



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

September 4, 2025

TO: Interested Parties

RE: Consultation Summary for Project Number 2527-BH - Derek Waskul, et al. v. Washtenaw County Community Mental Health, et al. Settlement Agreement

Thank you for your comment(s) to the Health Services Administration related to Project Number 2527-BH. Your comment(s) have been considered in the preparation of the final publication, a copy of which is attached for your information.

Responses to specific comments are addressed below.

Comment: How can you use Medicaid dollars that are assigned to one beneficiary to staff that assist that beneficiary?

Response: This is a clarification on both direct and indirect billable costs of this service.

Comment: What are the parameters for community fees?

Response: The Michigan Department of Health and Human Services (MDHHS) will consider this as it develops technical assistance.

Comment: There were concerns around the inconsistent use of "Financial Management Services" and "Fiscal Intermediary."

Response: "Fiscal Intermediary" language has been changed to "Fiscal Management Services (FMS)."

Comment: Can a standby guardian provide Community Living Supports (CLS)?

Response: Yes, if the standby guardian is not the legal guardian at the time the service is being provided.

Comment: There are concerns about the role of the Administrative Law Judge (ALJ) in determining medical necessity.

Response: ALJs will not determine medical necessity but will have the authority to review the proof presented on the record at the hearing and determine whether the Prepaid Inpatient Health Plan's (PIHP)/Community Mental Health Services Program's (CMHSP) decision was consistent with medical necessity as set forth in the [MDHHS Medicaid Provider Manual](#)

Comment: I applaud MDHHS for making the changes outlined.

Response: Thank you for your feedback.

Comment: How can the FMS be involved in budget development?

Response: The court order and subsequent policy adjustments require the FMS does not make the decision on amount, scope, and duration, including setting the budget or number of units the beneficiary may receive. This language does not preclude the FMS from participating in the implementation of a budget, only from deciding the budget amount or total units the beneficiary needs.

Comment: What is the scope of the policy changes in the Medical Necessity Criteria section?

Response: These policy changes do not change the scope of the Medical Necessity Criteria Section.

Comment: I recommend adding language to clarify the timeframe in which clinical information is collected for use in medical necessity determinations.

Response: Thank you for your feedback.

Comment: I recommend changing language to say, "The item is listed in a separate section of the Individual Plan of Service (IPOS) titled SERVICE Requests Not Approved."

Response: Thank you for your feedback.

Comment: How does MDHHS define "reduction"?

Response: For self-directed (SD) service arrangements, a budget reduction occurs when a beneficiary's budget decreases or is reduced.

Comment: Units and budgets are typically determined at the Person-Centered Planning (PCP) meeting, not prior.

Response: Thank you for your feedback.

Comment: In the language “Any support may be covered as CLS...”, the use of the word “any” gives impression of broad coverage.

Response: The support must still meet the definition in this section to be covered.

Comment: There are concerns with the language, “CLS does not include... FMS.” FMS is part of the SD budget as an administrative expense.

Response: No changes have been made to how FMS costs are budgeted.

Comment: There are concerns with the language “CLS may be provided in a licensed specialized residential setting...” as Specialized residential services (including H2016 CLS) are not permitted to be part of an SD arrangement.

Response: Thank you for your feedback. Refer to the [MDHHS Medicaid Provider Manual](#), Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter (Habilitation Supports Waiver for Persons with Developmental Disabilities >> Community Living Supports (CLS) subsection) for guidance.

Comment: I recommend defining community as 'individual's community'.

Response: Thank you for your feedback.

Comment: Determination cannot be made based on a single assessment. Other factors must be taken into consideration when determining medical necessity.

Response: Thank you for your feedback.

Comment: Regarding PIHP decisions, while we think this is good overall and appreciate the details included, we believe the safeguards should apply to everyone using the services.

Response: Thank you for your feedback.

Comment: We are concerned that PIHPs may require less costly alternatives that are not acceptable and are aware of instances where the less costly

alternatives were not appropriate for the individual. Please insert the word "similar" so the last sentence reads, "...less costly similar alternatives..."

Response: Thank you for your feedback.

Comment: How long after the denial of services should the beneficiary expect to receive the Adverse Benefit Determination (ABD)? A concrete timeline is needed.

Response: Thank you for your feedback. Please refer to the contractual requirements for ABD Notices.

Comment: We think this is good overall, and appreciate the detail included. We would also like this to apply to those directing their services who are not on a Habilitation Supports (HSW) waiver.

Response: Thank you for your feedback.

Comment: Regarding the ALJ Authority in Termination, we recommend changing the last two lines in the first paragraph to, "...the ALJ shall consider each of the following factors."

Response: Thank you for your feedback.

Comment: Please remove language that says, "so long as they are for work actually performed by the individual" as it is insulting and unnecessary.

Response: MDHHS has revised this language.

Comment: We appreciate the list of items to be covered in the CLS rate. We hope the items are considered when developing a sufficient rate at the state level.

Response: Thank you for your feedback.

Comment: Please add details on how to discuss SD arrangements during PCP.

Response: MDHHS has added clarifying language.

Comment: Please explain what an "allowable use of budget dollars to spend on all components of medically necessary service" means.

Response: MDHHS will consider this as it develops technical assistance.

Comment: This appears to be discriminatory towards individuals who make the choice to utilize a provider versus a SD arrangement. Will there be an updated Medicaid policy for individuals who receive services through a provider system?

Response: The proposed policy changes are driven by a federal court order.

Comment: There needs to be some definition of who is a health care professional with relevant qualifications. Does this now include the ALJ?

Response: ALJs will not determine medical necessity but will have the authority to review the proof presented on the record at the hearing and determine whether the PIHP/CMHSP decision was consistent with medical necessity as set forth in the [MDHHS Medicaid Provider Manual](#).

Comment: What is meant by reopening the PCP process? The PCP process is never closed unless the case is closed. This needs to be defined and clarified.

Response: Thank you for your feedback.

Comment: A budget is not a service, so this language is not clear. It seems there may be service reductions, but budget reductions are confusing language.

Response: The federal court order specifies how beneficiaries are protected against budget reductions just as they are against reductions in services.

Comment: If the IPOS establishes medical necessity, why would the CMHSP put something in the IPOS that is not medically necessary?

Response: MDHHS will consider this as it develops technical assistance.

Comment: Does “collaborative and meaningful problem-solving” involve the employer of record and guardian?

Response: MDHHS will consider this as it develops technical assistance.

Comment: There are concerns about the proper process of state promulgation.

Response: MDHHS believes it complies with all requirements of law.

Comment: There may be confusion about what is covered under CLS for non-HSW beneficiaries.

Response: MDHHS will consider this as it develops technical assistance.

Comment: There is concern about duplicative costs if FMS is not included in the CLS costs.

Response: Refer to the [MDHHS Medicaid Provider Manual](#), Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter (Habilitation Supports Waiver for Persons with Developmental Disabilities >> Fiscal Intermediary subsection) for guidance.

We trust that responses addressed the concerns and questions noted. If you wish to offer additional information, contact Dana Moore at moored61@michigan.gov.

Sincerely,

A handwritten signature in black ink that reads "Meghan E. Groen". The signature is fluid and cursive, with the first name "Meghan" and last name "Groen" clearly legible.

Meghan E. Groen, Chief Deputy Director
Health Services