UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

DEREK WASKUL, *et al*., Plaintiffs, v. WASHTENAW COUNTY COMMUNITY MENTAL HEALTH, *et al.*, Defendants.	No. 2:16-cv-10936-LVP-EAS Hon. Linda V. Parker Hon. Elizabeth A. Stafford

PLAINTIFFS' REPLY BRIEF IN SUPPORT OF APPROVAL OF THE SETTLEMENT

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GLOSSARY OF RECORD CITATION ABBREVIATIONS

Abbreviation	**Reference**
MPM	The Behavioral Health Chapter of the Michigan Medicaid Providers Manual. The BH Chapter is annexed as Exhibit 3. The full manual is available online at https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf
SDTRIG	The MDHHS Self-Determination Technical Requirement Implementation Guide, version 2.3 March 2024. Exhibit 8 and available online at https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder50/Folder7/Self-Direction_Technical_Guide.pdf?rev=81716785a9644ece89ac146b1a83f52b&hash=2C61CE8F316856761098ECB36236E5B0
HSW	The Habilitation Supports Waiver document currently in effect. Exhibit 1 and available at https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder2/Folder33/Folder1/Folder133/2010_HSW_Final_Renewal_Application-10-1-2010.pdf?rev=37d7ceafc44d4e83a7b49bbfc2f845ac&hash=C6A3496AADE4A54A9ADB835C0FC540B7. When used without a page, section, or appendix indication "HSW" refers to the program and not to the program document. ***Note***: The document annexed to Local Defendants' Johnson Declaration (ECF#336-2) is ***not*** the HSW but, as set forth in footnote 8, a different waiver altogether.
HSW2024	The currently pending renewal application for the HSW, Exhibit 2 and available at Medicaid Waivers (michigan.gov) (https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/medwaivers).

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INTRODUCTION

The decision to settle Medicaid litigation, and the terms on which to settle, is one of the most fundamental policy decisions a State can make. Under the Medicaid Act and the Sixth Circuit's controlling decision in *Grier*,[1] that decision is committed to—and only to—MDHHS, the "single state agency" created pursuant to 42 U.S.C. § 1396a(a)(5). The Local Defendants to the contrary notwithstanding, this Court's role in determining whether to approve the Settlement is *not* to rewrite the deal to which MDHHS agreed. Rather, it is to determine whether the State's policy judgments have produced a result that is "fair, reasonable, and adequate." The Settlement before the Court easily meets that test, and it should be approved.

Nowhere is the importance of this Court's limited role more evident than in WCCMH's argument heading "D":

> MDHHS should negotiate a resolution that protects the integrity of the Medicaid system and helps *all* Medicaid recipients requiring behavioral health services—not just self-determination recipients. (ECF#336 PageID10195; emphasis in original)

Really? This case was brought on behalf of *self-determination CLS recipients under the HSW*. The Local Defendants ask this Court to overturn a settlement of *this lawsuit*, on behalf of *these Plaintiffs*, because the Local Defendants and their declarants want a piece of the pie.

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[1] *Tennessee Ass'n of Health Maintenance Organizations Inc. v. Grier*, 262 F.3d 559, 565 (6th Cir. 2001).

The Settlement is plainly "fair, reasonable, and adequate" vis-à-vis *these Plaintiffs*, or vis-à-vis the other HSW self-determination recipients statewide. Plaintiffs obtained in settlement substantially all the relief they could have gotten at trial; Local Defendants do not suggest otherwise. Nor do they suggest (because they obviously could not) that this Settlement was the product of collusion or any other form of misconduct. It was negotiated by experienced counsel for parties that had been fighting one another for years, under the supervision of a distinguished mediator. Under any standards relating to the effect of the Settlement on the settling parties, the Settlement easily passes muster.

So the Local Defendants' opposition to the Settlement must take another tack. This is a consent decree, they say (and it surely is), so the Court has free rein to do as it pleases. The Settlement, Local Defendants say, violates the Medicaid Act, the Constitution, and every imaginable public policy. By choosing to fix the problems of the folks who sued, the State has supposedly committed all sorts of egregious wrongs against everyone else. None of that is true.

WCCMH's principal argument, made in various ways throughout its papers, is that by setting a minimum rate for HSW self-determination CLS arrangements, while leaving agency and non-HSW arrangements unchanged, the Settlement will have disastrous consequences for agency providers and, thus, supposedly disadvantages the poorer, Blacker individuals who use agency providers vis-à-vis the

richer, Whiter ones who use self-determination. This argument is the core of Sections C.1 and C.3 of WCCMH's brief and is likewise one of the bases of supposed illegality in Section C.2, with the Settlement there being said to violate Title VI of the Civil Rights Act of 1964.

We show below that Local Defendants' warnings of impending disaster are wildly overblown and that their disparate impact argument ignores the law in numerous respects and is simply wrong. Local Defendants impermissibly attempt to compare CLS SD recipients under the HSW with *all* CLS agency recipients, under *any* Medicaid program. When looked at, as it must be, by comparing SD and agency recipients *under the HSW*, the Settlement is in fact race-neutral.

But regardless of who is being compared to whom, it bears emphasis that ***the Settlement does not decrease the amount of money available to non-self-determination or non-HSW Medicaid recipients in any way, shape, or form.*** One will find this crucial fact *nowhere* in Local Defendants' papers. Not only must the State's actuary certify that the increase in capitation rates is "actuarially sound" to "account for the . . . Minimum Fee Schedules" but, crucially, the actuary must *also* certify that the HSW CLS "rate cell" is not cross-subsidized by any other rate cell. In other words, the amount of money available to pay for the Minimum Fee Schedule must be certified to stand on its own. There can be no "robbing Peter to pay Paul." Paul is

getting additional money, but the amount of money available for Peter is not being reduced by as much as a penny. This is all ***new money***.

Beyond that, this crucial, omitted fact demonstrates that Local Defendants' "Actuarial Soundness" and related claims of illegality are precisely backwards. They say the Settlement is illegal because MDHHS will not be able to certify "actuarial soundness" of the capitation rates capturing services furnished by agency providers. But the Settlement does nothing to lock in those rates. If MDHHS's world-renowned actuarial firm cannot certify actuarial soundness, then it will tell MDHHS that it must raise rates, and MDHHS will comply. Like Local Defendants' disparate impact argument, the actuarial soundness argument is an attempt to manufacture a claim where none exists.

For these and many other reasons, as we demonstrate in detail below, the Settlement of this action should be approved.[2]

[2] Citations to certain MDHHS documents, which have long names and even longer URLs, use abbreviations that are set forth in the Glossary at page v.

ARGUMENT

MDHHS's Decision to Settle *This* Lawsuit by Providing Financial Relief to SD Participants in the HSW Is Well Within Its Policy-Making Authority as the "Single State Agency" and Is Neither Illegal nor Against Public Policy

Local Defendants' disparate impact argument is everywhere. It is close to their entire case. Accordingly, we first establish that Local Defendants have not begun to make out a disparate impact claim under the Civil Rights Act of 1964, either legally or factually. With that foundation, we then show that none of their other arguments holds water, either.

A. The Settlement Does Not Violate the Civil Rights Act

Claims that one group is disadvantaged vis-à-vis another start with a classification: What are the two groups, and why do they matter?

Here, the classifications complained of are not explicitly based on race or on socioeconomic status. Rather, they are a pair of classifications that, on their face, are *race-neutral*: SD vs. agency and HSW participants vs. other Medicaid recipients.[3] Specifically, Local Defendants are asserting that (1) the Settlement's funding mechanism will disadvantage agency and/or non-HSW recipients vis-à-vis HSW/SD

[3] We will sometimes refer to non-HSW Medicaid recipients as "State plan" recipients, a term based on the fact that the Habilitation Supports Waiver is, as its name implies, a "waiver" of certain Medicaid requirements with which the overall State plan must comply.

recipients and that (2) HSW/SD recipients are Whiter and wealthier than non-HSW/SD recipients. Thus, although Local Defendants never use the phrase, they claim that the Settlement will have a "disparate impact" on non-HSW/SD recipients vis-à-vis HSW/SD recipients in Michigan and is thus illegal.

Local Defendants, however, cite no authority describing how one goes about making a disparate impact determination, and for good reason. Lined up against the clear, controlling authority applicable to disparate impact claims, Local Defendants' disparate impact assertions simply fall apart. Moreover, the causation element of the disparate impact claim provides an excellent vehicle for analyzing and disposing of Local Defendants' assertions that the Settlement is illegal and against public policy.

1. The Race Claim Fails Because Local Defendants Have Not Even Attempted to Show Intent to Discriminate

A party other than the Federal Government cannot assert a violation of Title VI on the basis of disparate impact alone. Rather, the party must allege and prove *actual intent to discriminate*. *Washington v. Davis*, 426 U.S. 229, 242 (1976).

Here, this requires a showing that MDHHS acted at least in part "because of," not merely "in spite of" the Settlement's claimed impact on minorities. *E.g.*, *Castillo v. Whitmer*, 823 F.App'x 413, 415–16 (6th Cir. 2020); *Fowler v. Johnson*, 2017 WL 6379676, at *8–9 (E.D.Mich. Dec. 14, 2017), *rev'd on other grounds sub nom. Fowler v. Benson*, 924 F.3d 247 (6th Cir. 2019).

Local Defendants, however, have not so much as mentioned intent to discriminate, let alone asserted that the State's actions in settling with the persons who sued it—SD recipients under the HSW—evince such an intent. Nor could they. For this reason alone, Local Defendants' entire disparate impact construct must fail.

2. Even if Intent Were Not Required Here, Local Defendants Ignore the Law Applicable to Disparate Impact and Cannot Possibly Satisfy *TDH* or *Wards Cove*

Suppose, however, for argument's sake, that for some reason intent to discriminate is not applicable in this settlement-approval context (perhaps abstract "illegality" is all that matters, even if those crying "foul" have no personal right to say so). Even then, Local Defendants must fail.

(a) The Four-Step Legal Framework

Although Local Defendants never so much as mention the law applicable to disparate impact analyses,[4] the Supreme Court and the Sixth Circuit have established a specific rubric for how such analyses are to proceed. The analysis has several steps, and the party claiming disparate impact must succeed at ***each*** step. Here, as we now

[4] The closest they come is their citation to *White v. Engler*, 188 F.Supp.2d 730, 745 (E.D.Mich. 2001) (WCCMH Br. at 24). They neglect to point out, however, that their quotation from *White* is simply of a statement in the *Congressional Record* on the introduction of the Civil Rights Act (109 Cong.Rec. 11161 (1963)) and that the actual *holding* of *White*—that private disparate impact claims *can* be brought under Title VI through use of 42 U.S.C. § 1983—was long ago rejected by the Sixth Circuit in *Wilson v. Collins*, 517 F.3d 421, 431-32 (6th Cir. 2008). In short, the only possible point on which *White* is potentially relevant here is wrong as a matter of law.

show, Local Defendants ***fail*** at each step. Any one such failure is fatal to a disparate impact claim; here, the accumulated failures from step to step mean that the disparate impact claim cannot possibly succeed.

The disparate impact steps are as follows:

First, because policies being challenged on an equal protection basis always involve classifications of some sort, it is vital to determine at the outset what is being compared with what. Apples-to-oranges comparisons are not permitted. For a policy to have a disparate impact on one group vis-à-vis another, the two groups must be substantially similar with respect to the operation of the policy. That is, as the Sixth Circuit has held, "[t]o be 'similarly situated' for purposes of an equal-protection claim, the plaintiff and the comparator must be alike 'in all relevant respects.'" *Reform America v. City of Detroit*, 37 F.4th 1138, 1152 (6th Cir. 2022) (quoting *Nordlinger v. Hahn*, 505 U.S. 1, 10 (1992)).

Second, it is not enough to simply show a statistical disparity between the two groups. As the Supreme Court has held

> [A] disparate-impact claim that relies on statistical disparity must fail if the plaintiff cannot point to a defendant's policy or policies causing that disparity. A robust causality requirement assures that "[r]acial imbalance . . . does not, without more, establish a prima facie case of disparate impact" and thus protects defendants from being held liable for racial disparities they did not create. *Texas Dep't of Housing & Cmty. Affairs v. Inclusive Cmties. Project, Inc.*, 576 U.S. 519, 542 (2015) ("*TDH*") (quoting *Wards Cove Packing Co. v. Atonio*, 490 U.S. 642, 653 (1989), superseded by statute on other grounds, 42 U.S.C. § 2000e–2(k)).

Third, the person or entity creating the policy must have the opportunity to explain the distinctions drawn by the policy and why they matter. Very similar to the middle step of Title VII litigation under *Wards Cove*,

> An important and appropriate means of ensuring that disparate-impact liability is properly limited is to give [those whose policies are challenged] leeway to state and explain the valid interest served by their policies. This step of the analysis is analogous to the business necessity standard under Title VII and provides a defense against disparate-impact liability. *TDH*, 576 U.S. at 541.

There is an obvious relationship between the first step and the third: the reasons behind the policy (third step) will bear on the whether the two groups affected by the policy are "alike 'in all relevant respects'" vis-à-vis the operation of the policy (first step).

Fourth, if the person creating the policy (here, the State and the Plaintiffs fashioning the Settlement Agreement) provides a legitimate justification for the challenged practice, then the challenger (here, the Local Defendants) must proffer an alternative practice that ***both*** (a) would "serve the [policy creator's] legitimate . . . interest[s]" ***and*** (b) would not have a "similarly undesirable racial effect." *Wards Cove*, 490 U.S. at 660. That is, the proffered alternatives must result in "less disparate impact" compared to the challenged policy. *TDH*, 576 U.S. at 533. And the proposed alternative(s) must be "equally effective" as the defendant's chosen policy at serving the defendant's interest(s), taking into account "[f]actors such as the cost or other burdens" that alternative policies would impose. *Wards Cove*, 490 U.S. at 661.

Local Defendants cite none of this law, and their assertions of disparate impact cannot survive any of these steps, let alone all of them.

(b) Local Defendants Cannot Show a Relevant Numerical Disparity and Thus Fail at the First Step

The class of Medicaid beneficiaries who will be receiving the challenged $31/hour Minium Fee Schedule for their CLS hours consists of participants in the Habilitation Supports Waiver (the "HSW") who self-direct their CLS activities,[5] as opposed to receiving CLS services from an agency provider. There are thus two classifications in operation here: HSW vs. State plan (*i.e.*, the great bulk of Michigan Medicaid) and SD vs. agency. For purposes of describing the supposed impact of the Fee Schedule in the Settlement, Local Defendants talk almost entirely about agencies in general, not about agencies specifically supplying services to participants on the HSW. But the differences between the HSW and the rest of Michigan Medicaid are substantial.

In the first place, the HSW is limited to individuals with Intellectual and/or Developmental Disabilities (I/DD), whereas behavioral health in the overall State

[5] The terms "self-direction" and "self-determination" are not interchangeable, but they are close enough for current purposes. In general, "self-determination refers to a value underlying the federal and state policy to empower individuals with disabilities to make decisions concerning their lives, whereas "self-direction" (or "participant direction" in CMS-speak) refers specifically to a mode of service delivery in which the participant acts as the employer-of-record for staff, with concomitant management, administrative, and supervisory responsibilities. "SD" in this brief generally refers to that modality of service delivery, but any differences should be obvious from context.

Plan includes persons living with Mental Illness (MA) and Substance Abuse (SA) issues as well. More broadly (and dispositively), even within the I/DD community the HSW has a specific eligibility requirement that, without waiver services, the recipient would need the level of care provided by an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).[6] That level of care is set forth in 42 C.F.R §§ 483.440, .450 and is built around a need for a "continuous active treatment program," which includes

> aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward—
>
> (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and
>
> (ii) The prevention or deceleration of regression or loss of current optimal functional status.
>
> 42 C.F.R. § 483.440(a)(1).

As pointed out by the Medicaid Provider Manual in discussing Overnight Health and Safety Supports ("OHSS"), which is similar to CLS except that it focuses on preventing harm to the beneficiary overnight, "OHSS services typically fall into a category of 'round-the-clock' by the ***nature and institutional level of care required for Home and Community Based Services (HCBS) Waiver beneficiaries***" (MPM

[6] The full current application for the HSW, which was approved in 2019, is Ex. 1 and is referred to as "HSW" The pending application for renewal of the HSW, to be effective October 1, 2024 ("HSW2024"), is Ex. 2).

§ 15.1.J.1at 134).[7] OHSS services are part of the HSW and are part of the Settlement (ECF#300-1 §§ B(13), C(3)). But ***OHSS is not a State Plan service***.

In sharp contrast with the services and supports required under the HSW, outpatient SA services can only be provided to beneficiaries with "minimal or manageable medical conditions" and "emotional, behavioral and cognitive conditions that will not prevent the beneficiary benefiting from this level of care" (MPM § 12.1.A at 93). And overall State Plan behavioral health diagnoses and service needs, including Mental Health services, can range from the very mild to the quite severe (*id.* § 17.1.A, B at 148-49).

There is, of course, no such thing as a "typical" behavioral health Medicaid recipient, but individuals on the HSW occupy, in general and on average, a different portion of the behavior and treatment spectrum, with more serious issues and a higher level of service needs, than do other Medicaid recipients. The simplest way to see this is to note that participation in the HSW requires that the individual be living with an Intellectual/Developmental Disorder ("I/DD"), which requires "substantial functional limitations in at least ***three*** specified areas of major life activity, MCL 330-1100a(27)(a)(iv), whereas the State plan requires only one such limitation

[7] As set forth in the Glossary, the full current application for the HSW, which was approved in 2019, is Ex. 1 and is referred to as "HSW." The pending application for renewal of the HSW, to be effective October 1, 2024 ("HSW 2024"), is Ex. 2. The Behavioral Health Chapter of the Medicaid Providers Manual ("MPM") is Ex. 3

(MPM §17.1.A at 148). HSW recipients are simply not "similarly situated" to the general Medicaid behavioral health population.

At the provider level, moreover, the Settlement's distinction between SD and agencies makes complete sense. HSW CLS SD providers are hired for that purpose and ***only*** that purpose. They will have specific characteristics that, in line with the principles of self-determination and self-direction, mesh with the specific needs of the person for whom they are hired (*e.g.*, Ex. 4). Agency CLS staff, however, can be sent to fill any number of slots, from supporting a person with an almost-resolved substance abuse issue to helping an individual struggling with serious mental illness and on the verge of being shipped off to a psychiatric hospital.

As Plaintiffs have repeatedly pointed out, the biggest factual issue in this case is the differences (Plaintiffs say) or the lack of differences (Local Defendants say) between agency and SD CLS providers. That would have been the top issue in a trial that could have lasted a month or more. Plaintiffs and the State *settled* that issue, but now Local Defendants want to go back to the beginning and start over.

That huge factual issue aside, "agency" providers of CLS services include providers of such services in group homes and other congregate settings,[8] whereas

[8] WCCMH's agency declarants make it clear that they *are* including group home services in their scope (ECF## 336-16, -17). CLS services *are* provided in congregate settings, but under a different HCPCS code (H2016+T1020) than regular CLS (H2015), and they are reimbursed on a *per diem* basis rather than a 15-minute-unit basis as is H2015 (Ex. 5). One of the many flaws in

Self-Direction is ***not permissible*** in such settings.[9] Whatever similarities agency and SD CLS services may have in some circumstances, they are not even close to being "alike in all relevant respects," as the Sixth Circuit required in *Reform America*. For that reason alone, Local Defendants fail the first step of *TDH*.

But in fact, Local Defendants fail the first step for another reason as well, one that eviscerates their entire race discrimination theme. When looked through the lens of the only potentially relevant comparison—agency vs. SD providers *under the HSW* (even those are not "alike in all relevant respects," but nothing else is close)—

Local Defendants' presentation is their complete failure to explain how hourly rates such as the Minimum Fee Schedule can be shoehorned into a *per diem* structure.

Another "flaw" is less a flaw than a monstrous gaffe. WCCMH's declarant Joseph ("Chip") Johnston (*see* ECF#336-2) implies (but does not say expressly) that he is attaching the HSW to his declaration (*see id*. ¶ 15), but in fact he attaches ***an entirely different "home and community based services waiver,"*** one that is administered by an entirely different set of Medicaid agents. As Exhibit A to his declaration makes clear (PageID10210-10471) his attachment is the "MI Choice" waiver and ***not the HSW*** (*see* PageID#10211 ¶ 1.B). So far as we can tell, moreover, the language Mr. Johnston quotes in ¶ 15 of his declaration ***does not appear at all*** in the HSW, and the language he quotes in ¶ 16 appears as part of an appendix specific to self-determination and consequently concerns cost estimating only ***within self-determination***, not between self-determination and agencies.

[9] The Self-Determination Technical Guide (at 4) says, "Please note that provider controlled or congregate settings at places like day programs, group homes, and foster care, are not self-directed (or vouchered) because the funding and hiring of staff are not controlled by the individual. An exception would be if the person has a plan to move or transition out of these settings in the current IPOS." (Ex. 8). The currently approved application for the HSW (Ex. 1 at 163) checks the box for participant direction a private residence but does not check the box for other living arrangements or group homes.

and using the very data proffered by WCCMH through the declaration of its Deputy Director, Michael Harding (ECF#336-18), ***the classification effected by the Settlement Agreement is race-neutral***. As set forth in Exhibit 6:

> The percentage of African Americans receiving self-determination CLS services under the HSW is ***90.3%*** of the percentage of African Americans receiving CLS services under the HSW as a whole.
>
> *-and-*
>
> The percentage of all minorities (*i.e.,* non-Whites) receiving self-determination CLS services under the HSW is ***97.7%*** of the percentage of minorities receiving CLS services under the HSW as a whole.

Mr. Harding does not say this, of course. In fact, he and WCCMH have striven mightily to *avoid* saying it. Mr. Harding gives comparative agency/SD figures "[f]or CLS services in general" (*i.e.*, HSW and State Plan together) in ¶¶ 10 and 11 of his declaration, but there is nothing comparable for the HSW subset alone. The closest he comes is giving some "odds" figures in ¶ 12 and an overall breakout of the HSW by agency/SD—but ***not*** by race—in ¶ 13.

The difference in presentation between CLS as a whole and CLS under the HSW leaps off the page. Mr. Harding must have known the figures presented in the box above. Why did he choose not to present them? The answer, regrettably, is obvious.

What Mr. Harding apparently failed to realize was that it is possible to apply a little algebra to the data he did provide and obtain the percentages in the box above. The algebra is set forth in Exhibit 6. The percentages in the box are not estimates; subject to rounding, they are exact calculations. They are precisely as accurate or inaccurate as are Mr. Harding's own calculations.

Under the EEOC's "80%" rule, 29 C.F.R § 1607.4(D), "[a] selection rate for any race, sex, or ethnic group which is . . . greater than four-fifths . . . will generally not be regarded by Federal enforcement agencies as evidence of adverse impact." The 80% rule is not binding on the courts, but everyone uses it, and it is consistent with common sense. Here, of course, the selection rates are so far above the 80% threshold that the phrase "will generally not be regarded" from the Rule translates here to "is not." There is no disparate impact here at all. None.[10]

[10] Because of the lack of relevant disparate impact, we only point out briefly some other flaws in Mr. Harding's "analysis" that, if he were presented as an expert, would result in a swift and meritorious *Daubert* motion. For example, the statistical age differential is minuscule: 72.5% of individuals under 40 who chose to receive CLS through an agency provider versus 72.7% of individuals over the age of 40. For over/under 50, there was only a 1.9% increase in the

It is perhaps gilding the lily, but aside from the obvious point that Mr. Harding must have known what he was doing, there is strong circumstantial evidence that this was intentional concealment by WCCMH and not a mere oversight. Because the analysis of the "survey" data Mr. Harding presents in ¶¶ 9-20 of his declaration is a classic "summary, chart, or calculation" to "prove the content" of the survey responses under Fed.R.Evid. 1006, WCCMH was obligated by the Rule to make the underlying data "available for examination or copying, or both, . . . at a reasonable time and place." When we requested the survey data, however, WCCMH's counsel refused to provide it, giving the "explanation" that the declaration is "testimony based on Mr. Harding's personal knowledge" (Ex. 7 (e-mail of 7/10/24, 3:08 p.m)).[11]

Nonsense. The underlying data are data Mr. Harding "requested" from third parties (ECF#336-18 ¶ 3). He "analyzed the data" (*i.e.*, performed "calculations" as described by Rule 1006) and set forth the results of those calculations in his declaration. Except possibly for WCCMH and its three affiliates under the CMHPSM umbrella, Mr. Harding plainly had no "personal knowledge" other than reading what he received in response to his survey. The declaration is, and only is, a Rule 1006 summary of what was sent to him.

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use of agency providers. And Mr. Harding's respondents are not a representative cross-section but are simply those who chose to respond to his request.

[11] The original request was addressed to Mr. Marchand, but he was out of the office for a family matter, so we followed up with Mr. Harding.

Worse, as the "personal knowledge" e-mail (Ex. 7) reflects, counsel for WCCMH used Plaintiffs' request for the data to try to extract an agreement to re-open discovery, as WCCMH has been trying to do since even before the Settlement Agreement was executed. In other words, WCCMH refused to provide the data except on a condition to which it knew Plaintiffs would not agree. The circumstantial evidence of intent to mislead is damning.

Because there is no disparate impact as to any relevant comparator group, Local Defendants' disparate impact case fails at Step 1.

(c) Local Defendants Cannot Satisfy "Robust Causality" and Thus Fail at the Second Step

In addition to failing at Step 1, Local Defendants also fail at Step 2 of the disparate impact analysis for want of causation. In *TDH*, the Supreme Court pointed out that, on remand, plaintiffs might find it "difficult to establish causation because of the multiple factors that go into investment decisions about where to construct or renovate housing units." 576 U.S. at 543. Similar issues prevent any finding of causation here.

Unlike in *Southwest Fair Housing Council, Inc. v. Maricopa Domestic Water Improvement Dist*., 17 F.4th 950, 965-66 (9th Cir. 2021), this is not a situation in which the policy in question (here, the HSW/SD Minimum Fee Schedule) has a direct effect on a protected class (Medicaid recipients who identify as minority).

Rather, the effect here is at least one and possibly two steps indirect, and the impact on the protected class is in any event highly speculative.

(i) Any Impact That Might Exist Is Indirect

In *Maricopa,* the Water District imposed a $180 security deposit on residents of public housing but no security deposit on people who did not live in public housing. Because public housing residents were significantly more likely to be minorities than were non-public housing residents, the security deposit was a direct harm to the protected class. "Robust Causality" was easy. 17 F.4th at 965 ("After the implementation of the policy and as a direct result of it, a disproportionate percentage of protected-group members were subject to an increased security deposit.").

Here in contrast, any purported harm does *not* flow directly to the minority Medicaid recipients but only to the agencies that serve them. The recipients have no direct economic interest in the amount of money paid to their CLS staff; rather, their interest is solely in *obtaining services*. Neither agency nor SD recipients ever see a dollar of the "CLS rate," whether the new minimum fees or the existing payments to agencies. As is common with publicly provided medical benefits, that money goes to, and only to, *the provider* (Ex.9).[12] Moreover, with respect to the interest that the Medicaid recipients do have—the receipt of services—the County remains obligated

[12] *See also Waskul v. WCCMH*, 979 F.3d 426, 438 (6th Cir. 2020) (in self-determination arrangements "[a] fiscal intermediary actually holds the funds and pays bills directed to them.").

to provide those services to them, regardless of how much money the County receives to pay for those services.[13]

To be sure, it was part of Plaintiffs' case in this action that the County was not fulfilling that obligation, but that does not make the chain of causation any more direct. The primary asserted losers are the agencies—which do ***not*** constitute a protected class. The recipients are at best secondary losers (*i.e.* indirectly through the agencies). This case is thus similar from a causation standpoint to *Cnty. of Cook, Illinois v. Bank of Am. Corp.*, 78 F.4th 970 (7th Cir. 2023), in which banks allegedly targeted minorities with predatory lending practices. When the borrowers defaulted and the loans were foreclosed, the County lost tax revenue and had to deal with the socioeconomic effects of the foreclosures. As the Seventh Circuit held in rejecting that claim:

> Cook County seeks a remedy for effects that extend *way* beyond "the first step." The directly injured parties are the borrowers, who lost both housing and money. The banks are secondary losers, for they did not

[13] *E.g.*, MCL 330.1708(1) (recipient "***shall*** receive mental health services suited to his or her condition" (emphasis added)); Ex. 10 (PIHP contract with State requires PIHPs to "provide covered State plan or 1915(c) services . . . in sufficient amount, duration and scope to reasonably achieve the purpose of the service)"; *Waskul*, 979 F.3d at437 (PIHP receives "a fixed amount of funding for each person participating in the CLS program, regardless of how many services the entity ultimately provides to the recipient"; "PIHPs can make or lose money depending on how the amount they receive in capitation funds compares to the amount of funding they provide recipients, but they must ensure that the services they provide comply with the terms of their contract with the State, which itself must ensure that it complies with the terms of the Medicaid Act, federal regulations, and the Waiver.").

> collect the interest payments that the borrowers promised to make and often did not recover even the principal of the loans in foreclosure sales. The County is at best a tertiary loser; its injury derives from the injuries to the borrowers and banks. 78 F.4th at 972.

(ii) Superseding Causes: The Selection Process and Supports Brokers

Any putative racial disparities here would have been caused at least in substantial part by Local Defendants themselves. It is the PIHPs (and, through them, the Community Mental Health agencies, such as WCCMH) that are charged with screening applicants for the HSW for final approval by MDHHS.[14] If participants on the HSW are Whiter, or more affluent, than ordinary State plan beneficiaries, it is because those are the individuals that WCCMH and its confreres have put forward to go on the waiver.

Local Defendants' efforts to portray Self-Determination as some form of "Rich-Man's Medicaid" ignores that each of the Named Plaintiffs here is an adult and is on SSI or SSDI. Plaintiffs' families *do* assist in Plaintiffs' support and care, of course, but they are not obligated to do so, and CMHs are expressly *forbidden* to condition services on families' providing "natural supports."[15]

In any event, if there are socioeconomic differences in families' ability to handle self-determination, then it is the Local Defendants' fault for failing to use

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[14] HSW at 36 ("The procedure for enrollment begins at the PIHP. Each PIHP has an HSW Coordinator, who has primary responsibility for working with supports coordinators and potential enrollees to identify those individuals for whom the PIHP will submit an application.").

[15] MPM § 1.3 at 2; *Waskul*, 979 F.3d at 451-52; 42 C.F.R. § 441.301(c)(2)(v).

"supports brokers." These specialized services exist under the HSW *precisely* to help families navigate the system and handle their responsibilities thereunder.

The primary role of the supports broker is to assist the participant in making informed decisions (HSW at 171). The supports broker helps individuals develop an IPOS, find and get the services and supports in their IPOS, and "has a clear focus on helping people identify and meet the goals to increase independence and quality of life" (MPM § 13; SDTRIG § II). The supports broker helps the participant explore the availability of community services and supports, housing, and employment and then makes the necessary arrangements to link the participant with those supports (HSW at 171; MPM § 13).

A supports broker may be involved in discussions on how resources will be spent and in recruiting staff (SDTRIG § V), can assist the participant with any part of the employer responsibilities, and will provide ongoing support for as long needed or desired (SDTRIG § VI), including ensuring that service documentation meets the standards set forth in the IPOS (SDTRIG § VI), and assisting in implementing and monitoring the IPOS and budget (HSW at 171; SDTRIG App. A § F). Supports brokers offer practical skills training to enable participants to be as independent as possible, including providing information on recruiting, hiring, and managing workers (HSW at 171).

But a recent survey of 42 CMHs indicates that only between 11.9% and 16.7% of surveyed entities make supports brokers services available (Ex. 11 at 4),[16] with 33 out of 42 not using them at all (*id*. at 6). CMHs' broad non-provision of services specifically designed to address administrative issues of self-determination is clearly a superseding cause of any inability of lower-income families to handle those issues.

(iii) Any Impact That Might Exist Is Speculative

The alleged harm here is not merely indirect; it is also speculative. Even if there will be an impact on the agencies by the operation of the Minimum Fee Schedule, the *extent* of the harm is unknown and unknowable. The agencies are *already* suffering staffing shortages (*e.g.*, ECF#336-17 PageID10579-10580; ECF#336-16 PageID10568; Ex. 27, 42:18-45). Local Defendants' declarants offer nothing but their own speculation as to what *additional* harm will occur as a result of the Settlement. Perhaps the sky will fall, but there is good reason to believe that it will not.

First, the labor market in which DCWs operate is not a closed market. Plaintiffs' expert labor economist (Ex. 12 § 3.4 at 9 n.19; § 4.3) and agency witnesses themselves (*e.g.*, Ex. 13 at 44:23-45:2; ECF#336-16 PageID10568 ("In my experience, ALS-LM is often competing with fast food restaurants and automobile plants for workers. Heartbreakingly, we have been on the losing end of this fight to hold

[16] The document is hearsay, although because it bears the MDHHS logo it might qualify as a public record under Rule 803(8)(A)(iii). We present it here for what it is worth, noting that the firm that wrote it is a regular consultant for both governmental and private entities throughout Michigan Medicaid.

onto our staff for years."); Ex. 14) agree that people move back and forth between DCW jobs and jobs in retail, fast food, and convenience stores. The Settlement Agreement will fix that for DCWs providing self-determination CLS services under the HSW, but there is no reason to believe that it will make the competition from employers such as Wal-Mart and McDonalds any worse for the agencies than it already is.

And the opposite side of this coin is true as well. One of the purposes of the $31 Minimum Fee Schedule is to lure people who are potential DCWs away from their jobs at Wal-Mart, or from their positions as full-time students, into a job (SD CLS worker) that may be difficult but is also interesting and rewarding. [redacted]

[redacted]

Second, the overall DCW market in Michigan is a multi-billion-dollar operation.[17] The settlement will inject perhaps $30 million a year of new money into that system.[18] Even if the size of the market is the same now as it was 10 years ago—and, of course, it must have grown by leaps and bounds in the interim, as all medical-related costs have[19]— is beyond belief that a 3% change in the amount of money flowing into the DCW system could have the catastrophic effects posited by Local Defendants and their declarants. So, too, the number of HSW "slots" is fixed, and movement from State Plan Medicaid onto the HSW does not happen quickly or to any significant extent. Accordingly, the likelihood that many individuals will leave the State Plan for the HSW is quite low. For this reason too, the impact of the

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17 Michigan's 2016 "1009" Report (Ex. 16) estimated that CLS was just about 30% of the overall Medicaid DCW-related spend for Fiscal Years 2006-2014, averaging $325.8 million a year for that period, or $362.5 million if respite services are included (*id.* Table 2). This equates to just about a $1 billion overall DCW-related market for the period.

18 MDHHS's expert, Christopher Pettit, estimated prior to the Settlement that the scenario that, it turned out, the Settlement actually implemented as to CLS, would cost an additional $22.1 million annually (Ex. 17 at 11). That estimate did not include OHSS, which involves fewer hours and a lower rate than CLS, so we have rounded up to $30 million. The actual number could be somewhat larger without affecting the point made in text.

19 Mr. Pettit's dataset for his expert witness work (Ex. 18) shows that ***CLS alone*** was $774 million in FY2021. If CLS is still 30% of the market, that implies an overall market of more than $2.5 billion. And those data will be three years old by the time of the approval hearing.

Minimum Fee Schedule on labor markets other than the specific HSW SD market to which it is directed will be sharply limited.

Local Defendants' cries of "Doom" are thus vastly overstated.

(d) There Is an Undoubtedly Legitimate Purpose to the Settlement, and Local Defendants Have Not Come Close to Offering an "Equally Effective" Alternative, so Local Defendants Fail at Steps 3 and 4

In Step 3 of the *TDH/Wards Cove* protocol, the policy proponents explain why they did what they did and then, in Step 4, the opponents have the dual burden of proffering an alternative that both produces "less disparate impact" and, crucially, is "equally effective" in achieving the legitimate goals proffered by the proponent, taking into account "[f]actors such as the cost or other burdens" that alternative policies would impose. *Wards Cove*, 490 U.S.at 661. Here, the Settlement undoubtedly serves legitimate purposes, and there is no way to have less disparate impact than the zero actionable disparate impact shown to exist above. Even if that were not the case, moreover, Local Defendants' proposed alternatives are so unreasonable from a cost and effectiveness standpoint that they can be seen to fail merely by stating them.

In its response in support of the Motion to Approve (ECF#322 PageID9957-9974), MDHHS articulated better than we can the reasons why this Settlement is an immense positive for many Medicaid beneficiaries throughout Michigan. That takes care of Step 3, but one of its points is particularly relevant here:

> No settlement (especially settlements in programs involving finite resources) is perfect. But the positives here far outweigh potential negatives. While its terms do not apply to every Medicaid beneficiary, they do apply to many across the state. And *State Defendants have, in a first for any part of the managed care portion of the Michigan Medicaid program*, agreed to seek implementation of Minimum Fee Schedules. *State Defendants, like all other parties to this case, will be watching and learning about the effectiveness of the Minimum Fee Schedules as they are implemented. This is a much better alternative than not trying something new designed to help Medicaid beneficiaries*. Ultimately, the all-or-nothing approach that will likely be presented by CMHPSM and/or WCCMH will not allow for this growth to the Michigan Medicaid program. (PageID9974 (emphasis added)

The State is correct that Local Defendants' approach is "all or nothing." The Settlement they said the State should negotiate (WCCMH Br. Point D, ECF#336 PageID10195) would involve additional annual expenditures of $207.8 million, nearly ***nine-and-a-half times greater*** than the $22.1 million in additional money projected for the actual Settlement. (Ex. 17 at 11).[20] In a world that, as MDHHS points out—and as Plaintiffs necessarily acknowledged during settlement negotiations—involves finite resources, that is obviously a non-starter. And if, as objector Community Mental Health Association once suggested (Ex. 19), the State were simply to take the dollars allocated to this settlement and spread them across the entire Medicaid universe, the impact on DCW wages would be so small as to

[20] The actual multiplier would be even greater (over 11x) if agencies' indirect costs (part of Fee Schedule A but not Fee Schedule B) were factored in.

accomplish nothing at all. As CMHPSM's CEO pointed out in response to an earlier legislative initiative that created a $2.00/hour pass-through for all DCWs in the state:

> We know the staffing crisis has turned from a three alarm fire to a four alarm fire during the pandemic and the $2 premium pay isn't enough water. (Ex. 20)

In *Maricopa Water District,* the disparate impact claim failed at Step 4 notwithstanding clear showings—which are not present here—that there *was* a disparate impact from the security deposits at issue and that "robust causality" had been satisfied. 17 F.4th at 971-72. The reason was that two of the proposed alternatives would not have been effective, *id*. at 970-71 and the third would cost too much, *id*. at 971-72. The same is true here.

[redacted]

As MDHHS has pointed out, folks will be watching to see how well this Settlement works. Plaintiffs' expert Prof. Bishop made the same point: because supply elasticity in the DCW labor market is uncertain, it is very difficult to know what the

"right" market-clearing wage will be. One tries something, sees if it works, and makes adjustments (Ex. 12 §5.2). Perhaps Prof. Luz (ECF#336-27) is correct that this Settlement will not do all that Plaintiffs and the State hope it will do, but perhaps she is not. One step at a time. If one never takes the first step, one never gets anywhere.

As the Supreme Court said in *TDH* and the Ninth Circuit echoed in *Maricopa*, 17 F.4th at 971-72 (quoting *TDH*, 576 U.S. at 521), "Policies, whether governmental or private, are not contrary to the disparate-impact requirement unless they are artificial, arbitrary, and unnecessary barriers." Providing additional benefits to HSW CLS SD recipients is none of these things. It is not even close. Accordingly, Local Defendants fail at Steps 3 and 4.

B. Local Defendants' Other Claims of Illegality Likewise Fail

In addition to their pervasive disparate impact claim, Local Defendants raise several other claims that the Settle Agreement should be rejected as "illegal." None of those claims holds water.

1. The Settlement Is Completely Consistent with Michigan Administrative Law

Citing *Pedreira v. Sunrise Children's Servs. Inc*., 826 F.App'x 480 (6th Cir. 2020), WCCMH says that the Settlement is inconsistent with the rulemaking provisions of Michigan adminstrative law and thus should be disapproved. But Michigan's administrative scheme, particularly with respect to MDHHS's powers

over Medicaid, is very different from the Kentucky scheme at issue in *Pedreira*, and Michigan law provides ample authority for MDHHS to do exactly what it did here.[21]

In *Pedreira*, the Sixth Circuit held that "Kentucky law and courts have a significantly limited view of an agency's authority." 826 F.App'x at 488. "'Where reasonable doubt exists concerning the proper scope of an administrative agency's power, the question must be resolved against the agency to limit its power.'" *Id*. (quoting *Fisher v. Commonwealth*, 403 S.W.3d 69, 78 (Ky.Ct.App. 2013)). In sharp contrast with Kentucky, however, Michigan expressly grants MDHHS *special authority* to establish Medicaid policy that is binding on all participants in the system *without* the need to go through either notice-and-comment rulemaking or some form of "consultation" procedure. It is authority that, we are informed, MDHHS has consistently used over the years to issue revisions and updates to the *Medicaid Providers Manual.* It is the authority that MDHHS used to negotiate the Settlement here.

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[21] *Williams v. Vukovich*, 720 F.2d 909 (6th Cir. 1983), does not support Local Defendants' arguments. The illegality in *Williams* was the use of a non-validated exam for hiring and promotion purposes. *Id.* at 925-26. There could have been no serious dispute that the exam was illegal: There was not, for example, a factual issue concerning the propriety of validation; rather, there was no validation at all. Notwithstanding the undisputed illegality of using the test, the test pervaded the entire decree, governing the criteria for promotion and hiring set forth therein. *See id*. at 919, 927. In addition, there was a waiver of future claims and a limitation on the future hiring of non-minorities. *Id*. at 925-26. These were three specific, concrete illegalities embedded in the terms of the decree. Possibly except for Local Defendants' administrative law issue (not meritorious, as shown in text), nothing like this kind of alleged illegality is at issue here.

Thus, MCL 400.6(4) gives MDHHS broad authority to promulgate Medicaid policies "to implement requirements that are mandated by federal statute or regulations as a condition of receipt of federal funds." Such policies are "effective and binding on all those affected by the programs," and they are also "exempt from the rule promulgation requirements of [Michigan's APA]." The exemption in § 400.6(4) is reinforced by the definition of "rule" under the Michigan APA, MCL 24.207, subsection (o) of which *excludes* from the definition of "rule":

> (o) A policy developed by the department of health and human services under section 6(4) of the social welfare act, 1939 PA 280, MCL 400.6, to implement requirements that are mandated by federal statute or regulations as a condition of receipt of federal funds.

Here, ***every policy provision of the Agreement is an implementation of a Medicaid statute or regulation setting forth a condition of receipt of federal funds.*** The Agreement is a *Settlement* Agreement. It settles contested claims under at least four Medicaid statutes and at least one Medicaid regulation that carry with them the requirement that failure to comply risks loss of federal funding. That is, the Agreement settles claims that the Amended Complaint brought under

- 42 U.S.C § 1396a(a)(10)(B) and 42 C.F.R. § 440.230(b) [ECF#146, Count III],
- 42 U.S.C. § 1396a(a)(8) [*id.* Count IV],
- 42 U.S.C. § 1396n(c)(2)(A) [*id*. Count VII], and
- 42 U.S.C. § 1396n(c)(2)(C) [*id*. Count VIII],

and ***each of these statutes is a condition of receipt of federal Medicaid funding***.

Thus, the various subsections of § 1396a and the implementing regulation are "State Plan" requirements,[22] and 42 U.S.C. §§ 1396b, 1396c make compliance with all State plan provisions a condition of receipt of federal funding.[23] The State gets its federal Medicaid funding if and only if it complies with each of the subsections of § 1396a, including the two sued on in this action.

Similarly, the subsections of § 1396n(c)(2) invoked by Counts VII and VIII are the "waiver" provisions under which the HSW was adopted. Subsection (c)(1) permits inclusion "as medical assistance under [the State] plan" of payments made under a waiver that complies with §1396n(c)(2) and thus conditions receipt of federal Medicaid funding on such compliance. As under 42 U.S.C. §§ 1396a, 1996b, 1396c, therefore, the State gets its Medicaid funding only if it is in compliance with 42 U.S.C. § 1396n(c)(2)(A), (C). Those statutes, too, are *conditions*.

The gravamen of this lawsuit was that Michigan was not complying with the statutes listed in Counts III, IV, VIII, and VIIII, among others. The Settlement Agreement implements policy that *resolves* those claims, and Plaintiffs have agreed (by dismissing the action as part of the Settlement) that Michigan is now in compli-

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22 The preamble to 42 U.S.C. § 1396a says "A State plan for medical assistance must—. . ." and then goes on to set forth 83 subsections and countless sub-subsections.

23 Under 42 U.S.C. § 1396b(a)(1) the Secretary must reimburse States for expenditures made for "medical assistance under the State plan," so compliance with the State plan gets the State its funding. Conversely, § 1396c *cuts off* expenditures the State *fails* to comply with §1396a.

ance. Accordingly, both the policy decision to settle the litigation and the specific policies effected and to be effected by the Settlement were made to ensure compliance with statutes imposing "condition[s]" on Michigan's "receipt of federal Medicaid funding." The Settlement Agreement therefore fits squarely within the exception to the rulemaking requirement set forth in MCL 400.6(4) and 24.207(o).[24]

WCCMH also contends that even, if notice-and-comment rulemaking is not required prior to implementation of the policies at issue here, some form of "consultation" is required. Not so. The only provision WCCMH cites that mentions "consultation" requirements is MCL 400.111a, and that statute relates only to *provider* requirements, not to anything bearing on MDHHS's right to make policy that binds its managed care agents. Thus:

- MCL 400.111a has 17 subsections, and *all* of them deal with (and only with) provider issues.
- MCL 400.111b explains what MCL 400.111a means by "condition of participation and requirements of providers" and explains who gets to be a service provider and under what circumstances.
- The "consultation mentioned in 400.111a(1) is with providers and a provider-related medical council.

[24] In addition, although there is no pleaded claim under § 1396a(a)(3), the Fair Hearing provision of the State Plan statute, Section C.7 of the Settlement Agreement resolves Fair Hearing issues that came up during the course of this litigation and thus is also within the scope of MCL 400.6(4) and 24.207(o).

- The legislative history of the statute makes it clear that its purpose to "confer authority upon the Department of Social Services 'to enforce . . . current policy regarding Medicaid provider fraud and abuse.'"[25]

Accordingly, the Settlement triggered neither a rulemaking nor a consultation requirement. It fully complies with the Michigan APA.

2. Neither the "Adequate Provider Network" Claim Nor Those Relating to "Freedom of Choice" or "Actuarial Soundness" Begins to Establish Illegality

These three assertions of illegality are all effectively the same, and none of them involves the type of claimed illegality at issue in *Pedreira.* In *Pedreira* the claim was that specific provisions of the proposed decree violated positive Kentucky law, and the Sixth Circuit held that some of them did. The administrative law claim discussed in the previous section is that type of claim (albeit not meritorious, as demonstrated above), but the assertions of illegality discussed in this section are not. Here, the claims are not that settlement provisions themselves violate the law but rather that the amounts to be paid under the settlement for the benefit of Plaintiffs and other HSW SD CLS recipients will cause the amounts to be paid to *other* people to be insufficient. That is a very different kettle of fish.

It is a complete answer to these claims that Local Defendants' assertions of instant, catastrophic collapse of the DCW labor market are, as demonstrated at

[25] AG Op. No.6439 (May 29, 2987) (quoting House Legislative Analysis, HB 5868 (June 17, 1980)) (Ex. 23) (available at https://www.ag.state.mi.us/opinion/datafiles/1980s/op06439.htm:

pp. 23-26, surely overblown. A $30 million infusion of new money into a multi-billion-dollar system might have some effects on non-HSW/SD direct care costs, but it will not cause the entire agency system to come crashing down. And because it will not, MDHHS's actuary will surely be able to give the necessary "actuarial soundness" opinion, including the subsidiary determination that the capitation provided to the PIHPs will enable them to have an "Adequate Provider Network."[26] Perhaps the non-HSW/SD portion of the capitation rates will need to be raised somewhat; perhaps not. As Prof. Bishop pointed out (Ex. 12 § 5.2), nobody knows enough about the elasticity of supply in the DCW market (including, among other things, the adjacent retail and fast-food markets) to be able to make detailed predictions on such issues. All one can do is try something, watch the results, and make adjustments. And that, as MDHHS has pointed out, is exactly what Michigan plans to do as the Settlement goes forward.

Local Defendants and their declarants say the same thing over and over, but they are remarkably short on facts. No one—certainly not Plaintiffs—will say that there is not a shortage of direct care workers in Michigan. ***But that shortage already exists***. Pathlight, for example, has *already* lost workers (ECF#336-17). That is not a prospective consequence of the Settlement; it is an existing fact.

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[26] The same is true for Local Defendants' "Freedom of Choice" argument, since that also depends on a putative total collapse of the agency market.

In reality, Local Defendants and their declarants are not saying the Settlement will *cause* an illegality in actuarial soundness or network certifications. They are saying that there is *already* such an illegality. And *that* argument runs squarely into the problem that the State's world-renowned actuarial firm[27] has been certifying actuarial soundness every year. ***And CMS has been approving those certifications.***

The Settlement will not take a dime from agency providers' pockets. If the capitation rates for the coming fiscal year, or the next one, are "actuarially sound," then Milliman will so certify. If they are not at first, then Milliman will tell MDHHS that the rates must be raised, as they have in the past (Ex. 24). Are Local Defendants saying that Milliman has been breaking the law repeatedly for years on end? Perhaps they may think so, but they have no actuarial expert and no economics expert. Their declarants are all over the map, with some saying they are paying $14 for SD CLS (*e.g.*, Ex. ECF#336-3 ¶ 14) and others that they are paying a "CLS average hourly rate" of $26.40 (ECF#336-13 ¶ 12) The only thing Local Defendants have filed that looks like "data" is Mr. Harding's declaration, and we all know what that is.

Local Defendants have given this Court no basis whatsoever to make any determinations about what will happen when the Settlement is implemented. A finding of prospective illegality is, we submit, inconceivable.

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27 *See* https://www.milliman.com/en/our-story

C. The Settlement Is Entirely Consistent With the Public Interest

1. The Public Interest Here Is Already Embodied in the Supreme Court's Careful Balancing of the Factors Applicable to Disparate Impact Analysis Under *TDH* and *Wards Cove*

TDH makes it clear that creation of the four-step disparate impact test involves nuanced *a priori* balancing so that disparate impact claims do not interfere with other important public purposes (there, housing policy; here, Medicaid and disability policy). 576 U.S. at 540-44. Thus:

> Were standards for proceeding with disparate-impact suits not to incorporate at least the safeguards discussed here, then disparate-impact liability might displace valid governmental and private priorities, rather than solely "remov[ing] . . . artificial, arbitrary, and unnecessary barriers." *Id*. at 544 (quoting *Griggs v. Duke Power Co.,* 401 U.S., 424, 431 (1971)).

Accordingly, the four-step test of *TDH already* incorporates the necessary policy analysis. Any attempt to engage in a free-form substitute under the guise of "public policy" review would negate the careful balance struck by the Supreme Court.[28]

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[28] This is the portion of WCCMH's brief in which it cites *White v. Engler*. As noted (*see* footnote 4 *supra*), *White*'s disparate impact holding was long ago rejected by the Sixth Circuit. It cannot be the case that general notions of "public policy" can be used to resurrect legal theories that have been expressly held to be wrong.

2. The Settlement Agreement Reflects the Strong Federal and Michigan Public Policy to Foster Self-Determination

CMS grants the State of Michigan "broad discretion to design its [HSW] program to address the needs of waiver participants." (HSW at 1; HSW2024 at 1) This includes latitude to design a waiver program that "employs a variety of service delivery approaches, including participant direction of services." (*Id*., *Id*.) CMS urges states to afford all waiver participants the opportunity to direct their services, which includes decision making authority over workers who provide services and budget management. (*Id*. at 159, *Id*. at 149) In its waiver application form, CMS requires outlining goals for self-determination participation, and it tracks progress towards those goals on an annual basis. (*Id*. at 172, *Id*. at 162) In its CMS-approved 2019 application, Michigan sought to increase the number of self-determination participants from 1,435 to 1,744 over a five-year period (HSW at 172). In its pending renewal application, the State hopes to continue increasing HSW self-determination participants from 2,001 to 2,262 over the next five years. (HSW2024 at 162).

Michigan has a long history (since the early 1990s) of encouraging and supporting self-determination, and elements of participant direction are embedded in both policy and practice (HSW2024 at 151). In the mid-1990's, long before this settlement came into existence, Michigan codified person-centered planning in the Mental Health Code, and it has since created and implemented numerous technical documents and policy supporting self-determination services. Policy support for

self-determination can be found in MDHHS's Person-Centered Policy and Practice Guideline, Self-Directed Services Technical Requirements and Technical Guidance, the contract requirements in the contracts between the state and the PIHPs, and technical assistance at the state level (*Id*.) The Technical Guidance makes clear that "[t]he PIHP/CMHSP is required to develop and maintain a system that supports people who choose to use any method of the self-directed options (i.e. direct-employment, purchase of service, agency-supported self-direction). The PIHP/CMHSP must actively educate people about the option to direct services, ensure all CMHSP staff are aware of self-directed services, the different levels of control available, and the methods to exercise that control" (SDTRIG at 4). Moreover, the policy states: "A PIHP/CMHSP may not limit access to any self-directed options." (*Id*.) Despite the State's decades-long policy objective and clear CMS support, Local Defendants brief makes clear that the state's policy goals of encouraging and supporting self-determination are not shared values—which provides yet another reason why the Settlement must be enforceable against Local Defendants, as Plaintiffs have argued in the declaratory judgment portion of this motion.

3. The Settlement Does Not Promote "Fraud, Waste, and Abuse"

(a) Local Defendants' Fraud and Abuse Assertions Merely Confirm Their Antipathy to the Strong Michigan Policy Favoring Self-Determination and Should Be Rejected on That Basis

Local Defendants' assertion of fraud, waste, and abuse in self-determination arrangements are based on nothing more than a one-off example and declarations from some CMH/PIHP CEOs detailing (mostly by repetition of form declaration language) hostile feelings toward self-determination. The assertion that self-determination arrangements increase the likelihood of fraud, waste, and abuse is not supported by *any* data in this record.

Further, the notion that there is no or little oversight to self-determination is plainly false. There are remedies for self-determination fraud, waste, and abuse and none of those remedies has been waived by this settlement. Self-determination arrangements are subject to oversight from the Office of Inspector General, which investigates, and can remedy, instances of fraud, waste and abuse (Ex. 25). PIHPs need only report suspicions to the OIG, and MDDHS then works with that office to assist in processing complaints. (*Id*.). Second, there is a specific service required in all self-determination arrangements which provides additional oversight—Fiscal Intermediary Services. A fiscal intermediary assists the beneficiary with managing and distributing funds contained in the individual budget and with understanding billing and

documentation requirements (MPM § 15.1.F). Fiscal Intermediaries work under contract with and report to the CMH/PIHP.

Moreover, the unsupported assertion that agencies are less likely to engage in fraud, waste and abuse due to unidentified "internal controls and oversight" (ECF #336 at 26) falls flat when confronted with data. A review of 138 Recipient Rights complaints in Washtenaw County concerning CLS[29] reveals that agencies were the subject of all but six. In fact, agencies are exclusively responsible for all (or possibly all but one) *substantiated* complaints for neglect in Washtenaw County. Issues with agencies, which include staff not showing up to work, sleeping on the job, or actively harming consumers, are well documented. Despite substantiation through the CMH-SPs' Recipient Rights complaint process, the oversight controls almost always result in little more than reprimands and wrist slapping despite serious safety concerns identified by CMHSPs as a part of their oversight function.

Local Defendants' hostility towards self-determination is all over this case. As detailed in Plaintiff's Motion for Approval (ECF#316, PageID9428-9429), WCCMH repeatedly threatened Plaintiff Wiesner with termination of his self-determination arrangement after he had the temerity to seek a sufficient budget through a Medicaid Fair Hearing. At that Administrative Hearing, WCCMH's Program

[29] The ORR complaints were produced in discovery by WCCMH, so *this* is data that, as required by Rule 1006, WCCMH already has.

Administrator testified that if a self-determination beneficiary and the CMH cannot agree on a budget, then self-determination can be terminated by the CMH (Ex. 26). On appeal, WCCMH suggested *six times* to the Michigan Court of Appeals that the Court terminate Mr. Wiesner's self-determination arrangement altogether (*see* ECF #316, PageID9428-9429).

(b) As Applied to These Plaintiffs, the Assertions of Fraud and Abuse Are Wrong Factually and Are Based on an Apparently Intentional Butchering of the Record

[redacted]

[redacted]

30 [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

31 [redacted]

[redacted]

32 [redacted]

[redacted]

[redacted]

[redacted]

33 [redacted]

34 [redacted]

CONCLUSION

The Court should approve the Settlement and enter an Order directing the Plaintiffs and MDHHS to carry out its terms.

s/Kyle Williams	*s/Nicholas A. Gable*	*s/Edward P. Krugman*
Kyle Williams	Nicholas A. Gable	Edward P. Krugman

July 15, 2024

CERTIFICATE OF SERVICE

This day of July, 2024, I hereby certify that I served the foregoing document on all counsel of record in this action by filing it with the Court's ECF system, which will effect such service.

Nicholas A. Gable