

BULLETIN

Michigan Medicaid Policy (MMP) | Health Services

Bulletin Number: MMP 25-31

Distribution: All Providers

Issued: August 29, 2025

Subject: Derek Waskul, et al. v. Washtenaw County Community Mental Health, et al. Settlement Agreement

Effective: October 1, 2025

Programs Affected: Medicaid, Habilitation Supports Waiver (HSW)

I. Introduction

This bulletin is being issued for settlement-related action items identified in Derek Waskul, et al. v. Washtenaw Community Mental Health, et al. to update policy in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter within the [Michigan Department of Health and Human Services \(MDHHS\) Medicaid Provider Manual](#), including changes specific to the HSW. The updates include:

- Clarification of medical necessity language.
- Specification that determination criteria must be tailored to the beneficiary.
- Clarification that clinical information includes assessments and input from the beneficiary.
- Specification of limitations on Prepaid Inpatient Health Plan (PIHP) decisions.
- Specification of PIHP role in self-directed (SD) arrangements, including requirements for budget reductions and managing denial process, including the role for PIHPs specific to HSW only.
- Clarification of Administrative Law Judge (ALJ) authority in SD service arrangements and choice voucher budget hearings.
- Definition of ALJ authority in SD service arrangements terminations.
- Definition of Community Living Supports (CLS) inclusions and exclusions, including costs for HSW.
- Definition of Fiscal Management Services (FMS) in more detail.
- Definition of specific person-centered planning (PCP) requirements related to SD service arrangements.

II. Medical Necessity Criteria

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services and must be specific to the beneficiary.

A. Determination Criteria

Determination criteria are updated to include the following:

The determination of a medically necessary support, service or treatment must be:

- Tailored to the beneficiary's unique goals and objectives, as documented in the individual plan of service;
- Based on clinical information (e.g., assessments conducted with input from the beneficiary and their support system) from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, made in and as part of the PCP process; and
- For beneficiaries with substance use disorders, made during individualized treatment planning.

The following criteria language was removed:

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

B. PIHP Decisions

PIHP decisions, specifically including utilization management, will not replace the PCP process. For example, utilization management review may not remove or change the beneficiary's goals. It may provide for less costly alternatives that accomplish the same goals.

Edits to the beneficiary's Individual Plan of Service (IPOS) require PCP process be reopened.

i. PIHP Decisions for SD Service Arrangements/ Choice Voucher and Associated Budgets

When the PIHP, or Community Mental Health Services Program (CMHSP) acting on the PIHP's behalf, denies or approves a limited authorization of a verbal or written request for inclusion of a service in the IPOS, or one or more specific aspects of the amount, scope, and duration of a service, the PIHP, or CMHSP acting on the PIHP's behalf, must ensure that:

- the item is listed in a separate section of the IPOS titled “Requests Not Approved;” and
- the PIHP, or CMHSP acting on the PIHP’s behalf, provides an adverse benefit determination that briefly but concretely sets forth its reasoning for not approving the request.

This applies regardless of whether the non-approval or limited approval takes place during the PCP process (e.g., before the planning meeting, after the planning meeting) or after its conclusion.

ii. PIHP Decisions for HSW SD Service Arrangements/Choice Voucher and Associated Budgets

The PIHP, or CMHSP acting on the PIHP’s behalf, must provide written notice to HSW beneficiaries with SD service arrangements that are at risk of termination which shall specify, in such detail as is reasonably practicable, the issues that have led to the risk of termination, and shall provide opportunities for meaningful problem solving that involve the beneficiary.

Collaborative and meaningful problem solving should occur in a timely manner and should begin no longer than 30 days following the notification.

If there is no resolution from problem-solving activities, then the PIHP, or CMHSP acting on the PIHP’s behalf, shall issue an Advance Action Notice with appeal rights consistent with those provided in 42 CFR § 438.400 et.

Prior to when a PIHP, or CMHSP acting on the PIHP’s behalf, reduces a beneficiary’s SD budget at an annual renewal or otherwise, the PIHP, or CMHSP acting on the PIHP’s behalf, must provide written justification to the beneficiary. The written justification must include specific justification for the reduction and why the PIHP, or CMHSP acting on the PIHP’s behalf, determined the beneficiary does not need the same amount, duration, and scope of services that the beneficiary was previously assessed to need. A reduction in the SD budget must be in response to an identifiable change in the beneficiary’s need.

For the avoidance of doubt:

- A budget reduction and terminations made during the term of an IPOS shall be treated as a “reduction, suspension, or termination” for purposes of internal appeal and Fair Hearing rules (including advance notice through an adverse benefit determination and continuation of benefits, when applicable), and
- A budget reduction or termination made at annual renewal (e.g., during the PCP process between the time of pre-planning and when the plan is signed) must be treated as a denial of requested service AND the beneficiary must be notified in writing 14 calendar days before the PCP meeting for annual renewal.

C. Administrative Law Judge (ALJ)

i. ALJ Authority in Termination of Self-Directed Service Arrangements and Choice Voucher Hearings

Beneficiaries in a SD service arrangement may challenge the termination of the SD service arrangement in a Medicaid Fair Hearing. The ALJ shall reverse, rather than remand, the PIHP's/CMHSP's termination decision and direct the continuation of the SD if the proof presented on the record does not establish good cause to terminate the SD service arrangement. In determining whether there was good cause to terminate the SD service arrangement, the ALJ may consider the following factors, as well as any other factor relevant to the particular case:

- **Health and Safety Implications:** Consider whether the termination is due to a significant health, safety, and/or legal issue that has, and will continue to, put the beneficiary's health and safety at risk.
- **Problem-Solving Opportunities:** Consider whether the required good faith efforts were made to meaningfully solve the issues leading to a decision to end the SD service arrangement.
- **Support Opportunities:** Consider if ongoing support and assistance was provided to the beneficiary to SD their services (e.g., staff management, active budget management, education, services and supports broker).
- **Training:** Consider if the beneficiary/employer of record was provided with adequate training on SD service arrangements and supports available.
- **Written Notice:** Consider if the beneficiary/employer of record was provided with the obligatory written notice that the arrangement was at risk of termination.

ii. ALJ Authority in HSW Self-Directed and Choice Voucher Budgets Hearings

HSW beneficiaries in SD arrangements may: (1) challenge the CLS and Overnight Health and Safety Supports (OHSS) portions of the SD budget, and (2) challenge the number of units of CLS or OHSS authorized, including challenging the allocation of units allocated between CLS and OHSS. In either case, the ALJ shall do the following:

- If the ALJ concludes: (1) that the proof presented on the record at the hearing establishes that the PIHP's/CMHSP's decision was inconsistent with medical necessity as set forth in the [MDHHS Medicaid Provider Manual](#), and (2) that such proof establishes that the specific budget level or authorization requested by the Petitioner is (a) medically necessary, (b) otherwise consistent with state and federal law and policy, and (c) necessary to implement the IPOS, the ALJ shall reverse the determination and direct entry of the specific budget level or number of authorized units of SD CLS or SD OHSS requested by the Petitioner.

- If the ALJ concludes: (1) that the proof presented on the record at the hearing establishes that the PIHP's/CMHSP's decision was inconsistent with medical necessity as set forth in the [MDHHS Medicaid Provider Manual](#), but (2) that such proof does not establish that the specific budget level or authorization requested by the Petitioner is (a) medically necessary, (b) otherwise consistent with state and federal law and policy, and (c) necessary to implement the IPOS, the ALJ shall reverse the determination and remand to the PIHP/CMHSP for reconsideration based on the ALJ's findings and order, specifying to the extent reasonably possible the parameters of such reconsideration.
- If the ALJ concludes that the proof presented on the record at the hearing does not establish that the PIHP's/CMHSP's decision was inconsistent with medical necessity as set forth in the [MDHHS Medicaid Provider Manual](#) or with state or federal law or policy, the ALJ shall uphold the determination.

III. Community Living Supports (CLS) (Habilitation Supports Waiver Only)

Any support may be covered as CLS if it is described in the Community Living Supports section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter (Habilitation Supports Waiver for Persons with Developmental Disabilities >> Community Living Supports (CLS) subsection) within the [MDHHS Medicaid Provider Manual](#) and is determined through the PCP process to "facilitate an individual's independence, productivity, and promote community inclusion and participation," for the particular beneficiary. Basic coverage criteria are defined in the Medical Necessity Criteria section of this policy.

CLS does not include:

- Costs associated with room and board
- Fiscal management services
- Purchase or rental of a vehicle
- In-home entertainment subscription

Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian. However, payments to a non-guardian parent of an adult, or to a spouse of a legal guardian, are permitted.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living (ADL), and/or shopping may be used to complement Home Help services when the beneficiary's needs for this assistance have been officially determined to exceed MDHHS allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, Medicaid State Plan

coverage of Personal Care in Specialized Residential Settings.

Costs that may be covered for CLS (and thus are reimbursed through the CLS rate) include, but are not limited to, the following: (1) if they are not already covered by another Medicaid service provided to the beneficiary, (2) if they are medically necessary for a particular CLS beneficiary, and (3) if they are related to the beneficiary's IPOS goals of facilitating independence and productivity or of promoting community inclusion and participation:

- CLS staff compensation (wages, benefits [such as health insurance and retirement contributions] payroll taxes, and Human Resource requirements which include required trainings, supervision and planning meetings) for time spent on any activities covered by CLS, including CLS staff time spent on delivering CLS services in the beneficiary's residence, required training, planning meetings, supervision, travel with the beneficiary, and attendance at community activities with the beneficiary.
- Transportation costs for the beneficiary and the CLS staff (i.e., mileage) to go to and from community activities (not to and from medical appointments).
- Fees and other charges for a community activity for a CLS beneficiary and for the CLS worker to accompany the beneficiary in the community activity, including, for example: gym fee, movie ticket, theme park admission, meal in the community, fee for bowling, fee for horseback riding.
- Membership fees for organizations that support the identified CLS objectives.
- If a particular activity, put in the IPOS through the PCP process, meets the definition of medical necessity and the definition of CLS, then it is part of the "scope" of the CLS service.

IV. Fiscal Management

"Fiscal intermediary services" are updated to "Fiscal Management Services" (FMS) and include the following addition:

FMS does not make a final determination on the amount, scope, or duration of services. No aspect of creating the budget is delegated to FMS personnel. The role of the FMS is to support the beneficiary. For example, the FMS supports the beneficiary to help ensure the budget created is implemented as planned.

V. **Person-Centered Planning (PCP)**

The PCP criteria are updated to include the following:

The PCP process must:

- Offer the beneficiary choice to a SD service arrangement (other than those previously terminated from SD service arrangements). The offer must include a discussion on how budgets are developed and can be flexibly used to implement services, a description of the three options used to implement SD service arrangements, participant responsibilities, the role of the supports broker, how to work with an FMS, and the allowable use of budget dollars to be spent on all components of medically necessary service.
- Include discussion with the beneficiary regarding all components of services (i.e., for HSW SD CLS, this includes components such as transportation, activities, staff wages, employer costs, training time) as well as the amount, scope, and duration of each such component that may be medically necessary for the beneficiary. Components of services are defined in relevant service sections of the [MDHHS Medicaid Provider Manual](#) and MDHHS-developed Healthcare Common Procedure Coding System (HCPCS) Code Charts.

Manual Maintenance

Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 800-292-2550. Atypical Providers may phone toll-free 800-979-4662.

An electronic copy of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Approved



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Health Services