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' SUPPLEMENTAL BRIEF

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November 1, 2024

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INDEX OF AUTHORITIES

This brief is entirely factual, with substantially no legal argument. Accordingly, the "Index of Authorities" and "Most Appropriate Authority" sections are omitted.

INTRODUCTION

Plaintiffs respectfully submit this Supplemental Brief in further support of approval of their Settlement with the State in this action.

That the Settlement is "fair, reasonable, and adequate" as between the settling parties was demonstrated in Plaintiffs' initial brief in support of approval (ECF #316). It is further shown by the overwhelming support the Settlement has received from advocacy organizations on behalf of people with disabilities,[1] and it has not been contested either by the Local Defendants or by the individuals and organizations who have objected to the Settlement. Most of the briefing has been on other issues, because this is not merely a settlement between private parties but also a consent decree,[2] but that should not obscure that this ***is*** a marvelous settlement of a long, bitterly contested action. It is a settlement that affords the parties who sued virtually everything they could have gotten at trial.

But it is also a consent decree, so the public interest does matter, and the prior briefing has demonstrated that the public interest strongly supports this Settlement (ECF#316 PageID9408-9410; ECF#322 PageID9969-9974; ECF#365 PageID 12412-12422). The Objectors, led by the Local Defendants' lobbyist, CMHA, add

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1 ECF##330-331, 334, 350, 352, and 369.

2 This brief is not about the portion of the approval motion relating to holding the Settlement Agreement, and the consent decree to be entered thereunder, directly enforceable by Plaintiffs against Local Defendants. Briefing on that issue is concluded.

little if anything to what the Local Defendants have already said.[3] Notably, ***not one Objector addresses the provisions of the Settlement other than the minimum fee schedule.*** None of them has anything to say about Attachment C (the costing out policy which comes into effect if the fee schedules do not); nor does any Objector directly address the new and significant regulation of the daily interactions between beneficiaries and CMHs, the strengthening of self-determination protections, or the elimination of the Medicaid Fair Hearing "hamster wheel."

The Objectors focus solely on economics. They do have the good sense to forgo the Local Defendants' specious race discrimination claim, but their economic argument, like Local Defendants', is based (to put it gently) on speculation, hyperbole, and a complete absence of any sense of scale. They assert that injecting $30 million (or even $50 million) of new money into the SD CLS market under the HSW, so that recipients can attract and retain appropriate staff, will cause the entire multi-***billion*** dollar DCW market to implode. The assertion is unsupported and insupportable. It is as bogus in Objectors' mouths as it was in Local Defendants'. The Settlement should be approved.

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[3] There is significant overlap between materials submitted by Local Defendants in support of their opposition and those submitted by Objectors on their own behalf. Some duplication between this brief and the Reply Brief is therefore unavoidable, but we have done what we can to refer to or summarize arguments previously made and not lay them out all over again.

ARGUMENT

I. AS WERE LOCAL DEFENDANTS', OBJECTORS' ASSERTIONS THAT THE SKY IS ABOUT TO FALL ARE UNSUPPORTED AND INSUPPORTABLE

A. Who Did *Not* Object Speaks Volumes

The principal Objector is the Community Mental Health Association ("CMHA"),[4] the lobbying organization for Michigan's CMHs and PIHPs, including the Local Defendants. CMHA's objection is joined by all of its member CMHs and PIHPs. The other Objectors are (a) two relatively small provider agencies (Pathlight and Adult Learning Systems); (b) one parent of an individual with disabilities; and (c) Prof. Clare Luz of Michigan State University.

The Objectors claim that agency and group home providers will suffer catastrophic harm should the Settlement be approved, but virtually none of the supposedly affected entities agrees. ***Only two of the hundreds of providers statewide have actually objected to the Settlement.*** Where is everybody else? There have now been two rounds of notice, and CMHA and the Local Defendants have been out beating the bushes. ***Where are the provider Objectors?***

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[4] For convenience, we include within the term "Objector" all those individuals and organizations, other than Local Defendants and their employees, who either (a) submitted a formal objection, denominated as such; (b) submitted a declaration in support of Local Defendants' opposition; or (c) joined in CMHA's objection. Issues as to who may or may not formally have the right to object seem to us to be beside the point: we assume the Court will be interested in whatever anyone has to say, and we respond on that basis.

The CMHs and PIHPs incant the CMHA boilerplate of "feedback from agency providers,"[5] but not one of those agencies is even identified. Mid-State says it has 200 direct contract providers (ECF #336-10 ¶ 3), and Northern MI Regional Entity says it has 400 (ECF#372 Ex. F ¶ 3). No doubt they do, but why has none of those providers spoken for themselves? [redacted]

Nor have the vast majority of the fifteen other local agency providers that previously submitted declarations in this action.[6] Nor have any of Michigan's countless other agency providers and related organizations. The list goes on. The universe of providers that, on this record, are content to have the Settlement approved is staggering in breadth. First are the entities on WCCMH's proposed notice list (ECF#326

[5] ECF#336-2 ¶ 17, -5 ¶ 17, -7 ¶ 17, -10 ¶ 18, -11 ¶ 14, -12 ¶ 18, -13 ¶ 14, -14 ¶ 17, -15 ¶ 15).

[6] These declarations were collected during discovery; agencies to which Plaintiffs issued subpoenas were given the option of filing a declaration in *lieu* of sitting for a nonparty 30(b)(6) deposition. The declarations were provided to Local Defendants around two years ago and have been filed as ECF##376-377. They include Umbrellex; YPCS; Community Alliance; CABB Community Supports; Renaissance Community Homes (now Pathlight); Turning Leaf Behavioral Health Services; Avalon; College Nannies, Sitters, and Tutors; ExpertCare; Progressive Residential Services, Inc. (incorrectly listed as Progressive Services Residential in the declaration); Saints Incorporated; His Eye Is On The Sparrow; Spectrum Community Services; Joak American Homes, and Adult Learning Systems (of Lower Michigan).

PageID10065).[7] Apart from CMHA, however, only one of those eleven entities ended up objecting,[8] and one other has filed a declaration in ***support*** of the Settlement.[9] None of the following organizations on WCCMH's list[10] has objected:

- Michigan Assisted Living Association ("MALA"), a nonprofit organization whose members provide services to over 30,000 older adults and individuals with intellectual or developmental disabilities, mental illness, substance use disorders, traumatic brain injuries, or physical disabilities.[11] MALA, among other things, advocates for its members concerning "legislation, regulations, budget decisions, state agency policies, and other initiatives that impact association members." Plaintiffs have been informed that MALA not only knew about the proposed settlement but affirmatively decided not to oppose it.

- Incompass Michigan, a statewide network of human service providers "working to achieve community access and inclusion for all."[12] Its 60+ members include advocacy organizations and provider agencies such as Hope Network, one of the largest provider agencies in Michigan, serving over 34,000 people per year at over 300 locations across the

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7 All of them have now received notice of the Settlement at least through MDHHS's distribution.

8 IMPART Alliance is on the list (with a typographical error, but it did get notice), and Clare Luz is its Executive Director. We address Prof. Luz's declaration (ECF#336-27) in more detail in Point I.B.3 below.

9 The ARC Michigan (ECF#330-1).

10 "Michigan Care Council" was on WCCMH's list but is not included here because it does not appear to exist. WCCMH may have meant the Michigan Care Planning Council, but that entity did not object either.

11 https://miassistedliving.org/.

12 https://incompassmi.org/.

state.[13] Hope Network was itself on WCCMH's list but likewise did not object to the Settlement.

- Beacon Specialized Living, which bills itself as the "leader of specialized adult foster care in Michigan" and the "largest specialized individual service provider in the State of Michigan."[14] It provides services for recipients of all ages, including specialized adult care (which includes CLS).

- Michigan's sixteen Area Agencies on Aging,[15] which administer Michigan's MIChoice Waiver[16] and arrange for subcontractor delivery of services, including CLS.

- Michigan's chapter of the National Alliance on Mental Illness.[17]

- The Association for Children's Mental Health.[18]

But the universe comprises far more than just the entities WCCMH put on its list. As part of its "Independent Rate Model" development in January 2024, Milliman sent out a Wage Survey to provider agencies throughout the State. 558 responses were received (Ex. 1, p 3). Aside from ALS and Renaissance (now

13 https://hopenetwork.org/about.

14 https://beaconspecialized.org/michigan/.

15 https://4ami.org/members.

16 The MIChoice Waiver is what WCCMH's declarant, Chip Johnston, erroneously attached to his declaration (ECF#336-2) instead of the HSW.

17 https://namimi.org/.

18 https://www.acmh-mi.org/.

Pathlight), ***none of the other 556 entities (excluding 28 responding CMHSPs) that sent back survey responses has objected to the Settlement.***

This is not a matter of one or two dogs not barking in the night-time. Virtually every dog in the State has kept quiet.

In contrast, advocacy organizations and parents representing the entire spectrum of Medicaid behavioral and mental health recipients have ***supported*** the Agreement. These include organizations that broadly advocate for all individuals with disabilities, including Michigan Disability Network, the Michigan Disability Rights Coalition, the Michigan Statewide Independent Living Council, and Detroit Disability Power (ECF##330-3, 330-6, 330-9, 331-1); organizations that advocate for individuals with developmental disabilities, including The ARC Michigan, the Michigan Developmental Disabilities Council, and the Michigan Developmental Disabilities Institute (ECF##330-1, 334-1, 331-2); and organizations with highly varied focus areas, including the Autism Alliance of Michigan (ECF#330-2), the Epilepsy Foundation of Michigan (ECF#330-4), the Mental Health Association in Michigan (ECF #330-8), the Michigan Elder Justice Initiative (ECF#330-7), and Michigan United Cerebral Palsy (ECF#331-3). Longtime disability rights advocate Jan Lampman supports the Agreement (ECF#330-5), as does one of Michigan's largest parent groups (or perhaps *the* largest, with over 400 members) (ECF# 350-1). The leaders of that parent group individually submitted declarations (ECF#350-2), as did six

other individual parents (ECF##352-1, 369-1, 316-10-13). And all named Plaintiffs and the associational Plaintiff support the Agreement (ECF#316-5 to -9).

Many of these supporting declarants represent the interests of individuals who are not eligible for the HSW and will not directly benefit from the Agreement. All of them recognize, however, the importance of taking a significant first step to address Michigan's long-existing direct care crisis,[19] and all of them recognize the importance of fixing the problem for those on whose behalf this lawsuit was filed. In recognizing this, many of the supporters heard—and rejected—the anticipated objections of the CMHA and its members, which were circulated and discussed before the supporters submitted their declarations.

To be sure, the declarants' knowledge of the settlement was at least partly informed by outreach led by Disability Rights Michigan, and all of the declarants worked from drafts that had been put together by Plaintiffs' counsel. In choosing what to include and emphasize, however, the declarants made their own choices based on their own lived experiences. The declarants uniformly emphasize the importance of the provisions designed to address recipients' day-to-day interactions with CMHs, with many declarants highlighting provisions of particular significance

[19] Recognizing that the minimum fee provisions will operate as a pilot program for HSW SD CLS, the Michigan Developmental Disabilities Institute, which is based at Wayne State University, expressed interest in studying the effects of the fee schedules to evaluate the potential value of similar fee schedules in other parts of the Medicaid program (ECF#331-2 ¶ 7).

to them. All declarants, for example, emphasize the importance of the Agreement's person-centered-planning and/or costing out provisions as a means to ensure that recipients receive the services in their plans of care. Lampman, the Michigan Elder Justice Initiative, the Mental Health Association in Michigan, and parent Crystal Jackson single out the Medicaid Fair Hearing "hamster wheel" issue that Section C(8) of the Agreement remedies (ECF#330-5 ¶ 9; 330-7 ¶ 8; 330-8 ¶ 11). The Mental Health Association in Michigan highlights the importance of the provisions strengthening self-determination protections and correcting CMHs' persistent person-centered-planning violations (ECF#330-8 ¶ 10). Many other organizations applaud the Agreement's promotion of self-determination (*e.g.* ECF#330-2 ¶ 8; 330-7 ¶ 9; 330-3 ¶ 10; 334-1 ¶ 8).[20]

Taken as a whole, the combined universe of objections to the Settlement and declarations in support of the Settlement presents a stark picture of local bureaucrats and their lobbyist *versus* Medicaid beneficiaries and their long-term advocates. The

[20] Provider agencies have also spoken out against conduct of the Local Defendants' that the Settlement corrects. Katherine Grant, for example, who runs the umbrella organization that includes both a provider agency serving Washtenaw County and Plaintiffs' fiscal intermediary organization, submitted a declaration as part of this action asserting that budgets should be costed out (Attachment C of the Agreement), criticizing WCCMH's punting of amount/scope/duration decisions to the fiscal intermediary (Section C(9)(c)), and condemning WCCMH's practice of targeting CLS through abusive utilization management practices (all person-centered-planning provisions and the related notice and Fair Hearing provisions) (ECF#376-3 PageID13958-13959).

bureaucrats seek to preserve the *status quo*; the beneficiaries and their advocates are thrilled that the State is finally exercising its exclusive power to set Medicaid policy to take a serious and fundamental step addressing the desperate need for services. From the standpoint of the "public interest," we submit, only one side of that equation matters.

B. As Were Local Defendants', Objectors' Asserted Fears of a Catastrophic Effect on Michigan's Medicaid Program Are Wildly Overblown, Speculative, and Unsupported

Much of what we have to say about Objectors' fears of collapse of the Michigan Medicaid provider agencies has already been said in response to Local Defendants (ECF#365 §§ A.2.c(iii), B.2). Local Defendants ignored the tiny fraction of the market affected by the Settlement (maybe $30 million of effect in a market of well over $1 billion). They ignored that the DCW labor market is not closed but has substantial cross-elasticity of supply with the adjacent retail, fast food, and convenience store markets. They ignored that the Settlement is additive, providing new money for SD CLS under the HSW, but not taking a dime away from anyone else. They ignored that the HSW has a limited number of slots, and that people do *not* move on and off the waiver freely. All in all, Local Defendants committed just about every economic mistake one can make in what we shudder to call their "analysis" of the Settlement's potential effects on the DCW market in Michigan.

Objectors repeat those mistakes, but they also make some new ones of their own. In what follows, we will limit the discussion to the new mistakes and merely refer back to our Reply Brief with respect to the old ones.

1. CMHA's "Cost Neutrality" Assertion Is Nonsense: There Is Not Nearly Enough Money at Stake To Have the Effect CMHA Posits

Waivers under section 1915(c) of the Medicaid Act, 42 U.S.C. § 1396n(c), such as the HSW, are for "Home and Community Based Services (HCBS)." The statutory expectation is that community-based care is not only better for the individual than is institutional care but also cheaper for the funder. Accordingly, such waivers "have a cost neutrality requirement, meaning that states must provide assurances that the average per capita expenditures for covered HCBS services will not exceed 100 percent of the average per capita expenditures that would have been made for the level of care provided in an institution."[21] Without providing any evidence at all,[22] CMHA asserts that the Settlement's minimum fee schedules could render Michigan ineligible to continue the HSW, because (CMHA says) the HSW might no longer be cost neutral (ECF#372 PageID13837). CMHA's assertion is nonsense.

A state's "cost neutrality" demonstration is found in Appendix J of CMS's waiver application form. CMHA surely knows this: it is, after all, the lobbyist for

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21 https://www.macpac.gov/subtopic/1915-c-waivers/#.

22 CMHA says that it is "not presently in possession of the data necessary to make [the] comparison" necessary to support its assertion (PageID13837).

the CMHs and PIHPs, which live and die with Michigan's various 1915(c) waivers; CMHA's Executive Director ran a CMH for eighteen years (Ex. 2). The most current HSW renewal application was filed with CMS on September 12, 2024 and is annexed as Exhibit 3 (the "September Draft"). It is an update of the original 2024 HSW renewal application (ECF#365-3 PageID12929-12943) that MDHHS posted for comment on its website on May 2, 2024, well before CMHA filed its objection.

The September Draft lays out the projected number of service units, the average units per waiver user, and the average cost per unit. It does so separately for each waiver service and each of the five waiver years (App. J-2 (4 of 9 through 9 of 9; pages 261 of 275 to 275 of 275)). It then aggregates each waiver year's expected costs and compares those costs to what would be expected in an institution (App. J-1: Composite Overview and Demonstration of Cost-Neutrality Formula, page 258 of 275). The expected waiver costs are in columns 2 and 3 and are summed in column 4. The comparative institutional costs are in columns 5 and 6 and are summed in column 7. The expected difference—the key number for demonstrating cost neutrality—appears in column 8.

The original May 2024 application expressly purported to account for this Settlement,[23] but the State has informed us that the numbers in both the original draft

[23] *See* ECF#365-3 PageID12930 (referencing the cost of the CLS and respite fee schedules to be implemented by this Settlement). The State informs us that

and the September Draft do *not* take the Settlement into account—apparently because the State felt it could not file an application with CMS that did so unless and until the approval process was complete. So some analysis and inference is necessary to show cost neutrality under the Settlement from those documents. But the analysis is a one-way street: Cost neutrality is the only possible answer.

In each Waiver Year, there are 8,268 expected participants (*id*. page 258 of 275). That is the statewide cap on the number of HSW "slots." The average cost difference per slot between the HSW and care in an institutional setting ranges from $50,158.49 in Waiver Year 1 (Oct. 1, 2024-Sept. 30, 2025) to $57,223.75 in Waiver Year 5 (Oct. 1, 2028-Sept. 30, 2029) (*id*.). So the ***smallest*** amount by which the renewed HSW is projected to clear cost neutrality without taking the Settlement into account is ***$414,710,395.32***, which occurs in Waiver Year 1.

What happens if one does take the Settlement into account? Not much. The cost-neutrality leeway approaches ***half a billion dollars***, whereas the Settlement will inject perhaps $30 million into the system (ECF#365 PageID12400). Even if that number were $50 million (to account for OHSS and to be conservative), the HSW would still clear cost neutrality by $365 million. The amount of money involved in the Settlement is simply way too small to have the kind of effect CMHA speculates.

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this was a drafting error—a matter of the drafters of the text getting out ahead of the individuals inserting the numbers.

In any event, the state's actuary has now produced a revised Appendix J-1 that ***does*** take the Settlement into account (Ex. 4).[24] As set forth in that document, the HSW would clear cost neutrality ***under the Settlement*** by anywhere from $47,143 per slot in Waiver Year 1 to $53,499 per slot in Waiver Year 5, or by an aggregate ***minimum*** of ***$389,778,324***.

Cost neutrality is not an issue. Like all of the other issues raised by Local Defendants and Objectors, it is not even close.

2. The Objectors' Fevered Speculations About Impending Labor Market Disaster Are Premised on Multiple Incorrect Assumptions

The Objectors set forth two fundamentally contradictory arguments: (1) the Agreement is bad because it benefits so few people, and (2) the Agreement is bad because it will nevertheless cause Michigan's entire Medicaid system to collapse. CMHA asserts in one breath ***both*** that "only a very small percentage of disabled Michiganders receiving CLS—in some counties, in the *single digits*—would benefit from the proposed settlement" (ECF#372 PageID13836) ***and*** that the Agreement will destroy Michigan Medicaid's entire agency provider market. The Objectors cannot have it both ways.

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[24] The State has authorized us to say the following: Milliman prepared the attached amended J-table that reflects J-table figures that would be in place if the CLS and OHSS minimum fee schedules are implemented. If/when the Court approves the settlement agreement, MDHHS will submit an amended HSW application to CMS with the amended J-table.

As set forth in the Reply Brief (ECF#365 PageID12400-12401), the likelihood of the Agreement's minimum fee schedules having any significant impact on the rest of Michigan's Medicaid program is exceedingly low, precisely because the population impacted by the Agreement represents such a small part of Michigan's Medicaid program, both in dollars and numbers of participants.

In dollar terms, as above, it is simply not possible that injecting $30 million (or even $50 million) of new money into a multi-billion dollar DCW labor market could have any serious untoward effect, let alone the disaster Defendants and Objectors posit.

On numbers of participants, consider Defendant CMHPSM's service region. In FY23 there were only 747 HSW slots[25] in Region 6, and only about 538 of those individuals received unlicensed CLS (ECF#348-2 ¶ 17). Of those 538 HSW CLS recipients, only about 183 received SD CLS (*id*. ¶ 18).[26] CMHPSM's total Medicaid

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[25] HSW slots are capped (*see* ECF#365 PageID12400; ECF#370 PageID13739). Movement on and off the HSW is exceedingly restricted, and there is certainly nothing like the churn that Declarant Eric Kurtz attempts to describe (ECF#372 Ex. F ¶ 18). There is, however, a sick irony about Mr. Kurtz's objection, given that he was at the helm of WCCMH's predecessor as it accumulated the massive budget deficit that led to the service cuts at the root of this lawsuit. https://www.mlive.com/news/ann-arbor/2015/11/where_has_all_the_money_gone_w.html.

[26] The declarations contain similar statistics (*e.g.* ECF#372 Ex. D ¶ 16 (only 23% HSW SD CLS of its SD CLS); ECF#336-5 ¶ 6 ("SCCMHA currently serves 617 CLS cases in total; the SD-CLS-Hab Waiver portion of this total CLS caseload is thirty-five cases (5.6%)").

"plan enrollment" in FY23 was 150,797,[27] meaning that only about ***twelve hundredths of a percent*** of its enrollees stand to receive higher CLS rates under the Agreement. It is simply impossible that 0.12% of enrollees' getting higher CLS rates will cause catastrophic harm to the other 99.88% of Region 6's enrollees.

The Objectors' speculations about negative impact on the non-CLS-SD-HSW labor market, moreover, are premised on at least three incorrect assumptions.

(a) Failure to Account for Market Cross-Elasticity

As set forth in Plaintiffs' Reply Brief and discussed above, the direct care labor market is not a closed market, and movement between direct care positions and non-direct care positions in other markets (particularly the food service and retail industries) is fluid (ECF#365 PageID12398-12399). Economically, this is referred to as "cross-elasticity of supply" between the DCW market and the adjacent food service and retail markets. Clare Luz stresses in the article discussed in Section 3 below that direct care workers "leave their positions for a variety of reasons," including to go "to jobs with fewer and/or more reliable hours and higher pay in other industries such as retail or fast food" (ECF#336-27 PageID10640). Huron Behavioral Health complains that direct care workers "can go and work at a fast-food restaurant or retail store and make more money than they are able to providing direct

[27] FY23 Michigan Managed Care Program Annual Report, p 24 (https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/reportsproposals).

care services" (ECF#372 Ex. B p 2). Provider declarant ALS "is often competing with fast food restaurants and automobile plants for workers" and is "[h]eartbreakingly . . . on the losing end of this fight" (ECF#336-16 PageID10568). And the 2016 Section 1009 report[28] emphasized that "[w]ages are not competitive and do not attract qualified workers with the needed skills or attitude. Target, Wal-Mart, and Costco start employees at higher wages" (Ex. 5, p 14; *see also* p 16).

For purposes of opposing the Settlement, however, the Objectors either ignore this market cross-elasticity or assume that it only goes one way, with workers leaving direct care positions to go to retail or food industries but not vice versa. Indeed, the Objectors uniformly assume that the direct care market is a closed market, and that any new HSW SD CLS workers will consequently only be pulled from similar direct care jobs.[29]

This assumption is all over CMHA's brief and appears throughout the Objectors' declarations (*see, e.g.*, ECF#336-3 ¶¶ 15, 16, 18; ECF#372 Ex. B p 3; Ex. E p

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[28] James Colaianne, CEO of Defendant CMHPSM, was one of the authors of this report. Ex. 5 Appendix 3.

[29] Mr. Colaianne, for example, asserts that

> The workforce of DCWs that provide unlicensed CLS are the same labor pool across our region that provide other direct support professional or aide level services, such as skill building, respite, and licensed residential services (community living supports and personal care) and we fully anticipate that these workers will be unavailable [because of the Agreement] to readily provide those services.

ECF#348-2 ¶ 20 (*see also* ¶¶ (15-16).

2). Indeed, it is built into the boilerplate used in many of the objections: "By limiting the additional funding to those individuals on the Habilitation Supports Waiver who self-direct their CLS service, MDHHS is skewing the labor market away from agency providers (including [insert CMH])-the backbone of the system-and towards self-directed services" (ECF#336-3 to -6, -10 to -15).

The assumption that new HSW SD CLS workers will come only from other direct care positions fails to account for the relevant markets' cross-elasticity of supply. Plaintiffs' expert labor economist put it best when she wrote that "it is hard to imagine that there are no workers employed by nursing homes, retail stores, warehouses, or fast-food restaurants who would not be interested in a CLS job with compensation (wage plus benefits) $3 to $5 more than their current job" (ECF#365 Ex. 12, p 18 n. 36). And Prof. Luz, the Objectors' own proposed expert, cited some of the examples of ***partial*** DCW wage increases recounted in Section 3 below to conclude that "offering higher wages is an essential way to draw ***new*** workers to the profession, reduce turnover, and improve DCWs' economic security" (ECF#336-27 PageID10643) (emphasis added). In short, the Objectors have no basis, much less any evidence, to assume that new HSW CLS SD workers will come only from other

direct care positions.[30] In fact, it is highly likely that new workers will ***enter*** the direct care market as a result of the Agreement's minimum fee schedules.

The Objectors' "31n" analogies (*e.g.*, ECF#372 PageID13839; ECF#336-2 ¶ 17; 336-6 ¶ 16) stand in direct contrast to the situation at hand. "31n" refers to a statewide program to provide in-school counseling services to children with behavioral health issues. Whereas the labor market for direct care workers providing services like CLS is ***open*** and includes many of the same workers as the retail and food service industries, the labor market for *counselors* is much more circumscribed (*see* ECF#372 PageID13839 (the "talent pool for mental health professionals is limited")). Schools, of course, were not hiring 31n staff away from places like Costco or Target, whose employees generally lacked the requisite education, training, and experience. Rather, they could pull only from a limited pool of qualified professionals already working in that particular specialty. The staff who left CMHs to work in schools as a result of the 31n grants were masters-level social workers and clinical staff (ECF#336-2 ¶ 17; 336-6 ¶ 16; *see also* ECF#372 Ex. B p 3).

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[30] Local Defendants offered just a single concrete example (ECF#336-19 ¶ 21) to suggest that agency workers will migrate to HSW SD CLS, and that example is wrong. *See* ECF#365 PageID 12399-12400 (redacted). Objectors offer none of their own but simply point generally to staffing difficulties that long predate the Agreement. *See, e.g.*, ECF#372 PageID13834 ("longstanding DCW shortage crisis") and Exs. A ¶ 5, B p 2, C ¶ 3, D ¶ 3, E p 1, F, ¶ 7; ECF #336-2 ¶ 3; -3 ¶ 3; -4 ¶ 3; -5 ¶ 2; -6 ¶ 1; -7 ¶ 3; -8 ¶ 3; -9 ¶ 3; -10 ¶ 6; -11 ¶ 3; -12 ¶ 4; -13 ¶ 3; -14 ¶ 3; -15 ¶ 3; -16 ¶¶ 24-29; -17 ¶¶ 15-22; ECF#348-2 PageID10802.

The 31n analogies are inapposite for an additional reason. The Objectors themselves stress the several factors ***other than*** higher pay—none of which is present here—that motivated those masters-level social workers and clinical staff to leave CMHs to work in schools. These included working fewer hours (ECF#336-14 ¶ 16; -15 ¶ 14; ECF#372 Ex. B), having summer vacations off (ECF 336-15 ¶ 14), and less demanding work (ECF#372 Ex. B (no longer "required to provide 24/7 emergency services")). Indeed, the purpose of the 31n funding was to "expand the availability of mental health services and supports to K-12 students with mild to moderate mental health issues and provide appropriate referrals for students in need of more intensive services through the Community Mental Health system" (Ex. 6, p 1).

Needless to say, HSW SD CLS workers do not typically get summer vacations, and serving HSW SD CLS consumers is likely to be ***more*** difficult than most other direct care positions. As set forth in Plaintiffs' Reply Brief (ECF#365 PageID 12386-12388), HSW-eligible recipients require an exceptionally high level of care. ALS-LM's bare assertion that "there is no meaningful distinction between individuals who receive their services through HSW, and those who do not" (ECF#336-16

PageID10566), and similar assertions by other Objectors, are unsupported and false.[31]

In fact, ALS and Pathlight themselves have said that they do not serve individuals like Plaintiffs, in large part because they ***are*** so difficult to serve. In its prior declaration, ALS said that it "did not provide services to any consumers in Washtenaw County who lived alone or with their families" (ECF#377-1 ¶ 5). Nor did it provide services "to any consumers who required 1:1 supervision or posed an elopement risk," or who "had physically aggressive tendencies" (*id*. ¶ 6). This description fits Plaintiffs (and many other HSW recipients) to a T. Likewise, Pathlight said in its prior declaration that most of the recipients it serves do not receive 24/7 services (ECF#376-14 ¶ 14), and that it was unsuccessful at providing CLS in family homes in part because it was difficult to find staff for individuals with autism who had "the right skills and demeanor to be effective at their job" (*id*. ¶ 9).

So, too, with the Objectors' assertions about the effect on full-time lower-to-middle-level managers at CMHs, agencies, or group homes. It certainly cannot be assumed that such managers will flock to this highly demanding work, particularly since the hourly wage will be significantly less than the $31/hour that many of the

[31] Likewise, the Objectors' boilerplate about HSW recipients being more affluent, whiter, and/or better supported is not supported in any declaration by any example, data, or even anecdote. And even if it were true, it is the PIHPs and CMHs that are responsible for screening HSW applicants (*see* ECF#365 PageID12396).

Objectors erroneously posit (*see* Section (b) below). The Objectors likewise ignore that at least some CMHs and agency providers provide significant benefits to their full-time employees (*e.g.* ECF#336-3 ¶ 19 (CMHs)). Pathlight, for example, offers health, dental, and life insurance, paid time off, a 401k retirement plan, intensive paid training, flexible work schedules, and advancement opportunities (https://mi-path.org/careers/). HSW SD CLS workers, by contrast, receive none of these benefits (Ex. 5, pp 14-15)). Even if the $31/hour CLS rate turned out to be high enough to cover some employee benefits, the hourly wage for those staff would likely be reduced to a rate below the $25/hour average that ALS says its group home managers make (ECF#336-16 ¶ 6).

(b) Inaccurate Rate/Wage Assumptions

The $31/hour rate in the Settlement is an hourly *service rate*, which must provide for overhead and related direct costs, such as taxes and unemployment. It is ***not*** an hourly *wage.* Many Objectors misapprehend this fundamental distinction, and their errors are compounded by the fact that their comparison rates are all over the map.

CMHA (joined by various members) repeatedly asserts that $31 is an hourly staff wage instead of an hourly service rate (*see, e.g.*, ECF#372 PageID13835 (the Agreement "would raise the ***pay rate*** to $31 per hour for only a small fraction") and 13840 ("the proposed settlement would increase ***pay rates*** by roughly 50-100% (to

$31 per hour) for DCWs who work in that setting while leaving pay rates in other settings unchanged (generally around $14-$23 per hour")))). Saginaw County CMH, to take another example, describes $31/hour as a "wage" (ECF#336-5 PageID 10489), and uses that "wage" to assert that its group home managers will be making $8.57-$12.57 less per hour (*id*. PageID10490).

After accounting for employer costs like taxes and for transportation and activity costs, the hourly wage rate for HSW CLS SD workers will be substantially less than $31/hour (*see* ECF#370, PageID13740). [redacted]

Compounding this disturbing error, the Objectors' comparative figures are all over the map. Thus, to complete CMHA's "state funding currently permits" boilerplate (itself a fallacy, as explained in the next section) some Objectors provide "CLS hourly rates" with no distinction between agencies, SD, state plan, and waivers.[32]

[32] Thus "approximate" or "average" CLS hourly rates" include $25.04 (Mid State Health Network PIHP, ECF#336-10 ¶ 16); $19.76 (Montcalm, 336-4 ¶ 12); $15 (Newaygo, 336-7 ¶ 14); $20.50 (Bay Arenac BH, 336-11 ¶ 12); $26.40 (Health West, 336-13 ¶ 12); $20.50 (Cass County Woodlands, 336-14 ¶ 14); $19.72 (Pivotal, 336-15 ¶ 12) (described as a "H2015 CLS hourly rate," which could include unlicensed CLS under any waiver or the state plan); $22.97 (Centra Wellness Network, 336-2 ¶ 14 (described as a "midpoint CLS hourly rate"); and $20.44 (WCCMH, 336-19 ¶ 9) ("average hourly rate . . . for CLS services"); from $15.50-$17.50/hour (Huron, ECF#372 Ex. B) ("CLS

All but four Objectors[33] also lumped in CLS provided in congregate settings (H2016+T1020 billing code vs. the H2015 billing code for regular CLS).[34] Others offer "self-directed CLS rates" with no distinction between state plan and various waivers.[35] Still others provide only wages paid to CLS agency providers and group home managers.[36] Astonishingly, ***nobody*** gives a comparison service rate or wage figure for HSW SD CLS.[37] And the figures themselves vary wildly between declarants, ranging between $14 and $26.40 per hour.

It is simply impossible to determine what is being compared to what and why, much less to draw any meaningful conclusion from the comparisons. The only thing for sure is that CMHA's boilerplate about the Settlement "providing 40% less funding to agency providers who deliver the exact same CLS service" (*e.g.* ECF#336-4 ¶ 14; -5 ¶ 17; -8 ¶ 16) is wholly unsupported.

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hourly rate"); $21.98 (Shiawassee, *id*. Ex. D ¶ 14); approximately $20.50 (On-Point, *id*. Ex. E, p 2); approximately $20.50 (NMRE, *id*. Ex. F ¶ 17).

33 Three reference self-determination CLS without reference to billing codes, but self-determination cannot generally be provided in congregate or provider-run settings.

34 *See* Footnote 32.

35 These include $14 (Copper Country, ECF#336-3 ¶ 14); $21 (CMHCM, 336-8 ¶ 13); and $17 (Gratiot Integrated Health Network, 336-12 ¶ 15).

36 These are $19.84 FT/$14.13 PT (Van Buren County, ECF#336-9 ¶¶ 14-15 (only CLS agency providers)); $18.43-22.43 (Saginaw, 336-5 ¶ 8) (group home managers).

37 State Defendants describe the rates in WCCMH's Exhibits 3 and 12 as HSW SD CLS rates, but they are not specified as such.

(c) Inaccurate Assumptions About Funding/Capitation Rates

Several Objectors complain about increased expenditures at the local level resulting from the fee schedules. Central Michigan CMH, for example, asserts without explanation that the Agreement will "increase [its] costs by over $1.8 Million annually" (ECF#336-8 ¶ 17). Saginaw says that the Agreement will cause an "unnecessary"[38] increased cost of serving its HSW SD CLS recipients of $1.245 million, apparently based on a comparison between its current recipients' service rates/hours and the Agreement's rate/hours (*id*. at -5 ¶ 6). And OnPoint CMH manages both to get the rate wrong ($32/hour instead of $31/hour) and to give an irrelevant comparison: A $32/hour rate for all self-determination services, it says, will increase its "direct" costs by $272,000 (ECF#372 Ex. E p 3).[39]

None of these Objectors seems to be aware (and certainly none of them acknowledges) that the projected cost of the fee schedules must be accounted for by ***new*** legislative appropriations (*see* ECF#365 PageID12378-12379; ECF#370 PageID13742-13743), and that the State's actuary must certify (and CMS must sign off on the certification) that the new appropriations are sufficient to cover the cost (*id*.) before the minimum fee schedules can even take effect.

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38 Saginaw does not explain what it means by "unnecessary," and the other objections related to "increased expenditures" suffer from a similar lack of clarity and specificity.

39 The fee schedules, of course, apply only to self-determination CLS recipients served under the HSW.

The Objectors also misrepresent the nature of managed care Medicaid and the capitation methodology that funds these services. If the Objectors' wildly disparate comparison rates (*see* Section (b)) demonstrate one thing, it is that service rates can vary dramatically across (not to mention within) CMHs. As the State says, that is how managed care Medicaid works (ECF#370 PageID13741-13742).

In a capitation system, CMHs (through the PIHPs) receive a set amount of money per enrollee ("per capita") prior to providing services, and they are responsible for using that money to provide all medically necessary services. *Waskul et al. v. WCCMH et al.*, 979 F.3d 426, 437 (6th Cir. 2020) ("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."). The capitation rates are developed based on historical costs, current trends, one-time adjustments like fee schedules or direct care wage passthroughs, administrative costs, and certain area-specific factors (*see* Ex. 7, particularly pp. 7 and 25-26). Capitation rates must be approved by the federal Centers for Medicare and Medicaid Services (42 C.F.R. § 438.4(b)), and they must be "projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the [managed care organization]" (42

C.F.R. § 438.4(a)). The state's actuary must, as it has done in the past, propose a rate increase if it becomes apparent during the fiscal year that current rates do not provide for those costs (*see* ECF#365 PageID12411; ECF#370 PageID13743).

The Objectors' references to "prevailing rates" (ECF#372 PageID13837) are nonsensical in a system where rates are ***not*** set Statewide but only at the local level, and where State funding must be certified (with CMS signoff) to be sufficient for the PIHPs and CMHs to set rates necessary to meet expected costs. Indeed, the Objectors' repeated assertions that "MDHHS's funding permits a [rate of x]" are essentially meaningless in a capitated payment system. To the extent they do have meaning, they are contrary to the local and regional entities' obligations as managed care entities to pay the rates necessary to provide medically necessary services.

3. The Objectors' Assertion That Recipients Whose Direct Care Workers Do Not Receive a Wage Increase Will Be Harmed Is Unsupported and Contradicted By Their Own Proposed Expert's Article

The centerpiece of CMHA's argument is the proposition that, if Michigan increases wages for a small section of Michigan's direct care workers, recipients who rely on other direct care workers will be harmed (ECF#372 PageID13834, 13840). Nearly all the CMH and PIHP declarants make the same assertion (*e.g.* ECF#336-3 ¶ 11; -4 ¶ 9; -5 ¶ 12; -6 ¶ 7; -7 ¶ 11; -8 ¶ 10; -9 ¶ 9; -10 ¶ 13; -11 ¶ 9; -12 ¶ 10; -13 ¶ 9; -14 ¶ 11; -15 ¶ 9; ECF#372 Exs. B pp 2-3; C ¶ 9; D ¶ 11; F ¶ 14).

The sole support for this proposition (other than the Objectors' wildly disparate and inaccurate rate comparisons and alleged feedback from unidentified and non-objecting agency providers) is one paragraph in the declaration (ECF#336-27) of Prof. Clare Luz of Michigan State University:

> Based on my decades of research and experience with DCW policy, a statewide, strategic, coordinated approach to addressing the DCW shortage is critical. It is my opinion, that it will not work to train some workers and not others, to give some workers a raise and not others. Evidence indicates that the opposite is true. A fragmented Band-aide approach perpetuates the problem. It undermines our common goals to increase wages, competency, and recruitment and retention rates for all DCWs. It consequently leads to uneven, unequal care for those in need of supportive services.

This paragraph says that, in Professor Luz's opinion, fixing Michigan's direct care shortage cannot be accomplished without addressing *all* direct care workers.[40] This "proves" far too much.

The direct care industry is enormous and encompasses far more than Medicaid-funded community-based behavioral health services. Professor Luz would appear to require an approach that fixes the crisis for ***all*** direct care services in ***all*** sectors *(e.g.*, Medicaid and non-Medicaid; schools, institutional settings (expressly including hospitals and nursing homes; *see* ECF#336-27 Page-ID10639), and

[40] Any "uneven, unequal care" resulting from fixing part of a problem is not, as the Objectors claim, the same as ***worse*** care ***resulting*** for those whose problem wasn't fixed; it is merely a recognition that some service recipients' situations may be improved while others' may not.

community-based settings; therapy services (masters degree), psychiatry services (medical degree), personal care services (high school or GED), etc.) where direct care is provided. This, of course, is wildly impractical, as the State has cogently demonstrated (ECF#370 PageID13724-13725). Nor would Local Defendants' or CMHA's desired rewritings of the Agreement, to the extent that they can be ascertained,[41] even come close to doing what Professor Luz says must be done. Rejecting a significant fix to a state's Medicaid program because it does not address every direct care worker in the state is—what? Patently absurd? Too mild. Adjectives fail us.

Professor Luz's assertions are pure *ipse dixit*. Despite writing that "evidence indicates that the opposite is true," no such evidence is cited in the declaration. Instead, Professor Luz highlights a section of an article she wrote asserting that raising wages in one direct care sector causes workers to leave lower paying direct care sectors (ECF#336-27 PageID10642). Like Professor Luz's declaration, however, ***the highlighted section of the article does not contain a single supporting citation.*** This is a remarkable omission given that the article is otherwise chock-full of 127 citations. And, as set forth below, the highlighted section is directly contradicted by

[41] Though vague as to what exactly they would like done instead, Defendant WCCMH wants some alternative that "treats all of [MDHHS's] behavioral-health recipients equally" (ECF#336 PageID10198), and CMHA and its members appear to be concerned almost exclusively with Medicaid-funded CLS services provided by agency providers.

much of the rest of the article. In short, Professor Luz's "opinion" is exactly the sort of "unsupported speculation" that does not "rest[] upon a reliable foundation" and consequently cannot be considered "reliable." *In re Scrap Metal Antitrust Litig.*, 527 F.3d 517, 529-30 (6th Cir. 2008).

The article emphatically does *not* support an "all-or-nothing" approach. It cites ***approvingly*** numerous examples of states taking initiatives that benefit only ***some*** direct care workers. Colorado, for example, increased Medicaid payments for home-based care (ECF#336-27 PageID10644). New Jersey increased the minimum wage for certified nurse aides working in nursing facilities, and it increased nursing facility rates by 10% (*id*.). One California county offered health insurance only to direct care workers providing at least 45 hours per month of care as In Home Support Service providers (*id*. at 10645). Connecticut gave home health agencies an extra 1% reimbursement rate if staff participated in racial equity training (*id*. at PageID 10649). Massachusetts provided signing bonuses to residential care facility staff for working a certain number of hours in their first month of employment (*id*. at PageID 10651).

Not one of those situations is described as negatively affecting any other part of the direct care market.

Likewise, the article applauds multiple states for taking actions that benefited only DCWs ***serving self-directed recipients***. Connecticut authorized collective

bargaining for Personal Care Assistants working under the state's self-directed services model,[42] which dramatically increased those workers' wages and benefits (*id*. PageID10645). Virginia passed a paid sick leave law that applied only to DCWs serving self-directed Medicaid recipients (*id*. at PageID10650). And Connecticut created a new system to deliver personal protective equipment to households self-directing services under its Community First Choice program (*id*.).

Wage or benefit increases for direct care workers in just one part of the Medicaid program are in fact quite common. A WCCMH contractor, the Center for Health and Research Transformation,[43] recently noted that at least six states have provided overtime pay specifically for DCWs working in self-directed arrangements (Ex. 8, p 3). Minnesota implemented a training program that offered a 7.5% enhanced wage rate for self-directed consumers and Personal Care Assistants (*id*. at 4), and it created a new self-directed Medicaid program and then set minimum wages specifically for that program.[44] And Pennsylvania set a fee schedule rate for a single procedure code to provide for a wage increase for direct care workers providing

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42 https://insideinvestigator.org/connecticut-legislature-passes-19-3-million-pca-labor-agreement/.

43 https://chrt.org/.

44 The article is linked in Professor Luz's article. https://www.chcs.org/media/Strengthening-the-Direct-Care-Workforce-Scan-of-State-Strategies.pdf, at p 3.

agency-directed personal assistance services."[45] Indeed, the vast majority of the wage pass-throughs surveyed in the report cited in Professor Luz's footnote 53 were ***not*** across states' entire Medicaid programs, much less across states' entire direct care populations.[46]

The Luz article supports Plaintiffs far more than it does the Objectors, and it directly contradicts the opinion on which the Objectors purport to rely. Whether the Court strikes the declaration under *Daubert* (we recognize there is no jury in the box) or merely gives it the zero weight it deserves, the result is the same.

II. THE AGREEMENT IS DIRECTLY IN LINE WITH THE STATE'S LONGTIME POLICY GOAL OF PROMOTING SELF-DETERMINATION

A. The Opposition's Hostility Toward Self-Determination Is Directly at Odds With the State's Policy Goals

The Objectors nearly unanimously complain that this Settlement "skews" in favor of self-determination,[47] baldly proclaiming that "[t]his is not what the State

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45 This article is linked in Professor Luz's footnote 53 (relating to "action areas" that Professor Luz and her colleagues support). https://ihje.org/wp-content/uploads/2024/02/2.28.24-Wage-Pass-Through-Law-Final-Report_Institute-of-Healing-Justice-and-Equity.pdf, p 47.

46 Indiana, for example, passed a law to increase the wages of direct care workers providing home and community-based services under one Medicaid waiver program (p 20). Illinois increased wages for workers who provide services through Illinois Medicaid's Community Care Program, which focuses on preventing institutionalization for individuals 60 or older who have or are at risk for developing Alzheimer's and related conditions (p 18).

47 ECF#336-2 ¶ 15, -3 ¶ 15, -4 ¶ 13, -5 ¶ 16, -6 ¶ 11, -7 ¶ 15, -8 ¶ 14, -9 ¶ 17, -10 ¶ 17, -11 ¶ 13, -12 ¶ 17, -13 ¶ 13, -14 ¶ 15, -15 ¶ 13, -16 ¶ 37; ECF#372 Ex. C ¶13, Ex. D ¶ 15, Ex. E p 2, Ex. F ¶ 18.

intended when de-institutionalization happened." ECF #336-16 ¶ 37. To the contrary, building self-determination demand and capacity has been the State's policy goal for decades.

In the late 1990s, the State started a small self-determination pilot program within four CMHSPs, including Defendant WCCMH's predecessor. ECF#365-2 (HSW 2019 at 161); Human Services Research Institute, The Robert Wood Johnson Foundation Self-Determination Initiative: Final Impact Assessment Report November 2001 p 97.[48] Since then, self-determination has expanded statewide. In keeping with its long existing policy of promoting self-determination, MDHHS has set targets in the current and forthcoming waiver applications designed to significantly *increase* the number of HSW recipients using self-determination, from 1,435 to 1,744 between 2019 and 2024 and from 2,001 to 2,262 between 2025 and 2030. HSW 2019 at 172; Ex. 3 (HSW 2025 at 180). Far from being merely "an alternative option for [a] minority of individuals," ECF #336-16 ¶ 37, self-determination has become a core HSW feature, and it is now *agency providers* who are considered an "alternate" delivery method.[49]

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48 Accessible at https://www.hsri.org/files/uploads/publications/767aRWJFinalImpactAssessmentReport_2.pdf.

49 "The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria." HSW 2019 at 163; HSW 2025 at 169-170.

By promoting self-determination in this Settlement, MDHHS is acting completely consistently with its longstanding policy priorities. The objecting PIHPs and CMHs may not like it, but it doesn't matter whether they like it: only MDHHS is entrusted with Medicaid policy-making authority. *See* 42 C.F.R. § 431.10(e).

B. The Objecting PIHPs And CMHSPs Are Responsible for Providing The Supports Necessary To Make Self-Determination Work for Everyone

Many of the objecting PIHPs and CMHs stress the responsibilities of self-determination, arguing that many individuals lack the supports necessary to use that arrangement.[50] The responsibility for providing the supports necessary for recipients to access self-determination, however, lies solely with the PIHPs and CMHs, and the expectation is that ***every*** recipient should be able to use self-determination if they choose. Thus, for individuals who do not have the resources or support necessary to manage self-determination alone, PIHPs and their subcontracting CMHs are responsible for providing "many options for participants to obtain assistance and support in implementing their arrangements." HSW 2019 at 162, HSW 2025 at 168. These supports include supports brokers (*see* ECF#365 PageID12396-12398) and fiscal intermediaries (*id*. at 12415-12416).

[50] ECF#336-2 ¶ 8, -3 ¶ 9, -4 ¶ 8, -5 ¶ 11, -6 ¶ 6, -7 ¶ 9, -8 ¶ 8, -9 ¶ 8, -10 ¶ 11, -11 ¶ 8, -12 ¶ 9, -13 ¶ 8, -14 ¶ 9, -15 ¶ 8; ECF#372 PageID13855, 13861, 13868, 13874, 13881.

Supports brokers in particular can play a significant role in helping recipients navigate self-determination: among other things, they help determine how resources will be spent, help recruit staff, and help recipients manage budgets and ensure proper service documentation. *See* ECF#365 PageID12397. A 2022 survey[51] of CMHs, however, revealed that 76-78% of responding CMHs ***never*** use supports brokers during IPOS development or during IPOS implementation. Only 2.4% reported using them "frequently," while 11-15% reported using them "occasionally" and roughly 5-10% reported using them "rarely." 24 CMHs—including Defendant WCCMH and Objectors Montcalm, Saginaw, Newaygo, Genesee, Lapeer, Sanilac, St. Clair, and Pivotal—reported that supports brokers are "not available" and "never" used in IPOS development. Objectors Macomb, Bay-Arenac, and Woodlands responded that supports brokers are "never" or "rarely" used in IPOS development. And supports broker usage in IPOS monitoring is similarly dismal across the objecting CMHs.[52] These same CMHs now attempt to oppose the Settlement by arguing that self-determination is too hard for most recipients.

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51 Safeguards in Conflict-Free Service Planning (tbdsolutions.github.io), also attached as Ex. 9. These percentages appear in the bar graph titled "How Often do CMHs Indicate Using Resources During The IPOS Process?"

52 18 responding CMHs, including Defendant WCCMH and Objectors Montcalm, Saginaw, Newaygo, Van Buren, and Gratiot, have no supports brokers available for IPOS monitoring. Objectors Woodlands and Pivotal further distinguished themselves by reporting the use of ***no*** "safeguards" at all (including supports brokers) during IPOS monitoring.

In addition to being responsible for causing the problem they complain of (to the extent that such a problem exists), the Objectors manage to offer only a single concrete example of a recipient rejecting self-determination, which itself is not based on personal experience but on what the declarant "heard from other families." And if the Objectors had given that example more thought, they may well have decided against including it.

Jill Barker—the mother of a recipient served by Defendant WCCMH and, incidentally, the only beneficiary or parent of a beneficiary to oppose the Settlement—describes in her declaration why she believes self-determination would not to be a good fit for her family. ECF#336-24 PageID10617. Ms. Barker does not assert that she ever tried self-determination; nor does she appear to be aware (understandably) of the many supports that PIHPs and CMHs are supposed to make available to relieve some of the responsibilities (hiring staff, bookkeeping, etc.) that she describes. But the main problem for Ms. Barker does not appear to be those normal, day-to-day responsibilities, but rather that, "[i]n addition to these duties, the family member is responsible for being the "natural support" for the disabled individual: the back-up if a care worker doesn't show up or if there are insufficient funds to meet the individual needs of the disabled individual." *Id*.

In other words, Ms. Barker's main issue with self-determination is precisely what this Settlement aims to redress. The purpose of the minimum fee schedules, or

Schedule C in the alternative, is to ensure that there ***are*** sufficient funds "to meet the individual needs of the disabled individual," so that natural supports need ***not*** be compelled to step in. It was the very insufficiency of Plaintiffs' budgets and the resulting need to provide significant, involuntary natural supports that led Plaintiffs to file this lawsuit. And it is, at least in part, WCCMH's reprehensible and blatantly illegal practice of compelling natural supports (*see, e.g.*, ECF#316 PageID9425-9426) that informs the Settlement's enhanced person-centered-planning protections.[53]

If recipients have trouble successfully using self-determination, it is the objecting CMHs and PIHPs themselves that are to blame. They fail to make available supports that would ensure access for everybody, and they force parents into the role of involuntary natural supports when they fail or refuse to provide sufficient budgets for recipients to find and retain staff. This Settlement cannot fix all problems, but it certainly fixes the latter one, and the cause of that problem should not be permitted to stand in the way of its solution.

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[53] As for workers not showing up (which happens regardless of service modality), self-determination policy requires "a staffing back-up plan, which "must ensure delivery of critically medically needed services to continue without interruption." Ex. 10, p 12. The CMHSP is responsible for, among other things, providing support and counsel with staff call-in and back-up staffing plans. *Id*. at 15.

CONCLUSION

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

Respectfully submitted,

/s/ Nicholas A. Gable (P79069) /s/ Edward P. Krugman

November 1, 2024

CERTIFICATE OF SERVICE

This 1st day of November, 2024, I filed the foregoing in the Court's electronic filing system, which will effect service on all counsel of record in this action.

Dated: November 1, 2024

/s/ Nicholas A. Gable
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