances are enforceable by Plaintiffs and WACA (on behalf of its members) against Defendant Gordon pursuant to 42 U.S.C. § 1983.

465. The assurances given in the Waiver Application, however, included far more than boilerplate, check-the-box agreement to comply with the law. They included detailed and specific promises by MDHHS, in words chosen by the MDHHS, to conduct the waiver programs in certain ways.

466. Among these assurances were the following:

a. In Appendix C-4 of the application, Michigan checked the box that "The State does not impose a limit on the amount of waiver ser-

vices except as provided in Appendix C-3" (which does not have any limits applicable here).

b. In Appendix E-1 (at p. 123 of 192), Michigan states (emphasis added):

> An individual plan of service (IPOS) will be developed through this process with the participant, supports coordinator or other chosen qualified provider, and allies chosen by the participant. The plan will include the HSW waiver services needed by and appropriate for the participant. An individual budget is developed based on the services and supports identified in the IPOS *and must be sufficient to implement the IPOS*.

c. In Appendix E-2 (Opportunities for Participant-Direction), Michigan states:

> The amount of the individual budget is determined by costing out the services and supports in the IPOS, after a IPOS that meets the participant's needs and goals has been developed. . . . This process involves costing out the services and supports using the rates for providers chosen by the participant and the number of hours authorized by the IPOS. The rate for directly employed workers must include [taxes, unemployment insurance, and workers compensation].

467. The implementation of the WCCMH/CMHPSM top-down budgeting system in May 2015 breached the obligation of Section 3.0 of the Statement of Work that CMHPSM "provide covered state plan or 1915(c) services (for beneficiaries enrolled in the 1915(c) Habilitation

Supports Waiver) in sufficient amount, duration and scope to reasonably achieve the purpose of the service."

468. The implementation of the WCCMH/CMHPSM top-down budgeting system in May 2015 breached the obligation of Section 3.0 of the Statement of Work that CMHPSM "services to recipients shall not be reduced arbitrarily."

469. The service limitations effected by the implementation of the WCCMH/CMHPSM top-down budgeting system in May 2015 were not implemented to promote, but in fact flew in the face of, medical necessity, and they were not effected pursuant to "utilization control procedures that are consistent with the medical necessity criteria/service selection guidelines specified by MDHHS and based on practice standards," so that they breached Section 3.0 of the Statement of Work for this reason as well.

470. The service limitations effected by the implementation of the WCCMH/CMHPSM top-down budgeting system in May 2015 breached the assurance in Appendix C-4 of the HSW Application that "[t]he State does not impose a limit on the amount of waiver services except as provided in Appendix C-3" (which does not have any limits applicable here).

471. The service limitations effected by the implementation of the WCCMH/CMHPSM top-down budgeting system in May 2015 breached the obligation of Appendix D-1 that the budget be sufficient to implement the IPOS.

472. The imposition of the WCCMH/CMHPSM top-down budgeting system in May 2015 breached the obligation that the individual budget be determined by costing out the services and supports in the IPOS, because "costing out" involves applying actual rates to services listed, not imposing arbitrary limits based on what was left over in a predetermined cap after other services had been accounted for.

473. The imposition of the WCCMH/CMHPSM top-down budgeting system in May 2015 breached the obligation that the individual budget be determined by using the rates for providers chosen by the participant and the number of hours authorized by the IPOS, because the providers' rates (which had been previously approved) were not used, but the rates payable were reduced based on what was left over in a predetermined cap after other services had been accounted for.

474. The individual Plaintiffs and the members of WACA are entitled to an injunction requiring Defendant Gordon to enforce the PIHP Contract for the benefit of Plaintiffs and the members of WACA and reverse

the May 2015 decision of CMHPSM and WCCMH to impose top-down budgeting.

475. The individual Plaintiffs and the members of WACA are entitled to an injunction requiring Defendant Terwilliger to require Defendant CMHPSM to comply with the PIHP Contract for the benefit of Plaintiffs and the members of WACA and reverse the May 2015 decision of CMHPSM and WCCMH to impose top-down budgeting.

476. The individual Plaintiffs and the members of WACA are entitled to an injunction requiring Defendant CMHPSM to reverse the May 2015 decision of CMHPSM and WCCMH to impose top-down budgeting.

COUNT X – VIOLATION OF MICHIGAN MENTAL HEALTH CODE – VIOLATION OF MCL 330.1722(1) (All Plaintiffs Against Defendants WCCMH and CMHPSM)

477. Plaintiffs incorporate all paragraphs above.

478. The Michigan Mental Health Code provides that no "recipient of mental health services shall . . . be subjected to abuse or neglect." MCL 330.1722(1).

479. "Neglect means an act or failure to act" by, among others, a CMH agency, "that denies a recipient the standard of care or treatment to which he or she is entitled under this act." MCL 330.1100b(19) (internal quotation marks omitted).

480. A recipient is entitled to "mental health services suited to his or her condition." MCL 330.1708(1).

481. Defendants' failure to provide Plaintiffs with mental health services suited to their condition amounts to neglect.

482. Michigan's Mental Health Code also provides that "[t]he responsible mental health agency for each recipient" shall provide a written individual plan of service addressing, "as either desired or required by the recipient, the recipient's need for . . . health care . . . transportation, and recreation." MCL 330.1712(1).

483. As alleged above, the IPOS and its implementing budget are interdependent. One cannot exist without the other. Since May 2015, however, Defendants WCCMH and CMHPSM do not provide CLS participants with actual budgets tied to the services and supports listed in the IPOS but only with a single, top-line amount that is calculated solely from staff hours and does not include separate calculations for, among other things, transportation and recreation.

484. Defendants' failure to provide Plaintiffs and the members of WACA with an actual budget explicitly referring to transportation and recreation constitutes a failure to provide Plaintiffs with a written IPOS ad-

dressing their needs for health care, transportation, and recreation and amounts to neglect.

485. Plaintiffs and the members of WACA seek by this action injunctive relief against Defendants WCCMH and CMHPSM under MCL 330.1722(3) to prevent the continuation of this neglect.

RELIEF REQUESTED

A. Assume jurisdiction in this case;

B. Declare unlawful the rate reduction and new budget calculation imposed by Defendants WCCMH and CMHPSM and acquiesced in by Defendant Gordon on behalf of the Department;

C. Declare unlawful Defendants' denial of participants' right to self-determination generally;

D. Preliminarily and permanently enjoin Defendants from continuing to impose the new budget calculation method and/or any other method not in conformity with the assurances given and obligations assumed under the Habilitation Supports Waiver;

E. Preliminarily and permanently enjoin Defendants from denying participants their right to procedural due process;

F. Preliminarily and permanently enjoin Defendants WCCMH and CMHPSM from refusing to reinstate the pre-May 15, 2015 level of funding and services to Plaintiffs and to all other CLS service recipients until lawful IPOS meetings are conducted and CLS service recipients are offered notice of any proposed cuts and an opportunity to be heard regarding any objections they may have to the cuts;

G. Preliminarily and permanently enjoin Defendants from continuing to deprive CLS service recipients of CLS services in the most integrated setting appropriate to their service needs;

H. Assume continuing jurisdiction as may be necessary to monitor and enforce any relief granted;

I. Award Plaintiffs costs and reasonable attorney fees as provided by law; and

J. Grant such other relief as is just and proper.

Respectfully submitted,

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February 11, 2019

CERTIFICATE OF SERVICE

I hereby certify that on February 11, 2019 I electronically filed the foregoing paper with the Clerk of the Court using the ECF system, which will send notification of such filing to all counsel of record.

Respectfully submitted,

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INDEX OF EXHIBITS

A. HSW, Appendix E-2

B. Behavioral Health Task Force, Final Report

C. Waskul Budget, March 16, 2015 to March 11, 2016

D. Letter to CLS Participants from Sally Amos O'Neal

E. 2012 WCHO/CSTS Letter Describing Budgeting Process

F. Letter from Jeffrey Wieferich to Sally Amos O'Neal

G. WCHO Response to MDHHS

H. Post-June 4, 2015 Notice of Hearing Rights (for Plaintiff Schneider)

I. HMA Draft Report, page 12

J. Letter from Thomas Renwick to PIHP Executive Directors

K. Waskul Budget Created May 18, 2015

L. Notice of Hearing Rights, July 20, 2015

M. August 24, 2015 Local Dispute Resolution Committee Report of Findings

N. Letter from Maria Heck, DO

O. Order of Dismissal

P. Order Vacating Dismissal

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		650
Year 2		702
Year 3		744
Year 4		785
Year 5		827

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. **Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

In the Agency with Choice model, participants serve as managing employers who have the sole responsibility for selecting, hiring, managing and firing their workers. The agency (described in this document as "AWC provider") serves as employer of record and is solely responsible for handling the administrative aspects of employment (such as processing payroll; withholding and paying income, FICA, and unemployment taxes; and securing worker's compensation insurance). In the Agency with Choice model, participants may get help with selecting their workers (for example, the AWC provider may have a pool of workers available for consideration by participants). The AWC provider may also provide back-up workers when the participant's regular worker is not available. Like traditional staffing agencies, the AWC provider may be able to provide benefits to workers from its administrative funding (such as paid vacation, sick time, and health insurance) that participants directly employing workers cannot provide. The Agency with Choice model is also an important option for participants who do not want to directly employ workers or who want to transition into direct employment.

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

☑ **Recruit staff**
☑ **Refer staff to agency for hiring (co-employer)**
☑ **Select staff from worker registry**
☐ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The fiscal intermediary is responsible for conducting criminal background checks for directly employed providers. The cost is built into their monthly fee.

- [x] Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.
- [x] Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
- [x] Determine staff wages and benefits subject to State limits
- [x] Schedule staff
- [x] Orient and instruct staff in duties
- [x] Supervise staff
- [x] Evaluate staff performance
- [x] Verify time worked by staff and approve time sheets
- [x] Discharge staff (common law employer)
- [x] Discharge staff from providing services (co-employer)
- [ ] Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- [x] Reallocate funds among services included in the budget
- [x] Determine the amount paid for services within the State's established limits
- [x] Substitute service providers
- [x] Schedule the provision of services
- [x] Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- [x] Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- [x] Identify service providers and refer for provider enrollment
- [x] Authorize payment for waiver goods and services
- [x] Review and approve provider invoices for services rendered
- [ ] Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

An individual budget includes the expected or estimated costs of a concrete approach of obtaining the mental health services and supports included in the IPOS (SD Guideline II.C.). Both the individual plan of service (IPOS) and the individual budget are developed in conjunction with one another through the person-centered planning process (PCP) (SD Guideline II. A.). Both the participant and the PIHP must agree to the amounts in the individual budget before it is authorized for use by the participant. This agreement is based not only on the amount, scope and duration of the services and supports in the IPOS, but also on the type of arrangements that the participant is using to obtain the services and supports. Those arrangements are also determined primarily through the PCP process.

Michigan uses a retrospective zero-based method for developing an individual budget. The amount of the individual budget is determined by costing out the services and supports in the IPOS, after a IPOS that meets the participant's needs and goals has been developed. In the IPOS, each service or support is identified in amount, scope and duration (such as hours per week or month). The individual budget should be developed for a reasonable period of time that allows the participant to exercise flexibility (usually one year).

Once the IPOS is developed, the amount of funding needed to obtain the identified services and supports is determined collectively by the participant, the mental health agency (PIHP or designee), and others participating in the PCP process.

This process involves costing out the services and supports using the rates for providers chosen by the participant and the number of hours authorized in the IPOS. The rate for directly employed workers must include Medicare and Social Security Taxes (FICA), Unemployment Insurance, and Worker's Compensation Insurance. The individual budget is authorized in the amount of that total cost of all services and supports in the IPOS. The individual budget must include the fiscal intermediary fee if a fiscal intermediary is utilized.

Participants must use a fiscal intermediary if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs. If a participant chooses to contract only with providers that are already under contract with the PIHP, there is no requirements that a fiscal intermediary be used.

Fiscal intermediary is a §1915(b) waiver service and is available to any participant using a self-determination arrangement. Each PIHP develops a contract with the fiscal intermediary to provide financial management services (FMS) and sets the rate and costs for the services. The average monthly fee has ranged from $75.00 to $125.00. Actual costs for the FMS will vary depending on the individual's needs and usage of FMS, as well as the negotiated rate between the PIHP and fiscal intermediary.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Materials provided by the PIHP include written information on the development of the individual budget. During the planning process, a participant is to be provided clear information and explanation of current service costs and allotments, along with information that provides guidance on developing and utilizing provider rates that would be applied by the participant during individual budget implementation.

As noted in section E-2(b)(ii) above, the budget is developed in conjunction with the development of the IPOS, using the PCP process, or is determined as applied to a pre-existing, sufficient IPOS, using the PCP process. Budget authorization is contingent upon the participant and the PIHP entity reaching agreement on the amount of the budget and on the methods that will, or may, be applied by the participant to implement the plan and the individual budget. The budget will be provided to the participant in written form, as an attachment to the Self-Determination Agreement that outlines the expectations and obligations of the

participant and the PIHP. The participant's plan is also attached to the agreement.

The participant's supports coordinator, supports coordinator assistant, or independent supports broker (or other qualified provider selected by the participant) are expected to provide assistance to the participant in understanding the budget and how to utilize it. In situations where the participant also has an independent supports broker, the broker will assist the participant to understand and apply the budget. The participant may seek an adjustment to the individual budget by requesting this from their supports coordinator or other chosen qualified provider. The supports coordinator, supports coordinator assistant, or independent supports broker (or other qualified provider selected by the participant) will be expected to assist the participant to convene a meeting including the participant's chosen family members and allies, and to assure facilitation of a PCP process to review and reconsider the budget. A change in the budget is not effective unless the participant and the PIHP have agreed to the changes.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one:*

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The amount of the individual budget must be sufficient to provide a defined amount of resources. It must also be written to allow flexibility in its use, which means that an participant can decide when services and supports are used and make some adjustments between budget line items. The SD Guideline describes types of flexibility (SD Guideline II.E.4):

Adjustments that do not require a Modification to the Individual Budget:

Unless an adjustment deviates from the goals and objectives in the participant's IPOS, the participant is not required to obtain permission from the mental health agency (PIHP or designee) or provide advance notification of an intended adjustment. "The [participant] may adjust the specific application of CMHSP-authorized funds within the budget between budgetary line items and/or categories in order to adjust his/her specialty mental health services and supports arrangements as he or she deems necessary to accomplish his/her IPOS." (SD Guideline II.E.4.a.) The IPOS must be written in a way that contemplates and plans for the manner in which the participant may use the services and supports. Amounts, scopes and durations may be written in ranges or a length of time that makes flexibility possible (a month or a quarter). Services and supports that are similar and may be substituted for one another should be identified as well as services and supports for which there is no substitution. Adjustments in this manner should be communicated to the mental health agency (PIHP or designee) in a timely manner.

Adjustments that Require a Modification to the Individual Budget:
Sometimes, a participant wants to make an adjustment that fundamentally alters the IPOS (for example, substituting one service for another service that is not similar, forgoing services and supports, or using services and supports not authorized). If the adjustment "does not serve to accomplish the direction and intent of the person's IPOS, then the IPOS must be appropriately modified before the adjustment may be made." (SD Guideline II.E.4.d). In this situation, a modification can often be made over the phone between the participant and his or her supports coordinator, supports coordinator assistant, or independent supports broker (or other qualified provider selected by the participant). The change should be accomplished as expeditiously as possible. Larger changes may need to be made through the PCP process.

The mental health agency (PIHP or designee) must provide the participant with information on how to request a Medicaid Fair Hearing when the participant's Medicaid-funded services are changed, reduced or terminated as a result of a reduction in the individual budget or denial of the budget adjustment.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Participants must use a fiscal intermediary if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs. Most participants use FMS through a fiscal intermediary even if they only contract with providers already under contract with the PIHP; however, there is no requirement that they do so.

The funds in an individual budget are transferred to the fiscal intermediary, which handles payment for services and supports in the IPOS upon receipt of invoices and timesheets authorized by the participant. The fiscal intermediary provides both the participant and the mental health agency (PIHP or designee) a monthly report of expenditures and flags expenditures that are over or under the expected amount by ten percent or more. This report is the central mechanism for monitoring implementation of the budget. Over- or under-utilization identified in the report can be addressed by the supports coordinator (or other chosen qualified provider) and participant informally or through the PCP process.

The supports coordinator, supports coordinator assistant, or independent supports broker (or other chosen qualified provider) is responsible for assisting the participant in implementing the individual budget and arrangements, including understanding the budget report. A participant can use an independent supports broker to assist him or her in implementing and monitoring the IPOS and budget. When a participant uses an independent supports broker, the supports coordinator (other qualified provider selected by the participant) has a more limited role in planning and implementation of arrangements so that the assistance provided is not duplicated. However, the authorization and monitoring the IPOS and individual budget cannot be delegated to an Independent Supports Broker by the PIHP or designee.

If using FMS through a fiscal intermediary, the supports coordinator, supports coordinator assistant, or independent supports broker (or other chosen qualified provider) receives a copy of the budget and a copy of the monthly budget report. In the required monitoring and face-to-face contact they have with the participant, the supports coordinator, supports coordinator assistant or independent supports broker (or other qualified provider) must address any over- or under-utlization of the budget that they identify in the monthly budget report. If the participant does not use a fiscal intermediary because he or she only contracts with providers already under contract with the PIHP, the PIHP must provide a monthly budget report to the participant and supports coordinator, supports coordinator assistant or independent supports broker (or other qualified provider) so the participant can effectively manage his or her budget and thereby, exercise budget authority.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The State has established a grievance system that is compliant with 42 CFR 431 Subpart F through contract agreement with each of the 18 PIHPs. The Grievance and Appeal Technical Requirement is Attachment 6.3.2.1 of the MDCH/PIHP concurrent §1915(b)/(c) contract.

The notice of action to the beneficiary or his/her legal representative must be in writing and meet the language format needs of the individual in order that he/she understands the content, (i.e. the format meets the needs of those with limited English proficieney, limited reading proficiency or sensory impairments).

The content of both the adequate and advance notice of action must include:
- An explanation of what action the PIHP has taken or intends to take,
- The reason for the action(s) [42 CFR440.230(d) is the basic legal authority for an action to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures],
- The beneficiary or his/her legal representative's right to request a State fair hearing and instructions for doing so,
- The beneficiary or his/her legal representative's right to file a PIHP appeal and instructions for doing so,
- The circumstances under which an expedited resolution can be requested and instructions for doing so and
- An explanation that the beneficiary may represent himself or herself or use legal counsel, a relative, a friend or other spokesperson.

An advance notice of action must also include an explanation of the circumstances under which services will be continued pending resolution of the fair hearing or appeal, how to request that benefits be continued and the circumstances under which the beneficiary or his/her legal representative may be required to pay the costs of these services.

Both notices of action must include a Request for Hearing Form (DCH-0092) and a pre-addressed envelope.

If a beneficiary not enrolled in the HSW requests to apply for the HSW, the beneficiary must be given the choice of home and community-based waiver services as an alternative to the level of care provided in an ICF/IID by the PIHP. Evidence that the PIHP offered this choice to the beneficiary is documented in Section 3 of the HSW eligibility certification form. If the PIHP does not offer the choice between home and community-based services instead of the level of care offered by an ICF/MR, the PIHP must give adequate notice to the beneficiary or legal representative (if applicable) per the process described above.

Once the HSW application has been submitted to MDCH-MHSA for review, if the beneficiary is determined to not meet eligibility requirements for the HSW, an adequate notice is sent to the beneficiary and legal representative (if applicable) by the MDCH-MHSA HSW Program Manager. This notice follows the process described above.

Once a beneficiary has enrolled in the HSW, the participant may receive adequate or advance notice, depending on the decision related to their HSW or other Medicaid mental health services.

Upon completion of the development of the individual plan of services (IPOS) through the person-centered planning process, the beneficiary or his legal representative is provided adequate notice of action at the time of the signing that he or she may file a request for a fair hearing if he or she subsequently disagrees with the scope, duration or intensity of authorized services. Adequate notice of action is also provided when there is a decision by the PIHP to deny or limit authorization for services requested. Notice is provided to the beneficiary or his/her legal representative on the same date as the action takes effect.

Advance notice of action is provided/mailed to the beneficiary or his/her legal representative at least 12 days prior to the proposed date the action is to take effect when:
- the PIHP has denied or given limited authorization of a requested service;
- a decision has been made to reduce, suspend or terminate services currently being provided;
- the PIHP has failed to make a standard authorization decision and provide notice of such within 14 days from the date of receipt of the standard request for services;
- the PIHP has failed to make an expedited authorization decision within three working days from the date of receipt of the request for expedited service authorization;
- the PIHP has denied, in whole or in part, payment for a service;
- the PIHP has failed to provide services within 14 days of the start date agreed upon during the person-centered planning process and as authorized by the PIHP;
- the PIHP has failed to act within 45 days from the date of a request for a standard appeal or 3 working days from request of an expedited appeal; or
- the PIHP has failed to provide disposition and notice of a local grievance/complaint within 60 days of the date of the request.

PIHP policies and procedures vary as to upon whom the responsibility is placed to notify beneficiaries or their legal representatives of an adverse action, e.g. Utilization Management, Customer Services, person designated in the plan of service as responsible for assuring that committed services/supports are delivered. (MDCH Admin. Rule 330.7199)

The PIHP is required to maintain Grievance System records of beneficiary appeals and grievances for review by State staff as part of the State quality strategy. The HSW Program Manager also monitors Fair Hearing Requests and Decisions by the Tribunal for HSW participants and takes action with the PIHP when necessary to assure HSW services are provided as specified in policy.

PIHP Grievance System records must contain sufficient information to accurately reflect:
•The process in place to track requests for Medicaid services denied by the PIHP or any of its providers.
•The volume of denied claims for services in the most recent year.

All notices of action which include information on the opportunity to request a State fair hearing are maintained in appropriate PIHP administrative files and a copy in the beneficiary's record.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The State operates an additional dispute resolution process

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

a) The State has established a grievance and appeals system that is compliant with 42 CFR 431 Subpart F through contract agreement with each of the 18 PIHPs. The Grievance and Appeal Technical Requirement is Attachment 6.3.2.1 of the Medicaid Managed Specialty Supports and Services Concurrent §1915 (b)/(c) Waiver Program Contract.

b) Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, such as a denial, termination, or reduction of a service, and those challenging anything else, such as a beneficiary's dissatisfaction with service, e.g., quality of care or services provided or aspects of interpersonal relationships between a service provider and the beneficiary. A challenge to an action is called an appeal. Any other type of complaint is considered a grievance.

Beneficiary Appeals: Local appeals, like requests for fair hearings, are initiated by notice of an adverse action. The beneficiary or his/her legal representative may request a local appeal concurrently with filing a request for a fair hearing and under the following conditions:
- The beneficiary or his/her legal representative has 45 days from the date of the notice of action to request a local appeal;
- An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the beneficiary or his/her legal representative requests expedited resolution;
- The beneficiary or his/her legal representative may file an appeal with the PIHP organizational unit approved and administratively responsible for facilitating local appeals, e.g. Customer Services, Office of Recipient Rights;
- If the beneficiary or his/her legal representative requests a local appeal not more than 12 days from the date of the notice of action, the PIHP must reinstate or continue the service(s) until disposition of the fair hearing.

When a beneficiary or his/her legal representative requests a local appeal, the PIHP is required to:
- Give the beneficiary or his/her legal representative reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability;

COUNTY ADMINISTRATOR
220 NORTH MAIN STREET, P.O. BOX 8645
ANN ARBOR, MICHIGAN 48107-8645
PHONE: (734) 222-6850
FAX: (734) 222-6715

TO: Andy LaBarre
Chair, Ways & Means Committee

FROM: Verna J. McDaniel
County Administrator

DATE: February 18, 2014

SUBJECT: Behavioral Health Task Force – Final Report

BOARD ACTION REQUESTED:
Approval of the final report and recommendations submitted by the Behavioral Health Task Force, dated December 31, 2014; authorization of an adjustment to the 2014/15 Community Support and Treatment Services budget; authorization of position modifications related to the provision of mental health services; and authorizing the implementation of the recommendations and timeline proposed by the Behavioral Health Task Force.

BACKGROUND:
In the summer of 2014, it became apparent that there was a serious crisis in financing mental health services for publicly funded consumers in Washtenaw County. The County Board of Commissioners approved the budget for Community Support and Treatment Services (CSTS). CSTS, a county department, is the principal provider of direct mental health consumer services in Washtenaw County, via a contract with the Washtenaw Community Health Organization (WCHO). Subsequently, WCHO informed the county that there was a shortfall of several million dollars in funding (see attached Executive Impact Summary of Proposed Reduction to Mental Health FY15 Budget).

Immediately, the County Commissioners raised questions concerning the perceived inefficiencies and ineffectiveness of WCHO as they no longer held the designation of the PIHP by the State; duplication of administrative expenses between WCHO and CSTS; and the desirability of maintaining the WCHO partnership between Washtenaw County and the University of Michigan. The partnership agreement contains a provision for giving a one-year notice for ending the partnership.

Washtenaw County and the University of Michigan Health System (UMHS) established the Behavioral Health Task Force on September 3, 2014, to evaluate the issues, options and implications of either maintaining or eliminating the partnership and the

WCHO (The charge to the Task Force is contained in the Exhibits to the Final Report, which are on file with the Washtenaw County Clerk).

DISCUSSION:

The WCHO was established as a separate legal entity in 2000 as a partnership between Washtenaw County and the University of Michigan. Each partner appoints six members to the Board of WCHO. WCHO is one of only two such Community Mental Health Organizations in Michigan. The original purpose for WCHO was to establish an integrated health care delivery system to provide mental health, substance abuse and primary and specialty health care to Medicaid, low income and indigent consumers. There are only three models allowed in the State mental health code for organizing mental health services for publicly funded consumers: a Community Mental Health Organization (WCHO), a Community Mental Health Authority, and a Community Mental Health Agency. WCHO is a Community Mental Health Organization.

The Task Force consisted of three voting members: Verna McDaniel, Washtenaw County Administrator; Brent M. Williams, M.D., MPH, Medical Director, UM Complex Care Management Program; and Robert Laverty, the Chair of Task Force. The Task Force invited participation of advisors, consultants and experts from the University of Michigan Health System, county government, the WCHO, CSTS, the State of Michigan and the regional agency for mental health services. The Task Force met eleven times, conducted interviews, and reviewed numerous documents and financial information. The three alternative organizational models were evaluated. The Task Force was provided valuable voluntary assistance by the Center for Healthcare Research and Transformation.

A significant unanticipated event was the retirement of the WCHO Executive Director on December 27, 2014. This called for accelerating the time frame for the Task Force to complete its work.

The University of Michigan Health System (UMHS) and Washtenaw County have enjoyed a long-standing relationship in serving publicly funded consumers needing mental health services. The WCHO partnership was established to provide for improved integration between physical and mental health services, to foster innovation, to provide for educational sites to train new practitioners, to seek grant funding and, most importantly, to improve the quality of care. Both the county and the UMHS wish to continue and strengthen this relationship, and further broaden the arrangements to include the St Joseph Mercy Health System.

In evaluating the current partnership (WCHO), the Task Force concluded that this arrangement has not achieved the potential envisioned in its original purposes and goals. This view is widely held. The Task Force identified numerous factors that have contributed to this outcome. The most significant factors are:

- Frequent changes in leadership.
- WCHO and its major contractor for direct consumer care (CSTS) are separate entities with separate management teams. They do not coordinate planning,

budgeting and evaluation; and lack effective communication and joint problem solving.

- Changing role of WCHO from a regional entity to a local entity.
- Confusing and declining funding.
- Ineffective management of the partnership by the parent entities (Washtenaw County and UMHS).
- Lack of adequate governance of WCHO.
- Lack of funding and focus on integrating medical and mental health care.

The future funding, organizing and integration of mental health services with physical health care will be even more challenging in the future. Contributing to this uncertainty are new global payment systems, the Affordable Care Act, increased numbers of Medicaid consumer eligible for mental health services, and expanded emphasis on care management. In the future, the organization and management of mental health services must be more flexible, efficient, effectively governed, effectively managed, responsive, innovative and clear on its purpose and goals.

SUMMARY OF THE EIGHT TASK FORCE RECOMMENDATIONS:

1. Discontinue the legal partnership and dissolve the WCHO.
2. Implement a Community Mental Health Agency model (Agency) for providing mental health services for publicly funded consumers.
    a. Confirm the financial impact on the county by moving to an Agency model.
    b. Appoint a Community Mental Health Board that is capable of assuming the role of a governing body for a Community Mental Health Authority.
    c. Seek recommendations from UMHS and SJMHS for representation on the Mental Health Board.
3. Prepare to transition from the Agency model to a Community Mental Health Authority model (Authority) within two years.
4. Establish an affiliation agreement between the county, UMHS and SJMHS to conduct strategic planning for mental health services, identify and implement pilot programs, provide educational opportunities, conduct research and seek grants.
5. Formalize specific programmatic agreements between the county, UMHS and SJMHS for mental health services.
6. Provide for the involvement of Packard Health, other safety net clinics and the Washtenaw Health Initiative (WHI) in the planning, assessment and delivery of mental health services.
7. Conduct a formal search to select a person capable of providing leadership to the Agency and to manage the transition to the Authority.
8. Implement an annual, formal evaluation process, conducted by an external consultant, to assess the performance of the Agency. This should include a focus on clinical quality, client satisfaction, financial performance, program development, and results for the clients served.

Implementation will follow acceptance of these recommendations by county leadership, the UMHS, and the State of Michigan. It will require three to six months to accomplish the transition from WCHO to a Community Mental Health Agency and to prepare for the

eventual development of a Community Mental Health Authority. In the interim, the WCHO Board will need to continue its governance duties. Washtenaw County Administration will bear the responsibility for managing the implementation plan.

PROPOSED IMPLEMENTATION TIMELINE TO TRANSITION TO AGENCY:

- Verify financial impact (*Completed 2/5/15)*
- Staff Meetings with CSTS and WCHO Staff (*Ongoing)*
- Seek support and endorsement from WCHO Board and University of Michigan Health System of Task Force recommendations. (Completed 1/20/15)
- Amend service agreement between WCHO and CSTS to include remaining required functions (issued 2/9/15, fully executed no later than 2/27/15)
- Consolidate administration (1/1/15 – 7/31/15)
- Initiate search process for the Executive Director of the Agency (by 3/9/15)
- Hire New Executive Director of the Agency (by 5/31/15)
- Notify the State of intent to change CMHSP designation (by 4/1/15)
- Seek formal approval from the State of Michigan of CMHSP designation (by 9/30/15)
- Initiate discussions with UMHS and SJMHS to establish an affiliation agreement and specific programmatic agreements (beginning 7/1/15)
- Initiate the process for identifying and selecting the CMH Board (by 7/1/15)
- Create a formal Board development and education program (7/1/15 – 8/31/15)
- Orient the new CMH Board (by 9/30/15)
- Initiate discussion regarding labor, legal, financial, and programmatic implications of transition to an Authority
- Develop a process and identify an external consultant to perform an annual evaluation of the Agency
- Initiate annual evaluation of external contractors within the provider network (by 10/1/15)

IMPACT ON HUMAN RESOURCES:

Effective 2/1/15, Washtenaw County has implemented a hiring review for all CSTS vacancies. There are currently 28 vacancies within the CSTS Department, all of which will be placed on hold vacant status.

Moving to an Agency as recommended in the Task Force report will necessitate the elimination of 23 positions.

IMPACT ON BUDGET:

There exists a $3,862,142 deficit for FY15 for mental health funding within Washtenaw County. Administrative efficiencies and other contract modifications are currently being made to bridge the gap and close the deficit by 9/30/15. Reductions made mid-year during FY2015 shall carry forward as annualized savings in FY2016.

Savings are quantified as follows:

Community Living Services (CLS) - $2,312,975

- Staff, Providers & Consumers collectively reviewing staffing patterns
- Alignment of provider rates with regional partners
- Realignment between Utilization Management, Finance, Clinical and Contracted Providers under a single line of authority

Consolidation of Administrative Functions and Services - $1,549,167

- Elimination of duplication of administrative functions

IMPACT ON INDIRECT COSTS:
WCHO contributes to the county's General Fund through payments for indirect costs as specified by the Cost Allocation Plan, budgeted at $394,676 in 2015. As the dissolution of WCHO means that the department will no longer make these payments, the county will not receive all anticipated revenues, though the exact shortfall is unknown. This revenue is expected to return in future years as the resources formerly utilized by WCHO are put to use elsewhere in the county.

IMPACT ON OTHER COUNTY DEPARTMENTS OR OUTSIDE AGENCIES:
None.

CONFORMITY TO COUNTY POLICIES:
The Task Force and implementation timeline conforms to County policies.

ATTACHMENTS/APPENDICES:

- Resolution
- Behavioral Health Task Force Final report
- Agency Organizational Chart
- Executive Impact Summary of Proposed Reduction to Mental Health FY15 Budget

A RESOLUTION APPROVING THE FINAL REPORT AND RECOMMENDATIONS SUBMITTED BY THE BEHAVIORAL HEALTH TASK FORCE, DATED DECEMBER 31, 2014, AUTHORIZING POSITION MODIFICATIONS, AS WELL AS A BUDGET ADJUSTMENT

WASHTENAW COUNTY BOARD OF COMMISSIONERS

March 4, 2015

WHEREAS, in the summer of 2014, it became apparent that there was a serious crisis in financing mental health services for publicly funded consumers in Washtenaw County. The County Board of Commissioners approved the budget for Community Support and Treatment Services (CSTS); and

WHEREAS, CSTS, a county department, is the principal provider of direct mental health consumers services in Washtenaw County, via a contract with the Washtenaw Community Health Organization (WCHO). Subsequently, WCHO informed the county that there was a shortfall of several million dollars in funding; and

WHEREAS, immediately, the County Commissioners raised questions concerning the perceived inefficiencies and ineffectiveness of WCHO; duplication of administrative expenses between WCHO and CSTS; and the desirability of maintaining the WCHO partnership between Washtenaw County and the University of Michigan. The partnership agreement contains a provision for giving a one-year notice for ending the partnership; and

WHEREAS, Washtenaw County and the University of Michigan Health System (UMHS) established the Behavioral Health Task Force on September 3, 2014, to evaluate the issues, options and implications of either maintaining or eliminating the partnership and the WCHO (The charge to the Task Force is contained in the Exhibits); and

WHEREAS, the WCHO was established as a separate legal entity in 2000 as a partnership between Washtenaw County and the University of Michigan. Each partner appoints six members to the Board of WCHO. WCHO is one of only two such Community Mental Health Organizations in Michigan. The original purpose for WCHO was to establish an integrated health care delivery system to provide mental health, substance abuse and primary and specialty health care to Medicaid, low income and indigent consumers. There are only three models allowed in the State mental health code for organizing mental health services for publicly funded consumers: a Community Mental Health Organization (WCHO), a Community Mental Health Authority, and a Community Mental Health Agency. WCHO is a Community Mental Health Organization; and

WHEREAS, the Task Force consisted of three voting members: Verna McDaniel, Washtenaw County Administrator; Brent M. Williams, M.D., MPH, Medical Director, UM Complex Care Management Program; and Robert Laverty, the Chair of Task Force. The Task Force invited participation of advisors, consultants and experts from the University of Michigan Health System, county government, the WCHO, CSTS, the State of Michigan and the regional agency for mental health services. The Task Force met eleven times, conducted interviews, and reviewed numerous documents and financial information. Three alternative organizational models were evaluated; and

WHEREAS, a significant unanticipated event was the retirement of the WCHO Executive Director on December 27, 2014, necessitating the accelerating the time frame for the Task Force to complete its work; and

WHEREAS, the University of Michigan Health System (UMHS) and Washtenaw County have enjoyed a long-standing relationship in serving publicly funded consumers needing mental health services. The WCHO partnership was established to provide for improved integration between physical and mental health services, to foster innovation, to provide for educational sites to train new practitioners, to seek grant funding and, most importantly, to improve the quality of care. Both the county and the UMHS wish to continue and strengthen this relationship, and further broaden the arrangements to include the St Joseph Mercy Health System; and

WHEREAS, in evaluating the current partnership (WCHO), the Task Force concluded that this arrangement has not achieved the potential envisioned in its original purposes and goals. This view is widely held. The Task Force identified numerous factors that have contributed to this outcome. The most significant factors are:

- Frequent changes in leadership.
- WCHO and its major contractor for direct consumer care (CSTS) are separate entities with separate management teams. They do not coordinate planning, budgeting and evaluation; and lack effective communication and joint problem solving.
- Changing role of WCHO from a regional entity to a local entity.
- Confusing and declining funding.
- Ineffective management of the partnership by the parent entities (Washtenaw County and UMHS).
- Lack of adequate governance of WCHO.
- Lack of funding and focus on integrating medical and mental health care; and

WHEREAS, the future funding, organizing and integration of mental health services with physical health care will be even more challenging in the future. Contributing to this uncertainty are new global payment systems, the Affordable Care Act, increased numbers of Medicaid consumers eligible for mental health services, and expanded emphasis on care management. In the future, the organization and management of mental health services must be more flexible, efficient, effectively governed, effectively managed, responsive, innovative and clear on its purpose and goals; and

WHEREAS, the Summary of the Eight Task Force Recommendations

1. Discontinue the legal partnership and dissolve the WCHO.
2. Implement a Community Mental Health Agency model (Agency) for providing mental health services for publicly funded consumers.
    a. Confirm the financial impact on the county by moving to an Agency model.
    b. Appoint a Community Mental Health Board that is capable of assuming the role of a governing body for a Community Mental Health Authority.
    c. Seek recommendations from UMHS and SJMHS for representation on the Mental Health Board.
3. Prepare to transition from the Agency model to a Community Mental Health Authority model (Authority) within two years.

4. Establish an affiliation agreement between the county, UMHS and SJMHS to conduct strategic planning for mental health services, identify and implement pilot programs, provide educational opportunities, conduct research and seek grants.
5. Formalize specific programmatic agreements between the county, UMHS and SJMHS for mental health services.
6. Provide for the involvement of Packard Health, other safety net clinics and the Washtenaw Health Initiative (WHI) in the planning, assessment and delivery of mental health services.
7. Conduct a formal search to select a person capable of providing leadership to the Agency and to manage the transition to the Authority.
8. Implement an annual, formal evaluation process, conducted by an external consultant, to assess the performance of the Agency. This should include a focus on clinical quality, client satisfaction, financial performance, program development, and results for the clients served; and

WHEREAS, implementation will follow acceptance of these recommendations by county leadership, the UMHS, and the State of Michigan. It will require three to six months to accomplish the transition from WCHO to a Community Mental Health Agency and to prepare for the eventual development of a Community Mental Health Authority. In the interim, the WCHO Board will need to continue its governance duties. Washtenaw County Administration will bear the responsibility for managing the implementation plan.

NOW THEREFORE BE IT RESOLVED that the Washtenaw County Board of Commissioners hereby approve the final report and recommendations submitted by the Behavioral Health Task Force, dated December 31, 2014, and authorize the County Administrator to implement such recommendations and timeline as attached hereto and a part hereof.

BE IT FURTHER RESOLVED that the Washtenaw County Board of Commissioners authorizes the following position modifications:

Position #	Position Title	Grade	Group	Eliminate	HV
12080008[a]	Data Entry Clerk	12	12	1.0	
13330008[a]	Fiscal Assistant I/II	13/15	12	1.0	
15810008[a]	Peer Support Specialist	15	11	1.0	
20630006[a]	Health Educator I/II	20/22	11	1.0	
20760001[a]	Revenue Contract Analyst	20	11	1.0	
21800002[a]	Health Services Access Prof	21	11	1.0	
22790001[a]	WCHO Data Coordinator	22	11	1.0	
75560001[a]	WCHO Reimbursement Sup	75	10	1.0	
72230005[a]	Office Coordinator	72	10	1.0	
90060001[a]	WCHO Deputy Staff Director	2	32	1.0	
90080001[b]	WCHO Finance Director	2	32	1.0	
90130001[c]	WCHO Program Administrator	5	32	1.0	
90130007[a]	WCHO Program Administrator	5	32	1.0	
90140002[c]	WCHO Health Data Analyst	5	32	1.0	
90160002[c]	WCHO Chief Rights Officer	5	32	1.0	
90180001[c]	WCHO Finance Manager	5	32	1.0	
90230002[f]	WCHO Sr. Management Analyst	7	32	1.0	
90230004[c]	WCHO Sr. Management Analyst	7	32	1.0	
90250001[a]	Utilization Review Analyst	9	32	1.0	

90280007[a]	WCHO Management Analyst I/II	10/8	32	1.0	
90280013[e]	WCHO Management Analyst I/II	10/8	32	1.0	
90320006[d]	WCHO Management Assistant	10	32	1.0	
90350002[a]	WCHO Administrative Coordinator	12	32	1.0	
12080004	Data Entry Clerk	12	12		1.0
15340019	Vocational Specialist	15	11		1.0
17400001	Health Svcs Access Intake Spec	17	11		1.0
17400010	Health Svcs Access Intake Spec	17	11		1.0
19130001	Contract Procurement Rep	19	11		1.0
19760014	Client Services Manager	19	11		1.0
19760027	Client Services Manager	19	11		1.0
19760028	Client Services Manager	19	11		1.0
19760036	Client Services Manager	19	11		1.0
19760047	Client Services Manager	19	11		1.0
19760058	Client Services Manager	19	11		1.0
19760062	Client Services Manager	19	11		1.0
19770011	Supports Coordinator I/II-DD	19	11		1.0
19770027	Supports Coordinator I/II-DD	19	11		1.0
21100039	Mental Health Professional	21	11		1.0
21100100	Mental Health Professional	21	11		1.0
21100170	Mental Health Professional	21	11		1.0
21100176	Mental Health Professional	21	11		1.0
21100190	Mental Health Professional	21	11		1.0
21700006	Crisis Services Professional	21	11		1.0
21700014	Crisis Services Professional	21	11		1.0
21700015	Crisis Services Professional	21	11		1.0
21700025	Crisis Services Professional	21	11		1.0
23460017	Mental Health Nurse	23	11		1.0
23490001	Medical Case Manager-IHI	23	11		1.0
25850002	Service Coordinator-80	25	11		1.0
27190096	Management Analyst I/II	27/29	32		1.0
34330001	Staff Child Psychiatrist	34	32		1.0

[a] vacant
[b] effective 7/15/15
[c] effective 3/31/15
[d] effective 3/6/15
[e] effective 4/10/15
[f] effective 6/11/15

BE IT FURTHER RESOLVED that the Washtenaw County Board of Commissioners authorizes amending the CSTS budget, as attached hereto and a part hereof.

SUMMARY OF THE EIGHT TASK FORCE RECOMMENDATIONS:

1. Discontinue the legal partnership and dissolve the WCHO.
2. Implement a Community Mental Health Agency model (Agency) for providing mental health services for publicly funded consumers.
   a. Confirm the financial impact on the county by moving to an Agency model.
   b. Appoint a Community Mental Health Board that is capable of assuming the role of a governing body for a Community Mental Health Authority.
   c. Seek recommendations from UMHS and SJMHS for representation on the Mental Health Board.
3. Prepare to transition from the Agency model to a Community Mental Health Authority model (Authority) within two years.
4. Establish an affiliation agreement between the county, UMHS and SJMHS to conduct strategic planning for mental health services, identify and implement pilot programs, provide educational opportunities, conduct research and seek grants.
5. Formalize specific programmatic agreements between the county, UMHS and SJMHS for mental health services.
6. Provide for the involvement of Packard Health, other safety net clinics and the Washtenaw Health Initiative (WHI) in the planning, assessment and delivery of mental health services.
7. Conduct a formal search to select a person capable of providing leadership to the Agency and to manage the transition to the Authority.
8. Implement an annual, formal evaluation process, conducted by an external consultant, to assess the performance of the Agency. This should include a focus on clinical quality, client satisfaction, financial performance, program development, and results for the clients served.

PROPOSED IMPLEMENTATION TIMELINE TO TRANSITION TO AGENCY:

- Verify financial impact (*Completed 2/5/15*)
- Staff Meetings with CSTS and WCHO Staff (*Ongoing*)
- Seek support and endorsement from WCHO Board and University of Michigan Health System of Task Force recommendations. (Completed 1/20/15)
- Amend service agreement between WCHO and CSTS to include remaining required functions (issued 2/9/15, fully executed no later than 2/27/15)
- Consolidate administration (1/1/15 – 7/31/15)
- Initiate search process for the Executive Director of the Agency (by 3/9/15)
- Hire New Executive Director of the Agency (by 5/31/15)
- Notify the State of intent to change CMHSP designation (by 4/1/15)
- Seek formal approval from the State of Michigan of CMHSP designation (by 9/30/15)
- Initiate discussions with UMHS and SJMHS to establish an affiliation agreement and specific programmatic agreements (beginning 7/1/15)
- Initiate the process for identifying and selecting the CMH Board (by 7/1/15)
- Create a formal Board development and education program (7/1/15 – 8/31/15)
- Orient the new CMH Board (by 9/30/15)
- Initiate discussion regarding labor, legal, financial, and programmatic implications of transition to an Authority
- Develop a process and identify an external consultant to perform an annual evaluation of the Agency
- Initiate annual evaluation of external contractors within the provider network (by 10/1/15)

Community Support & Treatment Services
Business Unit: 29303000
Fiscal year: 10/1/14-9/30/15
Budget Amendment

	FY 2014/2015 Original Budget	FY 2014/2015 Amended Budget	Variance
REVENUES			
Fees and Services	$1,355,595	$1,355,595	
WCHO Revenue	$31,477,708	$30,931,140	-$509,568.00
WCHO Revenue (Grants)	$1,168,117	$1,205,117	
Other Revenue & Reimbursements	$674,847	$674,847	
Transfers In	$165,192	$165,192	
	$34,841,459	$34,331,891	-$509,568.00
EXPENDITURES			
Personnel Services	$28,852,757	$28,343,189	-$509,568.00
Supplies	$309,285	$309,285	
Other Services & Charges	$2,731,545	$2,731,545	
Internal Service Charges	$2,921,872	$2,921,872	
Capital Outlay	$25,000	$25,000	
	$34,841,459	$34,331,891	-$509,568.00

WCHO

Self Determination CLS Budget Worksheet

Provider: FI: CLN

Consumer Initials: DW Consumer ID#: 13431 Habilitation Waiver Consumer? ◉ Yes ○ No

Is the consumer on a Medicaid spend down? ○ Yes ◉ No

Living Arrangement: ◉ Lives Alone ○ Shared Housing

Budget Created: 2/12/2015 Authorization Period: 3/16/2015 To: 3/11/2016

CLS Requested: 5 days/week

A variable hourly rate should be utilized for less than daily CLS (6 days a week or less).

Choose One: CLS Payment Structure: Hourly (H2015) ◉ Daily Per Diem (H0043) ○

Annual Budget Worksheet
Community Support Costs (Supported Independent Housing)
Estimated Annual Number of Per Diems : days/year

Total Weekly Individual Personnel Care Hours (CLS Only):	32.5	hrs/week
DHS Home Help Weekly Hours:		hrs/week
Other Hours:		hrs/week
Other Hours		hrs/week
PERS Weekly Hours		hrs/week
(Not to exceed 168 hours)TOTAL WEEKLY HOURS	32.5	hrs/week
Staff Training Annual Hours:	74	hrs/year
Months PERS Service will be authorized:	0	months

Other Community Support Costs

Monthly Transportation Cost:	$175.00	$/month
Monthly Goods/Activity Material Cost:	$0.00	$/month

View Michigan Medicaid Provider Manual Definition ☐

Other Budgeted Costs

Description	Monthly Cost	Annual Cost
Workman's comp (1 PT Staff)	$16.59	$199.08
Workman's comp (1 PT Staff)	$16.59	$199.08

Exhibit B p. 7 of 12

Community Participation	$60.00	$720.00
Annual Recreation Pass	$23.34	$280.08
		$1,398.24

Rates (*Altered Rates are bold and italicized.*)

CLS Hourly Rate	$13.88	DHS RH Hourly Rate	$8.00
Shared Hourly Rate	$13.88	PERS Monthly Rate	$899.39
Training Hourly Rate	$13.88	Monthly FI Fee:	$100.00

Exhibit B p. 8 of 12

Budget

WCHO is the funder of last resort.
All other funding sources should be utilized before including them in the WCHO cost obligation.

CLS Hourly Rate:	$13.88	*DHS HH Hourly Rate:*	$8.00
Shared Hourly Rate:	$13.88	*PERS Monthly Rate:*	$899.39
Training Hourly Rate:	$13.88	*Monthly FI Fee:*	$100.00

	Weekly Hours	Annual Hours	Annual Cost
Personnel Hours (CLS)*	32.5	1690	$23,457.20
Shared CLS Hours*		0	$0.00
DHS Home Help Hours		0	$0.00
Staff Training*		74	$1,027.12
PERS Service			$0.00
		Direct Care Costs to be paid by WCHO*	$24,484.32

Other Community Support Costs	Monthly Cost	Annual Cost
Transportation	$175.00	$2,100.00
Goods and Services	$0.00	$0.00

Other Description	Monthly Cost	Annual Cost
Workman's comp (1 PT Staff)	$16.59	$199.08
Workman's comp (1 PT Staff)	$16.59	$199.08
Community Participation	$60.00	$720.00
Annual Recreation Pass	$23.34	$280.08
		$1,398.24
Subtotal Community Supports		$3,498.24
Subtotal WCHO Obligation		$27,982.56
FI Administration Fee	12025 $100.00	$1,200.00
Total Costs		$29,182.56

15 Minute H2015 Variable Rate		$4.14
15 Minute H2015 Authorizations	Weekly: 130 Annually: 6,760	
15 Minute H2015 TT Authorizations	Weekly: 0 Annually: 0	

Exhibit B p. 9 of 12

Budget Verification

Budget Completed By:

Name: Deb Mackenzie Organization:
CSTS

○ Submit to Supervisor DD-Karma Mohring

Approved By: Kathlene Mohring Date: 2/12/2015

○ Submit to Housing Coordinator Louise Hayward

Approved By: Louise Hayward Date: 2/12/2015

Notes:
--Training--would like to add additional training for staff driven by family regarding special issues/topics, such as but not limited to autism, communication, etc. 24 hours/year extra for individualized staff training in the home (added to staffing training line item)
--Community Participation increased to $60/month for therapeutic riding, movies, increase community participation.
--Recreation Center for 2014 was $280 put in other section.

◉ Submit to WCHO Finance Kristu Diephuis

Reviewed By: Date:

Notes:

○ Send to: (enter email address)

Notes:

Exhibit B p. 10 of 12

PAPERWORK ROUTING SLIP

Client Name: Derek Waskul Client Number: 13431

Today's Date: 4-9-15

DOCUMENT ENCLOSED TO BE ROUTED.

IPOS: Y

UPDATED/AMENDED IPOS:

Termination of Services:

	NAME	LOCATION/ADDRESS
	Debra Chisholm	CSTS VOCATIONAL PROGRAM
	Britt Paxton	CSTS VOCATIONAL PROGRAM
	Lydia Sattler	CSTS VOCATIONAL PROGRAM
	Debbie Owen	CSTS VOCATIONAL PROGRAM
	Other Supported Employment Provider (Name and Address)	

Supports Coordinator: D. Mackenzie # of Copies: 1

	Name:	Address:
Client:		
Guardian:	Cindy Waskul	[redacted]
Provider:		[redacted]
Other:		

Comments:

For Records Management Specialist Only:
Date Received:
Date Completed: 4/10/15
By Whom: SAS

UPDATED/AMENDED IPOS: NO G & A TO BE ATTACHED
Date Received:
Date Completed:
By Whom:

Termination of Services:
Include G & A

Date Scanned: 4/10/15
By Whom:

Revised: 08/12/2013

Exhibit B p. 11 of 12

Person-Centered Plan
Signature Page

Washtenaw County
Community Support and
Treatment Services

Name: Derek Waskul Identification Number: 13431

Meeting Date: 3-16-15 Meeting Location: Family Home

This plan expires on: 3-15-16 Next Periodic Review Date: 9-16-15

People who attended my Person Centered Planning meeting:

Print Name	Relationship	Signature
Derek Waskul	Self	
Christine Pulcifer	direct care staff	Christine Pulcifer
Debbie MacKenzie	CSTS Supports Coordinator	Debbie Mackenzie
Cindy Waskul	Cindy Waskul	Mom

I was offered a PCP satisfaction survey ☒ Yes ☐ No N/A

☒ I understand that I have the right to appeal any denial, reduction or termination in service and/or support. I understand that services and/or support must be maintained or provided during an appeal process. Further, I understand that I have the right to an informal or formal appeal and have been given the name(s) of individuals who will assist me in my appeal if desired.

☒ I have been informed of guidelines for receiving services in this program and discharge procedures. And my client services manager/supports coordinator/therapist has given me a notice of my hearing rights and a copy of a hearing request form.

☒ My signature indicates that I directed the planning process with the assistance of those persons I chose to have involved in the process

☐ Consumer declined to participate in the Person Centered Planning Process. A plan was developed that reflects the services the consumer has/needs.

☒ I am aware that I will receive a copy of my Person Centered Plan by mail or delivery within 15 business days and I agree with the plan.

- or -

☐ I am aware that I will receive a copy of my Person Centered Plan by mail or delivery within 15 business days but I disagree with the plan.

Client: DM Date: 3-16-15

Guardian/Parent: X Cindy Waskul Date: 3-16-15

Clinical Staff: Debbie Mackenzie LBSW Date: 3-16-15

Psychiatrist and supervisor will review/sign electronically.

PCP SIGNATURE PAGE - FILE IN PCP SECTION ORIGINAL FOR RECORD, COPY FOR CLIENT REVISED 6/05, 4/07 FF 4/04
ATTACH COPY OF ADEQUATE NOTICE OF HEARING RIGHTS

Exhibit B p 12 of 12

washtenaw community health organization

ADMINISTRATION

705 N Zeeb Road
Ann Arbor, MI 48103-1560
Phone (734) 222-3818
Fax (734) 222-3846

Sally Amos O'Neal,
Interim Executive Director

April 9, 2015

Dear Consumer/Guardian:

I am writing to update you on some upcoming changes to your Self-Determination/Choice Voucher arrangement. Effective May 15, 2015, the Washtenaw Community Health Organization (WCHO) will be reducing our Community Living Support (CLS) rate for services paid and supported though a Fiscal Intermediary (FI). This change is necessary to ensure that Washtenaw County's rate is the same as our regional partners and to ensure that we are being fiscally responsible.

The new rate will be $13.88 per hour, which includes worker's compensation, transportation, community participation, taxes, and training. While this is not a reduction in your current level of services, it may reduce the amount you can pay your staff. We understand that this change may be difficult and I encourage you to work with your clinical team to review your staffing needs and available options, including the option to use one of our contracted providers for CLS services. We want to allow you time to process this change and work with your clinical team, therefore this will not go in effect until May 15, 2015.

Your Community Support and Treatment Services (CSTS) clinical staff will be contacting you within the next 2 business days to begin developing a CLS site plan that will guide your staff on the hours and days of service you need. After discussing this change with your clinical team and you still have questions or concerns, please feel free to contact Customer Service at 734.544.3050.If you have any questions or feedback please feel free to contact me at amoss@ewashtenaw.org.

Thank you,

Sally Amos O'Neal

Sally Amos O'Neal
Interim Executive Director

2012 WCHO/CSTS letter describing Budgeting Process A

Washtenaw County Community Support & Treatment Services

Services to Persons with Developmental Disabilities
2140 E. Ellsworth Road, Ann Arbor, MI 48108
Phone: (734) 222-3400 Fax: (734) 222-3461
Voice-TDD: (734) 222-3425

April 17, 2012

Dear Self-Determination Voucher Individuals & Families,

Hello. As mentioned in a previous letter, Community Support & Treatment Services (CSTS) in collaboration with the Washtenaw Community Health Organization (WCHO) created individualized budgets for individuals who are in self-determined voucher arrangements. We went over the budget format during meetings held on 3/28/12 and 4/11/12 with those who attended. We feel that this new individualized budget is a benefit to you, so we did not want to delay this any longer. That is why you are receiving this letter.

Your new budget still has the same amount of community living supports hours you currently have, but with this budget you will have additional funding for staff training, transportation, goods and activity costs at your disposal (all based on the individual plan of service). If there is a question regarding any line item in your budget, it can be reviewed at anytime, all you will need to do is contact your Support Coordinator.

Included in this letter is a copy of your individualized budget along with a copy of your individual plan of service. If you would like to schedule a meeting to discuss this further, please contact me at 734.222.3495. I will be happy to meet with you.

Thank you for your time.

Sincerely,

Britt Paxton
WCCSTS, Self-Determination Coordinator

2012 WCHO/CSTS letter describing Budgeting Process A

Washtenaw County Community Support & Treatment Services

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2140 E. Ellsworth Road, Ann Arbor, MI 48108
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Your new budget still has the same amount of community living supports hours you currently have, but with this budget you will have additional funding for staff training, transportation, goods and activity costs at your disposal (all based on the individual plan of service). If there is a question regarding any line item in your budget, it can be reviewed at anytime, all you will need to do is contact your Support Coordinator.

Included in this letter is a copy of your individualized budget along with a copy of your individual plan of service. If you would like to schedule a meeting to discuss this further, please contact me at 734.222.3495. I will be happy to meet with you.

Thank you for your time.

Sincerely,

Britt Paxton
WCCSTS, Self-Determination Coordinator

Date: June 15, 2015

To: Jeffery L. Wieferich, M.A., LLP, Director

Division of Quality Management and Planning

From: Sally Amos O'Neal, M.S., LBSW, Interim Executive Director

Washtenaw Community Health Organization

Subject: WCHO CLS Rate Reduction Action

Washtenaw Community Health Organization (WCHO) is responding to your letter dated June 4, 2015. Per our telephone conversation with Tom Renwick and Belinda Hawks on June 11, 2015, we are conducting the following plan of action for all Self Determination and Choice Voucher Arrangements:

1. In coordination with the Washtenaw CSTS Clinical Team, we are collaborating with the individual and/or guardian to review the Individual Plan of Service (IPOS) and the Self Determination budget. Upon review with all parties, the IPOS will be reviewed and signed off on by the individual and/or guardian and the CMHSP.
2. Through the completion and signature on the updated IPOS, each individual and/or guardian will be provided Adequate Notice of Rights.
3. Should an individual and/or guardian disagree with the IPOS/budget, WCHO will attempt to negotiate a solution locally. Should a solution become unattainable, WCHO will ensure they are provided assistance with filing a Medicaid Fair Hearing.
4. Should an individual and/or guardian request a Fair Hearing regarding any IPOS/budget action, WCHO will ensure prior services/budget are reinstated pending completion of the Fair Hearings process.

In regards to the specific individual and/or guardian who raised the concern to both CMS and MDHHS, the following actions are or have been conducted:

1. The WCHO has reversed the CLS rate retroactive to May 15, 2015 pending results of the Medicaid Fair Hearings Process scheduled for July 1, 2015.
2. Washtenaw CSTS Clinical Team facilitated a Person Centered Planning meeting on June 12, 2015 in regards to individuals and/or guardians request for CLS hours and workman's compensation coverage. While no decision was reached at that meeting, the clinical team is still in the process of negotiating an updated IPOS. Should an agreement not be met within fourteen days, written notice will be provided to individual and/or guardian to ensure they are informed of their right to a Medicaid Fair Hearing.

Washtenaw County Community Mental Health
Notice and Hearing Rights

Notice and Hearing Rights

Notice and Hearing Rights
With the Department of Community Health Administrative Tribunal
for a MEDICAID beneficiary

Attention: CORY SCHNEIDER Case #: 0000010068 Date: 11/18/2015

Mail to: Marti Schneider
[redacted]

☑ ADEQUATE (at the time of action)
- ☐ Denial of public mental health/substance abuse services for an applicant
- ☐ Denial of service to a current consumer (something currently not receiving)
- ☑ Individualized Plan of Service/Periodic Review/Progress Review

☐ ADVANCE (12 days prior to action)
- ☐ Reduction of services
- ☐ Suspension of services
- ☐ Termination of services
- ☐ Delay of services
- ☐ Non Payment

ACTION EFFECTIVE ON: 10/19/2015

Legal Basis for the above decision is 42 CFR 440.230

Specifically, the action taken is described below:

Your individualized plan of service/periodic review/progress review defines the amount, scope, and duration of the services that are authorized and the services will start within 14 days from the agreed upon start date.

This notice, envelope and Request for Hearing form were given to Marti Schneider on 11/18/2015 and the notice was copied for the case record by ___ (initials).

If you do not agree with this action, you may:

- Ask for a Medicaid Fair Hearing within 90 days of the date of this notice:
  - Complete the Request for Hearing form enclosed with this notice
  - Send Request for Hearing form in envelope also enclosed to:

    State Office of Administrative Hearing and Rules
    For the Department of Community Health
    PO Box 30763 Lansing, MI 48909-9951
  - If you have any questions you may contact the Administrative Tribunal directly at:
    1-877-833-0870
  - You may represent yourself, or use legal counsel, a relative, a friend, or other spokesman.
  - Your services will stay in place until a judge makes his/her decision, if:
    - A hearing request is made within 12 calendar days from the date of this notice;
    - If the action is a termination, reduction, or suspension of a service that was previously authorized;
    - The authorization has not expired;
    - The service was ordered by an authorized provider; and
    - You ask for the service to continue.

  If you continue to receive benefits because you requested a fair hearing, you may be required to repay the benefits.
  This may occur if:
    - The proposed termination or denial of benefits is upheld in the hearing.
    - You withdraw your hearing request.
    - You or the person you asked to represent you does not attend the hearing.
  - You may request a faster hearing if waiting could seriously jeopardize your life, or health or ability to attain, maintain, or regain maximum function. To ask for a faster hearing you must call 1-877-833-0870;

and/or

HEALTH MANAGEMENT ASSOCIATES

Washtenaw County Community Mental Health Financial and Service Delivery Analysis

PREPARED FOR
WASHTENAW COUNTY LABOR-MANAGEMENT PARTNERSHIP

BY STEVE FITTON AND RICH VANDENHEUVEL

DRAFT REPORT

DECEMBER 17, 2015

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

ATLANTA, GEORGIA • AUSTIN, TEXAS • BOSTON, MASSACHUSETTS • CHICAGO, ILLINOIS • COLUMBUS, OHIO
DENVER, COLORADO • HARRISBURG, PENNSYLVANIA • INDIANAPOLIS, INDIANA • LANSING, MICHIGAN • NEW YORK, NEW YORK
OLYMPIA, WASHINGTON • PORTLAND, OREGON • SACRAMENTO, CALIFORNIA • SAN FRANCISCO, CALIFORNIA
SEATTLE, WASHINGTON • SOUTHERN CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, DC

Contents

HMA Scope of Work and Methodology

Introduction

Health Management Associates (HMA) was approached by Washtenaw County leadership to review the budget situation of the Community Mental Health agency. The county had concluded that they needed to outsource their vocational services program. The Labor Management Partnership was very concerned about the loss of good jobs and anxious to see if there was any alternative resolution. HMA was engaged to provide an independent and fresh look at the situation.

HMA is a consulting firm with deep expertise across all domains of publicly funded health care. We are leaders in delivery system restructuring, strategic planning, behavioral health, primary care practice transformation, long-term services and supports, managed care policy and operations, correctional health, and consultation to state and county governments and federally-qualified health centers. We have extensive front line experience and continue to lead innovations in the areas of hospital and health system operations, health care program development, health economics and finance, program evaluation, program integrity, and data analysis. HMA is widely regarded as a leader in providing strategic, technical, analytical and implementation services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved.

HMA Scope of Work and Methodology

HMA proposed the following steps in reviewing Washtenaw County Community Mental Health's financial and service delivery situation:

- Schedule and participate in kickoff meeting with the Labor Management Partnership (LMP) to ensure clarity on project scope, information sources, and prioritized activities within scope of work, and to identify key contact points and communication pathways with Washtenaw County Community Mental Health;
- Review existing prioritized materials and reports, including the Behavioral Health Task Force Final Report, that document the facts and findings of prior work efforts on these issues;
- Review and evaluate the cost of the current service delivery system compared to benchmarks and best practices in Michigan and other states, including administrative and service delivery costs;
- Consider and identify potential consequences of contracting vocational services on consumer employment and finances of other county functions;
- Review current funding by source and identify any possible opportunities within current state and federal policy for increase including:
  - Options for increased revenue under a modified PIHP allocation formula;
  - Improving Medicaid eligibility outcomes for the current non-Medicaid population;
  - Cost vs. return of maximizing Medicaid enrollment (investment in eligibility

determination, cost sharing investment, and other strategies);

- Explore more non-traditional opportunities for funding increases within current state and federal policy, including especially innovative service arrangements and financing mechanisms that may be possible through Medicaid such as foundation funding, contributions/contracts from health systems or hospitals, and local corrections and sustainable millage funding;
- Selectively review mental health service work currently contracted out to providers to analyze if it can be done more cost effectively and efficiently by current County Mental Health employees;
- Schedule weekly status updates via phone with designated lead contact points including Washtenaw County Community Mental Health and LMP designees to provide progress updates, address questions/clarifications that arise during analysis and to ensure clarity throughout process;
- Write a final report of the results of this review assessing the status of finances in the current service delivery configuration with any recommendations for financial improvement (including especially any possible increases in funding) ensuring the protection of beneficiaries as a core principle.

Weekly Status Calls with Labor Management Partnership

HMA participated in weekly status calls with the Labor Management Partnership. During these calls, HMA informed the group of progress and findings, answered questions, and discussed issues that were raised by the group. This process was very helpful in keeping the project on track, maintaining a shared sense of priorities, and providing ongoing information on findings.

Review of Documents

HMA conducted analysis of numerous publicly available reports and documents.Documents reviewed include:

- 2014 Medicaid Unit Net Cost (MUNC) Report Summary by PIHP
- 2014 Michigan Department of Community Health Section 404 Report (for Persons with Developmental Disabilities)
- Washtenaw County Behavioral Health Task Force Report
- Community Mental Health Partnership of Southeast Michigan (CMHPSM) Regional Analysis of H2023 and H2014 Service Codes
- CMHPSM/WCCMH Medicaid Contract
- CMHPSM Financial Policy
- CMHPSM Financial Risk Management Strategy
- CMHSPSM Powerpoint: "Regional Entity and Prepaid Inpatient Health Plan Funding and Structure"
- Milliman Actuarial Certification Letters for Fiscal Years 2015 and 2016 for the State of Michigan's Behavioral Health Programs Including Traditional Medicaid and Healthy Michigan

Key Informant Interviews

HMA interviewed key informants to supplement the information available from the reports and documents. Key informants interviewed include:

- Trish Cortes, Washtenaw County Community Mental Health Executive Director
- Nicole McMahon, WCCMH Chief Financial Officer
- Nancy Heine
- Cheryl E. Jones
- Krista Diephuis, Program Administrator for DD Services, WCCMH
- Felicia Brabec, Chair of Washtenaw County Board of Commissioners

Funding Landscape

Background

Almost all of Washtenaw County Community Mental Health's funding is from State of Michigan appropriations and the vast majority of that is for the Medicaid program. In 2002, the State required that Community Mental Health Boards (CMHBs) consolidate some functions and form Prepaid Inpatient Health Plans (PIHPs) for Medicaid purposes. This moved the flow of Medicaid funds from the State to the PIHPs rather than directly to the CMHBs, the method that had been used up to that point. There were originally eighteen PIHPs with a framework that allowed CMHBs to perform some of the required centralized functions with the agreement of the other members. In the past few years, the State of Michigan mandated the consolidation of PIHPs down to ten (from the eighteen) and required that a separate administrative structure be established to perform functions for the region.

This history is important for Washtenaw County primarily because of the role of the Washtenaw Community Health Organization (WCHO). The Behavioral Health Task Force Final Report provides a thorough review of this collaboration and some of the issues that became evident in the last few years. There is no reason to recount the information and findings of that report other than to observe that the changes in state policy regarding PIHP structure had a major impact on the funding available for WCHO administration and served to magnify issues that came to the fore in terms of overlap and duplication of functions. It is significant that the WCHO is being dissolved and the county has addressed cost issues that emanate from overlap with Community Support and Treatment Services (CSTS), the county department that is responsible for the delivery of most behavioral health services. It also is important to note that the need to fund a separate administrative PIHP structure disproportionately impacted Washtenaw County because its administration was previously performing most of the PIHP administrative functions. This translated into a loss of funding since the PIHP administration now needed these dollars to cover their costs.

State of Michigan Funding

Medicaid appropriations from the State of Michigan for behavioral health services were converted to a risk based, capitated managed care platform in 1998. These appropriations have been exclusively paid to the public mental health system over this time period with structural changes in the formation of PIHPs and then their composition and responsibilities as described above. Rates were originally heavily adjusted toward maintaining CMHB historical funding levels. Over the years, there has been an ongoing

process of equalizing rates across jurisdictions so that there is more consistency in the level of funding and services. In recent years, there has been more support for reaching the equalization goal and, hence, more actual movement in dollar amounts between jurisdictions as more responsibility for distribution of funds to CMHBs or counties rested with the PIHPs.

While Medicaid appropriations are the predominate source of financing, historically there were substantial general fund appropriations directly to the CMHBs to care for non-Medicaid residents as well as cover some costs for Medicaid beneficiaries that didn't fall within Medicaid coverages (spenddowns for example). These general fund appropriations were largely based on historical allocations. Over the years, the amount of general fund revenues has declined very significantly as the state and the behavioral health system figured out how to increase the services and costs that are covered by Medicaid. Over time Medicaid funding increases more than offset these declines but there was a loss in flexibility since the rules governing use of general fund dollars are far less constraining. The final shift away from general fund occurred with the passage of the Healthy Michigan Plan, Michigan's adoption of the ACA Medicaid Expansion. This moved the majority of persons served by the general fund into Healthy Michigan and off of general fund. The general fund dollars, still directly allocated to the CMHs, are now largely used to fund spenddowns and other Medicaid gaps.

While State of Michigan Medicaid funding for behavioral health has increased with the adoption of the Medicaid expansion and the historical conversion of general fund costs to Medicaid, the State's fiscal situation has resulted in modest overall increases. The Granholm administration was saddled with a decade long recession that constrained state budgets. The economic problems carried into the Snyder administration and, despite some recovery, funding has continued to be tight for multiple reasons. Looking to Fiscal Year 2017, funding will be constrained due to several factors. These factors include the obligation to begin funding the Healthy Michigan Plan with five percent general fund, the replacement or reauthorization of Medicaid specific taxes that are at risk, and competition for funding from roads and other state functions. The bottom line is that increases in Medicaid rates for behavioral health services have been relatively flat with increases of between zero and three percent the norm and the prospects for any appreciable increase in these amounts are dim.

PIHP

The PIHP is now the recipient of all Medicaid funding for mandated services. Each PIHP has discretion in how it distributes the funding among its county or CMHB members (noting that each CMHB or county has representation on the PIHP board). Because the PIHP method of allocating Medicaid funding to county CMH entities is the last and most vital step in the amounts of funding made available to Washtenaw County on an annual basis, our review focused on understanding and evaluating the distribution methodology along with the fiduciary responsibilities of the PIHP.

Washtenaw County Community Mental Health is part of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) which serves as the Prepaid Inpatient Health Plan (PIHP) for Washtenaw, Lenawee, Livingston and Monroe Counties. Funding with the most recent state rate rebasing has remained essentially flat for the current fiscal year and is expected to go down slightly in Fiscal Year 2017 based upon current discussions with the Michigan Department of Health and Human Services.

Medicaid revenues have multiple components and include Medicaid State Plan/B3 Capitation Payments (Mental Health and SUD services), Habilitation Supports Waiver Payments, Autism Benefit Payments, Healthy Michigan Plan Capitation Payments, Substance Use Disorder (SUD) Community Grant Funds, and Substance Use Prevention and Treatment Funds from Public Act 2 (governed by Oversight Policy Board).

Funds are distributed throughout the region using two methods: direct pass through of funds (minus the PIHP administrative costs) and an actuarially determined percentage distribution. Habilitation Supports Waiver, , Autism Applied Behavioral Analysis, and Healthy Michigan funds are directly passed through (i.e., each county receives its per member per month rate for enrollees in their county after a small contribution to PIHP administrative costs) to the Community Mental Health boards (CMH). Traditional Medicaid (State Plan and B3 alternative services) are distributed based upon actuarially determined percentages.

Traditional Medicaid funding is the predominant source of funds to the Region and to Washtenaw County Community Mental Health. The PIHP develops a Regional Budget for Medicaid estimating future year revenues based upon projected Medicaid enrollment. It then determines the administrative budget needs of the PIHP for contractual obligations and administrative costs. The remaining Medicaid funds are distributed to the four counties based on an actuarial model developed by Milliman. The current regional distribution across the PIHP members by percentage is as follows: Lenawee 13.9 percent, Livingston 17.64 percent, Monroe 19.05 percent, and Washtenaw 49.41 percent. For comparison, the revenue received by the PIHP from MDHHS based upon Medicaid enrollment by percentage for each member is as follows: Lenawee 17.96 percent, Livingston 13.71 percent, Monroe 23.46 percent and Washtenaw 44.87 percent. The differences in percentages are a result of the actuarial methodology which factors in beneficiary severity of need for the membership in each county. It is noteworthy that the actuarial methodology does not change the county distribution in response to short term changes in the number of Medicaid enrollees.

This latter reality impacts one of the areas viewed to have potential for increasing Washtenaw CMH revenues, increasing the number of Medicaid enrollees, especially among the population directly served by Washtenaw County. Improvement in outreach and retention of the eligible population results in increased payment from the State of Michigan since Medicaid pays a rate for each person enrolled in each month. The fact that the PIHP methodology does not respond to increases in Medicaid enrollees cuts off this area as a source of increased funds in the short term. Further, interviews with Washtenaw County CMH leadership revealed that there was an outstationed eligibility worker assigned and that the program staff do rigorous follow up on persons served who fall off of Medicaid eligibility. Finally, Washtenaw County has other activities that put it among the best for Medicaid outreach and enrollment. Much of this can be attributed to the Washtenaw Health Plan.

PIHPs are Medicaid managed care organizations that are responsible for managing financial risk. There are risk corridors that require that the PIHPs be able to fund expenditure overages up to 7.5 percent of the annual allocation. In order to fulfill this responsibility, PIHPs actively oversee county CMH finances throughout the fiscal year. Further, they have a reserve fund (in the form of an internal services fund referred to as the ISF) that they establish and maintain to cover unanticipated cost overruns and crises.

The CMHPSM is responsible for managing the shared risk responsibility in the contract with MDHHS. For all PIHPs, this shared risk represents 7.5 percent of Traditional Medicaid and 7.5 percent of Healthy Michigan Plan funding. With an overall budget of approximately $157 million dollars, CMHPSM currently has an ISF reserve of $8.8 million, or approximately 5.6 percent. Executive Leadership of CMHPSM and Washtenaw County Community Mental Health have confirmed that use of the regional ISF to cover cost overruns in the current time period is not being pursued, nor is it likely to be approved by the regional board, as the current situation is not based on "significant revenue changes by the State, new high-cost consumers enrolled by a CMHSP or changes to the State's requirement on how services are to be provided to consumers".

The current proposal to contract for Vocational Services is part of a plan of correction to address structural issues causing the cost overruns. The CMHPSM offered Washtenaw County a 90 day contract for the first quarter of FY 2016 pending MDHHS certification of Washtenaw County Community Mental Health (WCCMH). Extension of the contract beyond the first quarter is contingent upon:

- "Capability to execute PIHP delegated functions,
- Adherence to budget and
- Quality service provision".

If these are not met, the PIHP would assume all delegated PIHP functions for Washtenaw County and would offer the county the opportunity to contract for specific services on a fee for service basis paid at the average PIHP regional Medicaid rate for FY 2014. If the rates are not satisfactory for WCCMH, the PIHP will contract externally for service provision.

MDHHS is aware of and supportive of the regional approach to addressing cost overruns, reinforcing the PIHP's responsibility to manage risk and authority to seek alternative providers if necessary. A detailed explanation of the PIHP budgeting and oversight process is in Appendix A.

Funding Outlook from Traditional Revenue Sources

In addition to the overall State picture, HMA reviewed and evaluated multiple aspects of the PIHP funding and budgeting process: 1) PIHP administrative costs; 2) PIHP financial oversight policies and practices; and 3) the methodology for distributing funds to counties. We will address these in sequence.

The State of Michigan Medicaid budget situation continues to show stress and it is unlikely that there will be substantial increases. The best that can be hoped for is continuation of modest rate increases based on actuarial rate-setting standards. Washtenaw County should carefully monitor the appropriations process as legislators grapple with the need to begin to fund five percent of the Healthy Michigan expansion and replace or continue Medicaid related taxes that are in jeopardy.

The CMHPSM functions very similarly to other regional PIHPs in the State of Michigan. Its administrative costs at 1.9 percent are in the lower range for PIHPs and for health care agencies generally. This compares to PIHP reported administrative costs statewide ranging from 1.2 percent to 8+ percent. The total administrative cost for the PIHP is $2.98 million, not including PIHP mandatory pass through and contractual tax costs. The administrative cost percentage is even more favorable considering that

CMHPSM is one of the smaller PIHPs and therefore has a smaller base service budget over which to spread its administrative costs.

Both PIHP and county officials reported to us that the PIHP has reallocated funding from the other counties to help offset recent deficits of Washtenaw County. It isn't surprising that the current PIHP stance and plans require that Washtenaw develop and manage a balanced budget. In regard to the reserve fund for risk, the current funding amount does not seem excessive in light of the potential obligations that could occur. Our interviews have included the perspective that the other counties are not sympathetic to sustaining Washtenaw beyond the funding enhancements already provided.

Finally, the distribution of Medicaid funding is largely based on the PIHP actuarial model that accounts for beneficiary need/severity. This results in funding for Washtenaw that is over 4.5 percent greater than a pro rata distribution based on enrollees.

Our general assessment of these factors is that neither the State of Michigan nor the CMHPSM (PIHP) are realistic sources of significantly increased revenue. We saw no systemic bias that disadvantages Washtenaw County CMH. Rather, it appears that the actuarial model in particular is important for Washtenaw in recognizing the need/acuity of its population.

The result of all of this is that in fiscal year 2016, Washtenaw County will receive $59.1 million for Traditional Medicaid, $4.3 million for Healthy Michigan Medicaid (with some carryover funding from the prior year as a supplement), and $2.7 million in general fund. The Traditional Medicaid allocation has dropped by $10 million from FY 2013 when it was $69.6 million. Healthy Michigan funding has largely replaced the loss of general fund but that is still being debated at the state policy level and is complicated. Actual general fund revenue in 2013 was $8.4 million but it included funding necessary to support individuals placed in state psychiatric hospitals, a responsibility that was removed from CMHs in 2016. For these purposes, the significant matter is the reduction in revenue. This is real and the unfortunate consequence is a very challenging financial situation for the county and its CMH.

Non-Traditional Revenue Sources

A number of possible non-traditional revenue sources were explored to assess how they might assist in resolving, or at least alleviating, Washtenaw County CMH's budget problems. These include foundation funding, contributions from local health systems, and raising revenue through a targeted millage or some other method to increase public funds. These options would be greatly enhanced if they could be used to match and thereby increase federal Medicaid funding.

For all of the potential funding sources mentioned, the key issue here is the ability to match Medicaid. At the services rate, the investment of one local dollar would yield almost a $3.00 payment since the federal matching rate is over 65 percent (each Medicaid dollar spent in Michigan is offset by $.65 of federal funding). Administrative matching is usually at 50 percent so the return on $1.00 is $2.00. There are legal tests for types of revenue that can be used to match federal Medicaid funding and all that we have described pass that test. That is not the problem.

The problem is that there needs to be a valid reason for the expenditure. Service costs that are higher than supported by the actuarially determined rates are not considered a sufficient reason. The federal government is concerned about its costs and, in a managed care structure, the rates that have been developed are supposed to be adequate for the cost of services to the covered population. Additional Medicaid funding could be leveraged for additional services beyond the scope of the contract assuming coverage in Michigan's State Plan or one of the waivers. But these would have to be services or functions over and above those expected as part of the standard contract that the State of Michigan has with the PIHPs and that the PIHPs have with the CMHs.

There is nothing that would prohibit any of these potential revenue sources from being used to support Washtenaw County CMH services, they just could not be multiplied by Medicaid match. This would not rule out pursuit of these alternative funding sources, but the return on investment would not include the Medicaid match and so would need to cover the full cost of programming. It is our understanding that there are already contributions from the area hospitals, partners who are impacted by the quality and quantity of CMH services to a population that they serve as well.

It also should be noted that these non-traditional revenue sources could be used to match Medicaid for projects that would be beyond the usual scope of the program and had the potential to improve the program over the longer term. These projects are sometimes labeled "Administrative Matching Projects." They do require state and sometimes federal approval and as such, would not be a likely short term option.

Finally, there are state and national initiatives that could provide additional revenue to Washtenaw County CMH. The initiatives with this potential currently integrate behavioral health services with physical health and sometimes even long term care services. Enhanced funding for Health Homes (under Section 2703 of the Affordable Care Act), Certified Community Behavioral Health Centers (CCBHC), and the Michigan's Blueprint for Health, the State Innovation Model are all in some state of development or implementation at this time. Washtenaw County can be encouraged that it is either participating in or actively pursuing all of these initiatives. In fact, the Health Home project has provided some modest funding and Washtenaw is a leader in the State.

While it is important to be forward looking and alert to non-traditional sources of revenue, they typically cannot solve short term, substantial budget problems. That is the case here. We strongly encourage the county to pursue any and all of these opportunities to the extent that they can be incorporated into the agency's vision and longer term plans. This should be helpful in the future.

Washtenaw County Community Mental Health Services Review

Current Financial Status

WCCMH was projecting an approximate $9 million financial deficit for the current fiscal year. The transition from WCHO to WCCMH has created some difficulty in completely understanding the deficit. Until January 1, 2014 the WCHO served as the PIHP for the region. It is clear that Medicaid funds were managed differently, and the transition from WCHO to a separate PIHP administrative body does result

in some loss of revenue to the county. However, the PIHP responsibilities and funding distribution methodology have not changed sufficiently to fully explain the deficit.

From the information gathered by HMA, the budget deficit appears to be the result of a number of factors that include the move by the State of Michigan to equalize funding among PIHPs and counties, the shift from Washtenaw led administration to the CMHPSM, and the adjustments that came with the implementation of Healthy Michigan and reductions in general fund allocations that go directly to the counties. While there have been actions taken by WCCMH to address its financial situation, a substantial deficit remains.

FQHC and Other Contractual Arrangements

HMA reviewed WCCMH's contractual relationships with both hospitals and FQHCs. The hospital contracts are on a per diem basis and the rates are in line with those paid by other public entities. The FQHC contractual relationship is reported as evolving since the Packard Clinic just received FQHC status. Currently, WCCMH is paid a rate based on its direct costs only. While HMA does not have intimate knowledge of the relationship or its history, we would recommend that both parties move toward a contractual relationship that reimburses WCCMH its fully loaded costs including some fair treatment of indirect costs.

Current Delivery System's Cost Effectiveness

HMA assessed the cost effectiveness of the Washtenaw County CMH through interviews with PIHP and various Washtenaw County officials as well as reviewing data from the PIHP and the county. We began at the PIHP level because there is more standardized reporting available and this PIHP region is heavily influenced by Washtenaw County results, since it makes up almost half of the region. It follows that it is very likely that Washtenaw County will have data within norms if the PIHP's results are within norms.

The State of Michigan provides service specific cost reporting to compare the different PIHPs. The main report is the Medicaid Unit Net Cost (MUNC) Report Summary by PIHP. (The most recent data is from 2014 and that is the data used for this analysis.) This report indicates that CMHPSM service costs in several areas appear higher on average than those of other PIHPs. The Region has cost outliers, defined as more than two standard deviations above the mean or average cost per unit, in 14 of 212 services listed on the 2014 Medicaid Unit Net Cost (MUNC) Report. While some Community Living Support costs also were outliers, most notably, the CMHPSM is an outlier on Skill-Building and Out of Home Non Vocational Habilitation and Supported Employment Services (Service Codes H2014 and H2023). Costs per unit for these services were $7.11 and $11.98 respectively. This compares to state average of $x.xx and $x.xx. (Values to be inserted in the final report.)

Skill-Building and Out of Home Non Vocational Habilitation and Supported Employment Services are the primary services/service codes provided by the WCCMH Vocational Services program. The county specific reporting for Washtenaw County for these services is available in the 2014 Michigan Department of Community Health Section 404 Report (for Persons with Developmental Disabilities). This report shows that Washtenaw County costs per unit are $11 and $14 respectively, well over the regional averages, which are already outliers compared to state norms. Drilling down further, analysis of WCCMH

direct costs for delivering H2014 and H2023 services show average costs per unit of $19.74 and $24.65 respectively. The cost of service for directly provided vs. contracted services in WCCMH shows a similar number of beneficiaries served with direct staff versus contractual providers so there is not a problem with a small number in making the comparison. While there are differences in the need and acuity of the populations served contractually versus directly provided as we will observe later, the extreme cost differences do point to this area as problematic from a cost standpoint. This was reinforced in many of our interviews.

In our efforts to better understand this cost differential, we assessed the financial implications of WCCMH being a county department. Multiple interviews pointed to this relationship as significantly impacting costs. Factors to consider included the County Cost Allocation Plan, employee fringe rates (60 percent) and employee pay increases. While these factors, especially fringe benefits, do contribute to higher costs for directly employed workers, we were unable to detect or identify any cost escalator that would account for the large spread in unit cost for the vocational program services. Further evidence that this isn't the overriding reason for higher costs is that Washtenaw's service costs for the vast majority of other services are within norms. Having reached this conclusion with reasonable confidence, it would be useful for the WCCMH to have a more precise calculation of the cost impact of the county relationship and for the county to be able to accurately quantify the impact of WCCMH moving to fewer county employees and possibly become an authority. Both of these endeavors were beyond the scope of HMA's engagement.

WCCMH Executive Leadership reported to HMA that they have reviewed all contractually provided services, as part of cost containment exercises overall, and moved services in house to be performed by county employees where this would result in fiscal savings or added value. While we were not able to review most outsourced services to form an opinion about all that might be candidates for such action, we were provided with examples by the leadership. The services insourced include child psychology and staff and provider training. WCCMH has maintained the contract for Department of Health and Human Services eligibility support, in part to ensure appropriate enrollment of beneficiaries, and we do encourage the continuance of that contract (which is 50 percent federally funded).

When considering actions that affect services, it is important to examine the costs of administration. Our review did not show Washtenaw County to be an outlier. Our interviews at the PIHP level conveyed the opinion that Washtenaw's administrative costs were in line for an agency of its size. Given the very recent actions to dissolve the WCHO and convert full administrative responsibility to the county, we would suggest that there be follow up and subsequent review of administrative costs once the transition has been fully executed.

Contracting for Vocational Services - Value and Risk Considerations

WCCMH conservatively anticipates savings for contracting out vocational services to be $ 1.6 million in the current year and $ 2.5 million for the full '16-17 fiscal year implementation, factoring in transition costs and supports. WCCMH has issued an RFP for vocational services and actively engaged the contractual provider network, encouraging those providers with a positive track record to respond. Concerns have been raised and it is acknowledged by WCCMH executive staff that the directly run Vocational Services Program serves many individuals who may have greater needs than those typically served by contractual service providers. This includes former residents at the Mount Pleasant Regional

Center, individuals needing personal care, tube feeding, medical support, toiletting assistance, persons with mobility challenges and persons actively working through their recovery. This includes individuals with substance use disorders, impulse and anger control issues and other factors that would typically cause them to be seen as unemployable, but who are supported via enclaves by the WCCMH program. Contractual community providers may not presently have capacity to provide supports such as lifts to support individual with the greatest severity of needs. Residents who have acquired skills via the directly run program have been referred to community providers in the past and referred back due to the severity of needs and the contractual provider being unable to support.

The WCCMH direct program is also notable for the continuity and experience of staff involved, helping support the comfort and routine for beneficiaries. Many staff have been with the organization for 20 or even 30 years. The program also provides a very high degree of community integration, possibly more so than current contractual providers, with multiple service/access points distributed throughout the county and the ability to serve residents regardless of where they reside in the county. While no formal assessment or comparison of severity of needs exists, WCCMH leadership has budgeted for additional support to help manage this transition and the potential for differential rates to support severity of beneficiary need. They are also considering some additional transitional staffing to ensure safety and quality of services through this transiton.

HMA does not have access to any comparative quality reports regarding directly provided vs. contractually provided services, but the severity of need, ability to meet this need, and transitional supports are all areas that should be carefully considered, planned for, and monitored. A transition workgroup has been meeting regularly and WCCMH program staff have discussed an interest in possibly setting up a separate private business to ensure continuity of care.

Recommendations

HMA Impressions

HMA has been impressed with the quality of both management and labor staff and their relationship as we have worked through this engagement. These organizations are facing a very difficult and challenging situation with options that have a very real and personal impact on the persons they serve, staff and beneficiaries alike. Both management and labor have provided important information and perspectives and asked pertinent questions. It is important to consider the various potential consequences not just to WCCMH but to other county and public functions as well.

The budget deficit facing Washtenaw County and its Community Mental Health Services Program is real. While there are multiple factors in play, the bottom line is that revenues from the State of Michigan and the PIHP have declined over the past few years. Funding from the State of Michigan comes from a policy and political environment that is difficult to impact from the county level. HMA can only comment that the policy trajectory toward funding equity is longstanding and one that has been accelerated by federal health policy and regulation. In regard to the PIHP and its funding distribution method to each county, HMA did not detect any systemic disadvantage or bias against Washtenaw County.

With increasing costs and service commitments from better financial times, it is understandable how a deficit could occur. HMA brought a fresh set of eyes to the situation along with knowledge of federal and state funding methods, and rules and regulations. We were not able to identify any additional

source of revenue, funding methodology flaw, or cost reduction potential that could provide the amount of short term relief needed to resolve the deficit.

Recommendations

HMA does not see an alternative to the county direction for contracting out all or part of its Vocational Services Program. There have been very legitimate concerns raised about this change and its impact on quality and effectiveness of these services. To that end, HMA recommends that WCCMH initiate or revisit assessment of beneficiary needs and person centered planning for the individuals currently served by the directly run Vocational Services Program to ensure that individual risk is managed and needs are met. Risk for service transitions can only be assessed on an individualized basis and this should be used to inform WCCMH decisions on whether to transfer this program to contractual providers and, if so, how this will be supported and monitored. If the transition support workgroup has not already done so, we recommend this also be an area for a focused plan for performance monitoring.

The Community Living Supports program area is another with cost metrics that bear scrutiny. WCCMH leadership has indicated to HMA that they already have made changes that will reduce costs in this area and that they will continue to evaluate and explore options for improved cost effectiveness while maintaining quality. We encourage these continuing efforts.

Finally, HMA encourages WCCMH and the County to pursue partnerships and initiatives that integrate behavioral health with physical health and long term care services. As observed in the body of this report, Health Homes and Certified Community Behavioral Health Clinics are initiatives with potential for increased effectiveness and new streams of revenue. Existing community partnerships with the Packard Clinic and the area hospitals should be further strengthened. From an outsider's perspective, Washtenaw County has a strong foundation of public services and community partnerships. That should provide a path forward as this very real immediate term problem is addressed.

Appendix A: CMHPSM Budgeting Process

Funding of CMH is based upon an approved budget, distributed on a 1/12 monthly basis. Member funding is not based directly on Medicaid eligibiles on a month to month basis. The PIHP approves member budgets as developed by each county and the PIHP. Budgets for the PIHP and each county are developed in June – July and recommended for approval by their respective boards in September. Once a budget is determined with each of the counties, the funds are paid monthly at 1/12 of the annual budget. This budget remains in place regardless of changes in revenue paid to the PIHP during the fiscal year. The CMHPSM Chief Financial Officer (CFO) reviews monthly CMHB financial reports (as presented to the local Boards) and auxillary detail as needed. Monthly, the CMHPSM reviews Traditional Medicaid and Healthy Michigan Plan Medicaid funding paid to the CMHBs versus their actual use of the funds. Excess Medicaid is only recouped by the CMHPSM in the event that it needs to be reallocated to another CMHB (prior to the end of fiscal year cost settlement). All such adjustments to the Medicaid distributions are discussed at the Regional Finance committee and agreed to by Executive Directors prior to making a recommendation to the Regional Board. Relevant sections from the CMHPSM Policy for Financial Stability and Risk Reserve Management read as follows:

- "Regional Board approval of the CMHPSM budget is required prior to funding being made available to the CMHSPs.
- Budgets at the CMHSPs will not exceed the agreed upon revenue projections.
- If significant changes such as new service provision modalities, administrative operations, labor agreements, etc. are anticipated in the upcoming budget year, explanations will be provided to the CMHPSM.
- The CMHPSM must develop an Administrative budget sufficient to remain compliant with the Medicaid Specialty Services Contract with the State.
- The total CMHPSM budget, including the Administration budget, must be balanced with the revenues being projected to be received from the Michigan Department of Health and Human Services (MDHHS).
- Budget adherence will be one of the Member Contract performance measures that is reviewed with the Regional Board on a Quarterly basis."

Regarding budget variances the policy states:

"If the monthly FYTD financial report indicates that significant underspending or overspending is occurring at a CMHSP, then that CMHSP will be required to present to the Board an explanation and plan to correct the situation within the present fiscal year. A significant amount of underspending or overspending shall be defined as either 4 percent or $1 million over or under the approved FYTD budget, whichever is lower.

- If during the subsequent month's FYTD financial review the situation has not been corrected or an explanation does not exist as to when the issue will be corrected, then the PIHP may conduct an operational review of the CMHSP.

- An operational review may include examinations of the contracts, costs, level of Consumer service provision, and other items as deemed necessary to understand the overspending or underspending situation.
- An initial consultative review lead by the CMHPSM will be conducted by individuals from the CMHPSM, as well as all CMHSPs, who are recognized as subject matter experts in the areas that will be reviewed.
- If the initial consultative review assessment indicates that the issues are structural and not able to be resolved within the current year, then outside experts may be brought in to provide assistance with the development of a corrective action plan that will resolve the budget issue.
- Recommendations to address a shortfall at one of the CMHSPs may include the use of excess funding at one of the other CMHSPs, as long as the use of such funds does not adversely impact the delivery of services at the contributing CMHSP.
- Recommendations may include the use of the Internal Service Fund (ISF) in the present year, which would require a plan for the following fiscal year that would not require the use of ISF.

- Corrective Action Plans may include the consideration of alternative sourcing options for service provision.
- Expenses related to an operational review will be reviewed with and approved by the Regional Board."

Regarding the use of the internal services fund (ISF) fund the CMHPSM policy states:

The ISF should be the option of last resort to address present fiscal year budget overruns.

- If there is no alternative means to address a present year budget overrun, then the CMHPSM will request approval from the Board to notify the State of Michigan that ISF will be required by a CMHSP within the Region.
- As noted under Significant Variance to Budget above, Corrective Action Plans and/or alternative sourcing options will be required to eliminate the overrun situation as quickly as possible.
- Generally, use of the ISF should only be requested if there are significant revenue changes by the State, new high-cost Consumers enrolled by a CMHSP or changes to the State's requirement on how services are to be provided to Consumers."

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

NICK LYON
DIRECTOR

October 22, 2015

TO: PIHP Executive Directors

FROM: TR Thomas Renwick, Director, Bureau of Community Based Services

SUBJECT: Inappropriate Use of Assessments and Screening Tools

Over the past few months I have had discussions with and/or sent correspondence to several PIHPs in response to situations where PIHPs and/or their provider networks had implemented a practice of using assessments or screening tools to determine, limit or restrict the amount, scope, or duration of a service. Unfortunately, the Behavioral Health and Developmental Disabilities Administration (BHDDA) continues to receive e-mails, letters and telephone calls from individuals, family members and advocates informing us that this practice is still occurring in places across the state.

The information provided to BHDDA shared that assessments and screening tools are being utilized in the following inappropriate and unallowable ways:

- As an arbitrary methodology for determining the amount, scope, and duration of community living supports and skill building services implemented outside of a person-centered planning process.
- As a means for achieving budget reductions.
- As a process which supplants use of medical necessity criteria for evaluating the need for community living supports, skill building, and other supports and services.

Please be advised that any assessment or screening tool, including those required by the Department, cannot be utilized by the PIHP as an arbitrary means for identifying the amount, scope or duration of services that an individual will receive. While such assessments can certainly help inform the person-centered planning process, it is the person-centered planning process and medical necessity criteria that determine the amount, scope and duration of services. With regards to determining medical necessity, I am not aware that any of the assessments or tools in use or proposed for use have any normed or research supported basis for determining an individual's medical necessity for services and supports. It also bears reminding that the PIHP is obligated to ensure that medically necessary supports, services or treatment are sufficient in amount, scope and duration to reasonably achieve their purpose.

Individuals have also informed BHDDA of instances where they were not provided information on available dispute resolution and Medicaid Fair Hearing rights when they disagreed with the amount, scope, or duration of services and supports identified in their plan of service. Some of these instances sprung from the inappropriate use of assessments to limit the amount, scope or duration of services. PIHPs must assure that individuals are provided proper notice of their rights if they are not satisfied with the outcome of their person-centered planning process.

Name of Employer Derek Waskul

Date created 5/18/2015

CLS hours/week 32.5 x 4 to get units = 130 x rate ($3.47)= $ 451.10 x 52 weeks = $ 23,457.20 equals CLS hours per year 1690

Total of Respite units for the year 1000 x rate ($3.50) $ 3,500.00 Respite Hours per year = 250

Beginning Budget amount	$ 26,957.20
Minus 12.5% taxes	$ 3,369.65
Minus Worker's Comp rate	$ 905.00
Minus estimated training cost	$ 270.00
Minus unbillable expenses	$ 1,200.00
Transportation	$ 2,100.00
Activities	$ 720.00
Rec pass	$ 280.00
Total left after Expenses	$ 18,672.55

1 # of PT emp @ $130.00 WC Constant fee of $ 250.00 Total WC insurance Fee $ 130.00 1 # of FT emp @ $525.00 $ 250.00 $ 525.00 $ 905.00

Estimate 15 hours of training per employee 2 at $9.00/hr $ 270.00

Duplicate billing at $100/month

175 /month transportation

60 /month Activity

FT WC- $525.00
PT WC 130.00
WC INS 250.00
905.00

ed by 52 weeks then divided by number of CLS and Respite hou $ 9.63 This is the max rate for employee wage.

1,250 annual
130.
525
705

PT

less

C. Waskul's or

Washtenaw Community Health Organization
Notice and Hearing Rights

(2)

Notice and Hearing Rights

Notice and Hearing Rights
With the Department of Community Health Administrative Tribunal
for a MEDICAID beneficiary

Attention: DEREK WASKUL

Case #: 0000013431 Date: 07/20/2015

Mail to: CINDY WASKUL
[redacted]

☐ ADEQUATE (at the time of action)
- ☐ Denial of public mental health/substance abuse services for an applicant
- ☐ Denial of service to a current consumer (something currently not receiving)
- ☐ Individualized Plan of Service/Periodic Review/Progress Review

☑ ADVANCE (12 days prior to action)
- ☑ Reduction of services
- ☐ Suspension of services
- ☐ Termination of services
- ☐ Delay of services
- ☐ Non Payment

ACTION EFFECTIVE ON: 08/05/2015

Legal Basis for the above decision is 42 CFR 440.230

Specifically, the action taken is described below:

Your services were Reduced as follows for the following reason(s):
During the person centered planning process on 6/12/15, a discussion of the rate was held and the CMH provider offered a rate 13.86. The family declined this rate. After fully reviewing the family's concerns, a conversation was held including the clinical team and utilization management to negotiate the hourly rate to $14.48 which is an established maximum rate for the Children's Waiver through the State. The family has declined this rate. At this time we are offering and implementing a rate of $14.48. This rate is all inclusive, with an additional $100 a month for FI services.

This notice, envelope and Request for Hearing form were given to CINDY WASKUL on 07/20/2015 and the notice was copied for the case record by ___ (initials).

If you do not agree with this action, you may:

Not true -
Received in mail
7-27-15

WCHO
washtenaw community health organization

ADMINISTRATION

555 Towner
Ypsilanti, MI 48197

Phone (734) 544-3050
Fax (734) 544-6732

Sally Amos O'Neal
Interim Executive Director

September 2, 2015

Ms. Waskul
[redacted]

RE: Local Appeal Meeting Report

Dear Ms. Waskul
Attached is the report of findings for the Local Dispute Resolution Committee meeting that was conducted on August 24, 2015 in response to your request to appeal Community Support and Treatment Services decision to appeal the denial of returning the Self Determination budget for your son, Derek to the pre May 15, 2015 rate.

The report includes the factors that were discussed during the meeting regarding your appeal, the decision that has been made by WCHO Local Dispute Resolution Committee, and any additional/further rights you have if you are not satisfied with the committee's decision.

The committee has decided to uphold the CSTS decision to continue the CLS rate at $14.48/hour.
Since there is a State Level Hearing scheduled, the budget will remain at the pre May 15, 2015 budget until there is a decision by the Administrative law Judge.

If you have questions about this report or need more information, feel free to contact me (Janet Barbour) or the Office of Recipient Rights at (734) 544-3000.
Sincerely,

Janet Barbour
Local Dispute Resolution Facilitator
Customer Service

Washtenaw Community Health Organization

LOCAL DISPUTE RESOLUTION COMMITTEE

REPORT ON FINDINGS

Date of Meeting: August 24, 2015 Consumer: Derek Waskul # 13431

Chosen Attendees: Cindy Waskul, mother/guardian; Derek Waskul, consumer; Nick Gable, attorney; Christina Pulcifer, caregiver

Committee Members Present: John Shovels, Program Administrator Adult Services; Lisa Gentz Program Administrator Access; Brandie Hagaman, Program Administrator Health Innovations

OTHER: Kelly Bellus, CSTS Utilization Review; Katherine Snay, WCHO Fair Hearings Officer; Janet Barbour, WCHO Local Dispute Resolution Coordinator

I. *Nature of Dispute*

Ms. Waskul is appealing the Self- Determination Community Living Supports (CLS) all-inclusive PIHP rate of $13.88/hour.

On July 20, 2015, WCHO/CSTS attempted to negotiate a CLS rate up to an all-inclusive hourly rate of $14.48, but Ms. Waskul chose not to accept that rate.

A. Appellant's View

Mr. Gable stated that the change in budget went against waiver policy and that it is impossible for caretakers to live on the new rate of pay. Mr. Waskul has a medical necessity for the increased rate.

Mr. Gable submitted the following documents:

- Letter from Jeffrey L. Wieferich, MDHHS dated June 4, 2015
- Letter from Dr. Maria Heck dated May 18, 2015
- CFR, Title 42, Chapter IV
- Social Security State Plan for Medical Assistance Section 1902
- Habilitation Waiver application

B. CSTS' View

On 4/9/2015, the WCHO sent a letter to the beneficiary regarding a rate alignment for Self-Determination CLS rates to be consistent with the PIHP that went into effect on 5/15/2015. The hourly rate was changed to $13.88 and included worker's compensation, transportation, community participation, taxes and training. After consultation with the Michigan Department of Health and Human Services, it was determined that the WCHO failed to comply with the Habilitation Waiver application by

not using the person centered planning process when negotiating the Self-Determination budget.
In order to remedy this, the WCHO reinstated the beneficiary's Self-Determination budget and previous CLS rate. In addition, the WCHO and the beneficiary/guardian met regarding the hourly all-inclusive rate of $13.88 and it was declined by the guardian. Through the Person Centered Planning process, an attempt was made to negotiate up to the all-inclusive hourly rate of $14.48. This rate was also declined by the guardian.
Services authorized are appropriate based on medical necessity criteria.
Thus, to be good stewards of Medicaid dollars, CSTS did not approve an increase above the hourly all-inclusive rate of $14.48.

II. *Other Circumstances Related to the Dispute*
A Medicaid Fair Hearing has been scheduled

III. *Relevant Legal Issues, Requirements, Policies, Guidelines, etc.*
- WCHO Consumer Appeal Policy
- Medicaid Provider Manual
- MDHHS Self Determination Implementation Technical Advisory
- MDHHS Self Determination Policy and Practice Guidelines
- Consultation with the State of Michigan and CMS
- MDHHS Frequently Asked Questions on self-determination choice voucher

IV. *Status at End of Meeting*
Voting members of the committee agreed to review the documentation provided before making a decision about the rate change.

V. *Committee Findings:*
The Local Dispute Resolution Committee upheld the CMH decision to continue at the CLS rate of $14.48/hour.
Since there is a State Level Hearing, the budget will remain at the pre-May 15, 2015 budget until there is a decision by the Administrative Law Judge.

VI. *Further Appeal Options*
The next option for appeal is a State Level Hearing.
This hearing has been scheduled.

IHA

October 12, 2015

Derek Waskul
[redacted]

DOB: [redacted]

To Whom It May Concern,

I am writing this letter as a follow up to my letter dated May 13, 2015. In view of the upcoming October 14th Medicaid fair hearing, I would like to reiterate Derek's medical necessity for continuing his services as they are. A lowering of Derek's self determination budget amount would be devastating to Derek.

As a young man with severe cognitive impairment and autism, Derek needs stability, consistency and dependability. With the proposed changes, which would lower the staff wage, Derek will lose his current staff whom he has developed relationships with. Derek's current staff have facilitated and helped Derek to develop meaningful relationships in the community. Social interaction with others is a very important piece in the purpose of the self-determination arrangement.

The self-determination arrangement has been working well for Derek, because he can choose what he wants to do and he can choose his staff. With a wage at such a low rate, He will not have that choice. The quality of his services will be lowered or possibly completely lost without staff.

Without constancy, Derek will inevitably have increased anxiety, increased behavior problems, and increased autism symptoms. Autism is a disorder that requires a need for sameness.

As his doctor, I ask that you consider Derek's specific medical needs when making this decision.

Sincerely,

Maria Heck DO

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 30763, Lansing, MI 48909
(517) 335-2484; Fax (517) 373-4147

IN THE MATTER OF:

Waskul, Derek,

Appellant

_____/

Docket No. 15-013180 CMH
Case No. 17428443

ORDER OF DISMISSAL

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, and upon a request for a hearing filed on Appellant's behalf.

After due notice, an in-person hearing was held on October 14, 2015. Nick Gable, an attorney with Legal Services of South Central Michigan, represented Appellant. Cindy Waskul, Appellant's mother and legal guardian; Christina Pulcifer, one of Appellant's caregivers; and Wanda Ide, another one of Appellant's caregivers; testified as witnesses for Appellant. Appellant; Kathy Homan from the Washtenaw Association for Community Advocacy; and attorney Lisa Ruby; were also present for Appellant. Katie Snay, Fair Hearings Officer, appeared on behalf of the Respondent Washtenaw Community Health Organization, (WCHO). Shane Ray, the former Deputy Director at WCHO, and Kristina Diephuis, Program Administrator for Developmental Disability Services, testified as witnesses for Respondent.

At the onset of the hearing, Appellant submitted ten exhibits that were admitted into the record (Exhibit 1-10).[1] Respondent also submitted twelve exhibits that were admitted into the record (Exhibits A-L).

During the hearing, Respondent moved for dismissal on the basis that there had been no negative action taken with respect to any of Appellant's Medicaid covered services and that, consequently, the undersigned Administrative Law Judge lacks jurisdiction in this case.

The undersigned Administrative Law Judge took Respondent's motion under advisement at the hearing and, upon further review, now finds that he lacks jurisdiction in this matter and that it must therefore be dismissed.

[1] In Appellant's brief, Appellant's exhibits were identified by letters. However, during the hearing, the undersigned Administrative Law Judge switched to identifying them by numbers in order to avoid confusion with Respondent's exhibits.

Waskul, Derek
Docket No. 15-013180 CMH
Order of Dismissal

The Code of Federal Regulations (CFR) affords a Medicaid beneficiary a right to a fair hearing when the PIHP or its designee, in this case WCHO, takes an action that is a denial, reduction, suspension, or termination of a requested or previously authorized Medicaid covered service. *See* 42 CFR 438.400.

Here, WCHO has taken no action that is a denial, reduction, suspension, or termination of a requested or previously authorized Medicaid covered service as Appellant's approved services have not changed. Respondent did decide to reduce the reimbursement rate it will allow for Community Living Supports (CLS) services for self-determination participants, but Appellant is still authorized to receive the same amount of CLS services he was previously authorized for. Specifically, Diephuis testified regarding how the amount, *i.e.* the number of CLS hours approved; the scope, *i.e.* what the CLS services encompass; and the duration, *i.e.* how long the current authorization is approved for; remain unchanged. Ray also testified regarding the provisions of the Michigan Department of Health and Human Services (DHHS) Self-Determination Implementation Technical Advisory and the MDHHS Self-Determination Policy & Practice Guidelines that provide the authority for Respondent to set the range of applicable rates and the maximum amounts that a person may spend to pay providers of specific services and supports. (Exhibit G, page 2; Exhibit H, page 9).

In response, Appellant argues that the negative action giving rise to the right to a Medicaid Fair Hearing is the reduction in Appellant's self-determination budget. According to Appellant, due to its financial concerns, Respondent improperly began with the reduced individual budget for Appellant and worked it way backwards to the Individual Plan of Service (IPOS), rather than developing the IPOS based on medical need before any budget concerns are addressed, as undisputedly required by policy. However, that argument is clearly a mischaracterization of what occurred as, whether or not it constitutes a negative action giving rise to the right to a fair hearing, the decision made in this case was clear and it was not a decision to reduce Appellant's individual budget. Instead, Respondent decided to uniformly set the reimbursement rate for CLS for all self-determination participants. That decision did lead to a reduction of Appellant's individual budget in this case, but Appellant cannot demonstrate that it led to any reduction in his services as his IPOS and services have remained the same. Complaints regarding the use of the arrangements that support self-determination do not give rise to a right to a Medicaid Fair Hearing.

While not a reduction in services, the general decision regarding the reimbursement rate, and the consequential reduction in the individual budget in this case, may have an effect on Appellant. As they previously wrote in letters (Exhibit 6, pages 1-2) and testified to during the hearing itself, at least two of Appellant's caregivers assert that they cannot afford to continue working with Appellant if the rate is reduced. Appellant also provided letters from his doctor stating that stability in Appellant's staff is crucial for Appellant's well-being (Exhibit 7, page 1; Exhibit 10, page 1). However, the rate that a particular agency, is able to pay for services is a matter determined at the local level

and, even it results in a possible reduction in pay for the care providers or a need to hire different workers, a change in the rate does not amount to a reduction in services when the amount of approved services remains the same and any effect it may have on staff does not confer jurisdiction.

Appellant further argues that the decision to reduce the reimbursement rate was based solely on budgetary concerns arising from WCHO's budget deficit, rather than medical necessity, and that it therefore violated the provisions of the Social Security Act and its implemented regulations providing that the State Plan for Medicaid must provide that state and federal funds will be appropriated on a basis that assures that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. *See* 42 USC 1396a(2); 42 CFR 433.53(c)(2). However, it is not clear that the general requirements for the State Plan and its allocation of funds has any bearing in this individual case or could confer a right to hearing. Moreover, whatever the reason for Respondent's across-the-board decision on rates, Appellant's services remain unchanged and the specific requirements of 42 CFR 438.400 are unmet.

Appellant's also argues that WCHO deprived Appellant of his rights to self-determination and to control his budget when it decided to impose an arbitrary, reduced rate over Appellant's objections and complaints. In particular, Appellant asserts that this decision to is no different form Respondent's first attempt to reduce the reimbursement rate, which was reversed after the DHHS wrote WCHO on June 4, 2015 to state that WCHO's decision to reduce CLS rate for all self-determination and choice voucher arrangements did not "conform to the approved Budget Authority Process in the Habilitation Supports Waiver (HSW) application" (Exhibit 8, page 1) and to direct it to reverse its decision, with a retroactive effect. In that letter, the Department also cited HSW application provisions providing that the individual budget and IPOS are developed in conjunction with each other through the person-centered planning process; that both the participant and the PIHP must agree to the amounts in the individual budget before it is authorized; and that the PIHP or its designee must provider the participant with information on how to request a Medicaid Fair Hearing when the participant's Medicaid-funded services are changed, reduced or terminated as a result of a reduction in the individual budget or denial of budget adjustment (Exhibit 8, pages 1-2).

Person-centered planning is the central element of self-determination and the individual budget should be determined through that process. However, regardless of whether Respondent properly engaged in person-centered planning, the end result in this case was that Appellant's Medicaid covered services did not change and there has simply been no change, denial, reduction, suspension or termination of a requested or previously authorized Medicaid covered service that would give rise to the right to a Medicaid Fair Hearing here. Appellant's IPOS and approved services remain the same and the undersigned Administrative Law cannot address his general complaints about that unchanged plan and services. To the extent Appellant believes that his rights have

been violated, he is free to file a grievance with the Respondent or a complaint with the local Recipient Rights office. As indicated above, the Department has previously directed WCHO to reverse its decision regarding CLS reimbursement rate for all self-determination arrangements and it may choose to do so again. Appellant's brief also states that the Centers for Medicare and Medicaid Services is currently investigating Washtenaw County's mental health budget deficit and meeting with the State to discuss compliance, and that this general issue is far from decided.

Whatever relief may develop through those other avenues, there has been no negative action in this case that would give rise to the right to a Medicaid Fair Hearing here and the undersigned Administrative Law Judge lacks jurisdiction. Accordingly, the matter must be dismissed.

IT IS THEREFORE ORDERED that:

This above-titled matter is DISMISSED.

Steven Kibit

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

Date Signed: October 23, 2015

Date Mailed: October 23, 2015

SK/db

cc: Derek Waskul
C/O Cindy Waskul
Nick Gable
Katie Snay
Jeff Wieferich

** NOTICE **
The Appellant may request a rehearing or reconsideration, or appeal the Dismissal Order to Circuit Court within 30 days of the receipt of the Order

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 30763, Lansing, MI 48909
(517) 373-0722; Fax (517) 373-4147

IN THE MATTER OF:

Waskul, Derek,

Appellant

/

MAHS Docket No. 15-013180 CMH
Agency Case No. 17428443

ORDER VACATING DISMISSAL

On October 23, 2015, an Order was issued in this matter dismissing the case for a lack of jurisdiction. However, upon further review, it has been determined that the Order of Dismissal was issued in error as the Michigan Administrative Hearing System (MAHS) does have jurisdiction over the action at issue in this case, *i.e.* the reduction in the hourly rate paid to Appellant's Community Living Supports (CLS) providers pursuant to the self-determination agreement. *See* 1915(c) Home and Community-Based Services (HCBS) Habilitation Supports Waiver (HSW) amendment, MI.0167.R05.01 – Apr 01, 2014, Item 6-I, page 7 of 213 (requiring that the State provide the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals who are denied the services of their choice or the providers of their choice) and Appendix E-1 Overview, page 152 of 213 (providing that a participant has a right to "request a Medicaid Fair Hearing when the participant's Medicaid-funded services are changed, reduced or terminated as a result of a reduction in the individual budget"). *See also* 1915(c) HCBS HSW amendment, MI.0167.R05.01 - Apr 01, 2014, Appendix E-2 Opportunities for Participant-Direction, page 151 of 213 ("A change in the budget is not effective unless the participant and the PIHP have agreed to the changes.").

IT IS THEREFORE ORDERED that:

- The Dismissal Order issued on October 23, 2015 is VACATED
- A new notice of hearing will be sent out under separate cover.

Steven Kibit

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

Date Signed: November 25, 2015
Date Mailed: November 25, 2015