STATE OF MICHIGAN

COURT OF CLAIMS

REGION 10 PIHP, SOUTHWEST MICHIGAN BEHAVIORAL HEALTH, MID-STATE HEALTH NETWORK, ST. CLAIR COUNTY CMHA, INTEGRATED SERVICES OF KALAMAZOO AND SAGINAW COUNTY CMHA,

Plaintiffs,

v

STATE OF MICHIGAN, STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, and STATE OF MICHIGAN DEPARTMENT OF TECHNOLOGY, MANAGEMENT, AND BUDGET,

Defendants.
_____ /

Consolidated Case Nos. 25-000143-MB and 25-000162-MB

Hon. Christopher P. Yates

CENTRA WELLNESS NETWORK, NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY, WELLVANCE, GOGEBIC COMMUNITY MENTAL HEALTH AUTHORITY, NORTH COUNTRY COMMUNITY MENTAL HEALTH AUTHORITY, and MANISTEE COUNTY,

Plaintiffs,

v

STATE OF MICHIGAN, STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, and STATE OF MICHIGAN DEPARTMENT OF TECHNOLOGY, MANAGEMENT, AND BUDGET,

Defendants.
_____ /

OPINION AND ORDER DENYING DEFENDANTS' MOTION FOR SUMMARY DISPOSITION UNDER MCR 2.116(C)(10) AND GRANTING, IN PART, PLAINTIFFS' REQUEST FOR SUMMARY DISPOSITION PURSUANT TO MCR 2.116(I)(2)

On October 14, 2025, this Court issued an opinion and order granting, in part, defendants' summary disposition motion, ruling that Michigan law allows defendant, the Michigan Department of Health and Human Services (MDHHS), to transition from a single-source procurement system to a competitive procurement system. The Court further determined that the MDHHS may reduce the number of prepaid inpatient health plan (PIHP) regions from ten to three. But the Court denied defendants summary disposition on the question of the legality of the terms in the 2025 request for proposal (RFP) that the Michigan Department of Technology, Management, and Budget (DTMB) issued on behalf of the MDHHS to effectuate that transition because the record was insufficient to decide whether the RFP conflicts with Michigan law and impairs the ability of community mental health service programs (CMHSPs) to carry out their statutorily-mandated duties. To address that question, the parties conducted discovery on an expedited basis, and they were joined by additional plaintiff-CMHSPs, which sued the same defendants in a separate complaint filed in case number 25-000162-MB.[1] The parties presented arguments and evidence at a three-day hearing that began on December 8, 2025.[2]

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[1] The plaintiffs in case number 25-000162-MB include Manistee County and numerous CMHSPs, including: Manistee-Benzie Community Mental Health d/b/a Centra-Wellness Network; AuSable Valley Community Mental Health Authority d/b/a Wellvance; Gogebic Community Mental Health Authority; Northeast Michigan Community Mental Health Authority; North Country Community Mental Health Authority. They filed their lawsuit against the State of Michigan, the MDHHS and the DTMB. The two cases were consolidated through a stipulated order of consolidation entered on November 26, 2025.

[2] The Court permitted the parties to present testimony as well as other evidence and oral argument because plaintiffs had requested a preliminary injunction in addition to declaratory relief regarding the actions of the MDHHS.

Based on the record developed by the parties, the Court shall deny summary disposition to defendants and grant plaintiffs partial summary disposition coupled with a declaration that the RFP violates Michigan law by inhibiting the CMHSPs from fulfilling numerous statutory mandates set forth in the Michigan Mental Health Code, MCL 330.1011 *et seq*. But the Court shall decline, at this time, to issue an injunction barring the MDHHS and the DTMB from selecting PIHPs through a competitive-bidding process or requiring specific action with respect to the 2025 RFP. The RFP must be brought into compliance with Michigan law, which requires, at a minimum, that sufficient Medicaid funds must be allocated to CMHSPs to allow them to perform their statutorily-mandated obligations through financial contracts with other providers. Whether compliance with Michigan law should be achieved through a notice of deficiency, an amended RFP, or a pull-back of the RFP is a matter that the Court must leave to defendants.

I. FACTUAL BACKGROUND

The underlying facts are set forth in the October 14, 2025 opinion and order.[3] The primary issue requiring further consideration is the relationship among the MDHHS, the CMHSPs, and the PIHPs in the provision of mental-health services to Medicaid and non-Medicaid beneficiaries.

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[3] After the Court issued its October 14, 2025 opinion and order, the parties submitted briefing prior to the hearing on December 8, 2025. Defendants cited the doctrines of ripeness and standing as defenses to plaintiffs' claims. Those defenses challenge the justiciability of plaintiffs' claims, but both lack merit. Specifically, ripeness attacks justiciability based on timing because "[a] claim is not ripe if it rests upon contingent future events that may not occur as anticipated, or may not occur at all." *Citizens Protecting Mich's Constitution v Secretary of State*, 280 Mich App 273, 282; 761 NW2d 210 (2008), aff'd in part, appeal denied in part, 482 Mich 960 (2008). In contrast, "the standing inquiry focuses on whether a litigant is a proper party to request adjudication of a particular issue[.]" *Lansing Sch Ed Ass'n v Lansing Bd of Ed*, 487 Mich 349, 355; 792 NW2d 686 (2010) (quotation marks and citations omitted). Plaintiffs were under contract with either a PIHP or the MDHHS to offer services that are the subject of the 2025 RFP, and their claims are based on an actual or alleged inability to continue doing so under the 2025 RFP. The instant case is not

Both the MDHHS and the CMHSPs play leading roles in providing mental health services in Michigan. As explained in the opinion and order, the MDHHS is responsible for "support[ing] the use of Medicaid funds for specialty services and supports for eligible Medicaid beneficiaries" that "shall be managed and delivered by specialty prepaid health plans chosen by [the MDHHS]." MCL 400.109f. The MDHHS must "continually and diligently endeavor to ensure that adequate and appropriate mental health services are available to all citizens throughout the state." MCL 330.1116(1). To this end, the MDHHS "shall" "[d]irect services to individuals who have a serious mental illness, developmental disability, or serious emotional disturbance," prioritizing those who have the "most severe forms of mental illness, serious emotional disturbance, or developmental disability" and who "are in urgent or emergency situations." MCL 330.1116(2)(a). The MDHHS must carry out that duty by including promotion and maintenance of "an adequate and appropriate system of [CMHSPs] throughout the state." MCL 330.1116(2)(b). "[I]t shall be the objective of the [MDHHS] to shift primary responsibility for the direct delivery of public mental health services from the state to a [CMHSP] whenever the [CMHSP] has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for . . . that service area." MCL 330.1116(2)(b).

CMHSPs play a crucial role not only as a direct provider of mental health services, but also in management or coordination of such care. Created pursuant to the Mental Health Code, MCL

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like *UAW v Central Mich Univ*, 295 Mich App 486; 815 NW2d 132 (2012), in which the plaintiff was found to lack standing to challenge procedures that existed solely in draft form. The 2025 RFP at issue in this case is final, bids were submitted months ago, and the results of the 2025 RFP will be contracts that significantly alter funding and services that the plaintiffs are authorized to provide to Medicaid beneficiaries in their geographic regions. Thus, plaintiffs' claims are ripe for review, and the CMHSPs have a sufficient interest in their claims to provide standing.

330.1204, CMHSPs are governmental entities, formed by one or more counties, with policies and procedures set by the CMHSP's board or the board of commissioners in the CMHSP's counties. MCL 330.1204(1), (2); MCL 330.1204a; MCL 330.1205. Each CMHSP receives an annual, direct appropriation through a general fund contract with the MDHHS, which each CMHSP can use for services for Medicaid or non-Medicaid beneficiaries. General fund allocations account for only a small portion of the budget through which CMHSPs provide services in their geographic regions, which include both Medicaid and non-Medicaid-eligible consumers.

A CMHSP is required by Michigan law "to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay." MCL 330.1206(1). Such services "shall include, at a minimum, all of the following":

> (a) Crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service that is prepared to respond to a person experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment.
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> (b) Identification, assessment, and diagnosis to determine the specific needs of the recipient and to develop an individual plan of services.
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> (c) Planning, linking, coordinating, follow-up, and monitoring to assist the recipient in gaining access to services.
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> (d) Specialized mental health recipient training, treatment, and support, including therapeutic clinical interactions, socialization and adaptive skill and coping skill training, health and rehabilitative services, and pre-vocational and vocational services.
>
> (e) Recipient rights services.
>
> (f) Mental health advocacy.
>
> (g) Prevention activities that serve to inform and educate with the intent of reducing the risk of severe recipient dysfunction.
>
> (h) Any other service approved by the [MDHHS]. [MCL 330.1206(1).]

CMHSPs must fulfill that obligation for both Medicaid and non-Medicaid recipients. In fact, CMHSPs are prohibited from denying services because a person is financially unable to pay. MCL 330.1208(4). And CMHSPs are statutorily authorized to bill Medicaid or other appropriate payers for the services. MCL 330.1202(2). Indeed, CMHSPs do not often know whether a person in need of services is covered by any third-party payor, including Medicaid.

The Mental Health Code recognizes that CMHSPs may contract with service providers for the services described above. This is evident in Section 206a, which requires that recipients must be afforded an opportunity to request mediation "to resolve a dispute between the recipient . . . and the [CMHSP] or *other service provider under contract with the* [*CMHSP*] related to planning and providing services or supports to the recipient." MCL 330.1206a(1) (emphasis added). There is good reason to believe that that applies to Medicaid recipients because that same section provides that the right to mediation does not preclude a recipient from pursuing other forms of alternative resolution, including "the state Medicaid fair hearing[.]" See MCL 330.1206a(6).

Further support for the right of CMHSPs to contract with service providers can be gleaned from the CMHSPs' duty to furnish at least a plan for services to individuals prior to their release to an appropriate community placement. Section 209a of the Mental Health Code makes clear that that CMHSPs, "with the assistance of the state facility or licensed hospital under contract with" a CMHSP, "shall develop an individualized prerelease plan for appropriate community placement and a prerelease plan for aftercare services appropriate for each resident" unless a state facility fulfills that duty. MCL 330.1209a(1). CMHSPs may contract with a service provider to carry out that duty, including a "licensed hospital under contract with a [CMHSP] or state facility," and the CMHSP must offer prerelease planning services and "develop a release plan in cooperation with

the individual unless the individual refuses this option." MCL 330.1209a(2), (3). The plan has to be prepared "within 10 days after release." MCL 330.1209a(4). The directors of CMHSPs find it impractical, if not impossible, to fulfill that duty without the ability to negotiate a financial contract with other providers that applies to services afforded to Medicaid recipients. Payment of funds is the consideration promised in exchange for ensuring each provider's cooperation with CMHSPs.

The Mental Health Code also requires CMHSPs to have "a written interagency agreement in place for a collaborative program to provide mental health treatment and assistance" to "persons with serious mental illness" who are involved in the criminal justice system. MCL 330.1207a(1). A CMHSP, rather than the MDHHS or a PIHP, is a required party to each interagency agreement, and the mandatory components of an interagency agreement include "(a) Guidelines for program eligibility, . . . (c) Day-to-day program administration, . . . (g) Resource sharing between the parties to the interagency agreement, (h) Screening and assessment procedures, (i) Guidelines for case management, . . . [and] (m) Procedures for first response to potential cases, including response to crises." MCL 330.1207a(3). Counties are not required to provide funds for the program except to the extent appropriated annually by the Legislature. MCL 330.1207a(7). The statute provides no release of this obligation for people within the CMHSP's duties who are recipients of Medicaid.

A similar situation exists with respect to the CMHSPs' duties for preadmission screening. The Mental Health Code permits CMHSPs to enter into contracts with hospitals and other agencies qualified to serve those needing urgent and emergent care. It also requires CMHSPs to coordinate with providers both before and after the provision of services. CMHSPs must "establish 1 or more preadmission screening units with 24-hour availability to provide assessment and screening for individuals being considered for admission into hospitals, assisted outpatient treatment programs,

or crisis services on a voluntary basis." MCL 330.1409(1). CMHSPs may satisfy that requirement by employing mental health service professionals or contracting with another agency with similar qualifications. MCL 330.1409(1). The duties extend beyond screening to mandate coordination with the various entities involved in the person's care. To address the needs of the individual being screened, the CMHSP "shall assess an individual being considered for admission into a hospital operated by [the MDHHS] or under contract with" the CMHSP. And if the individual is clinically suitable for hospitalization, the "preadmission screening unit shall authorize voluntary admission to the hospital." MCL 330.1409(3). A hospital that receives a person taken into protective custody who has been referred by a CMHSP's preadmission screening unit "shall notify the unit of the results of an examination of that individual conducted by the hospital." MCL 330.1427(3).

When an individual does not meet the requirements for hospitalization, the "preadmission screening unit shall ensure provisions of follow-up counseling and diagnostic and referral services if needed." MCL 330.1427(1). The preadmission screening unit is also responsible for providing "information regarding alternative services and the availability of those services" and "making appropriate referrals" to individuals who are found not clinically suitable for hospitalization. MCL 330.1409(5). A CMHSP's preadmission screening unit may also operate a crisis stabilization unit pursuant to MCL 330.1971 *et seq.*, followed by the "clinically appropriate level of care" including referrals to outpatient services, a partial hospitalization program, a residential treatment center, an inpatient bed, or an order for involuntary treatment. MCL 330.1409(7).

Even in the case of voluntary admissions, the CMHSP's preadmission screening unit must authorize admission to a hospital or an outpatient treatment program. Specifically, MCL 330.1410 states that "an individual who requests, applies for, or assents to either informal or formal voluntary

admission to a hospital or outpatient treatment program operated by [MDHHS] or a hospital or outpatient treatment program under contract with a [CMHSP] may be considered for admission by the hospital or outpatient treatment program only after authorization by a [CMHSP] preadmission screening unit." MCL 330.1410.

Ensuring that people receive the benefit of the recipient rights legislation is also within the purview of the CMHSPs. Chapter 7 of the Mental Health Code, MCL 330.1700 *et seq.*, identifies numerous rights that must be afforded to the recipients of mental health services. A CMHSP must "establish an office of recipient rights," MCL 330.1755, which shall have "unimpeded access" to programs and services offered by the CMHSP or licensed hospitals, staff employed under contract with the entities, and evidence needed to "conduct a thorough investigation or fulfill its monitoring function." MCL 330.1755(2)(a), (d)(*i*)-(*iii*). In addition, "[e]ach contract between the [CMHSP] or licensed hospital and a provider" must ensure each provider and its employees receive recipient rights training and that recipients are "protected from rights violations while they are receiving services under the contract." MCL 330.1755(2)(f). The office of recipient rights must "[p]rovide or coordinate the protection of recipient rights for all directly operated or contracted services" and ensure that recipients have access to summaries of such rights and that records are maintained of "reports of apparent or suspected violations of rights within the [CMHSP] system or the licensed hospital system." MCL 330.1755(5). CMHSPs are responsible for site visits and ensuring that people within the CMHSP, "contract agency, or licensed hospital" are trained on recipient rights protection. MCL 330.1755(5)(f). The board of the CMHSP is responsible for reviewing an annual report on the status of recipient rights within its community. MCL 330.1755(6).

CMHSPs are obligated to furnish all recipients with a "choice of physician or other mental health professional" in accordance with the policies of the CMHSP, licensed hospital, or "service provider under contract with the [CMHSP]." MCL 330.1713. Also, CMHSPs must "ensure that appropriate disciplinary action is taken against" entities or individuals who "have engaged in abuse or neglect" of recipients of mental health services. MCL 330.1722. Under that statute, CMHSPs are regarded as akin to the MDHHS, licensed hospitals, and service providers under contract with the MDHHS or the CMHSP. MCL 330.1722(2).

Defendants issued the challenged RFP on August 4, 2025, proposals had to be submitted by October 6, 2025, and contracted services are scheduled to begin on October 1, 2026. During the hearing, MDHHS representatives testified that the operational aspects of the RFP have not yet been worked out. By its terms, the RFP requires that bidders must be either a nonprofit, a public body or governmental entity, or a public university, and its proposal must provide services to one of three regions of the state, "not by individual counties." According to the RFP, "[b]idders must demonstrate the ability to be fully operational across the entire geographic area of the region for which they are submitting a proposal. Bidders that cannot provide services throughout the entire region will not be considered." Further, defendants have the right to discontinue the RFP process "at any time for any or no reason," or to "[a]ward multiple, optional-use contracts, or award by Contract Activity." The RFP affects between $5 and $6 billion in state-administered funding.

The successful bidder for each of the three regions is to serve as the PIHP with the sole and nondelegable right to provide managed care functions to Medicaid beneficiaries, except CMHSPs may authorize inpatient admissions through preadmission screenings. As Section 1.1 of the RFP explains:

> Contractors are expected to provide managed care functions to beneficiaries. Those functions cannot be delegated to contracted network providers with the exception of Preadmission screening for emergency intervention services per Mental Health Code MCL 330.1409 which shall be performed by the CMHSP with Contractor authorization of inpatient admissions as indicated by the preadmission screening unit. Managed care functions include, but are not limited to, eligibility and coverage verification, utilization management, network development, contracted network provider training, claims processing, activities to improve health care quality, and fraud prevention activities. . . . Contractor may not directly provide or deliver health care services beyond these managed care functions.

The contractor is responsible for managing the Specialty Behavior Health Services population in one of three regions and serving beneficiaries eligible for Medicaid Specialty Behavioral Services in the service area identified in the contract. The contractor must ensure that "the residential (adult foster care, specialized residential, providers owned/controlled) and non-residential services (skills building, community living supports, and out of home non-vocational)" furnished to individuals supported by several federal and state programs "maintain a home and community character setting as required by federal regulation and outlined in the HCBS Section of the Medicaid Provider Manual."

The RFP places responsibility on each contractor to pay service providers and to establish, maintain, and evaluate an effective provider network. But the "Contractor remains the accountable party for the Medicaid beneficiaries in its service area." According to the RFP, the contractor is "responsible for development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this Contract." When subcontractors are employed to do the work, the contractor must adhere to applicable provisions of the federal procurement requirements.

The contractor is responsible for "medically necessary community-based SUD treatment services for individuals under the supervision of the [Michigan Department of Corrections]" who

are "typically under parole or probation orders." Those "referred by court and services through local community corrections (PA 511) systems must not be excluded from these Medicaid/Healthy Michigan program funded medically necessary community-based behavioral health and SUD treatment services." With respect to those services, the contractor is "solely responsible for the composition, compensation, and performance of its contracted provider network." The contractor is also required to "develop and implement a transition of care policy," as well as the provision of "certain enhanced community support services for those beneficiaries in the service area who are enrolled in one of three Michigan's 1915(c) HCBS Waivers."

The RFP also requires the contractor to provide substance abuse home health services and behavioral health services that consist of "comprehensive care management and coordination" to Medicaid beneficiaries with serious mental illness or substance use disorders. The substance use and behavioral health services are the "central point of contact for directing patient-centered care across the broader health care systems." Additionally, the RFP requires the contractor to "restrict the entity (CMHSP or contracted provider) that develops the person-centered service plan from providing services without the direct approval of the state."

The Court heard testimony during the hearing from executive directors of CMHSPs, who stated that up to 95% of the CMHSPs' budgets were paid through Medicaid's capitated payment system, and performing the duties assigned to CMHSPs under the Mental Health Code necessarily required CHMSPs to perform some of the functions designated as "managed care functions" in the RFP. CMHSPs serve as more than just providers. Rather, they coordinate with a local provider network through contracts with the providers that involve not only payment, but also an agreement that the provider will allow an investigation into noncompliance that includes, without limitation,

the failure to provide beneficiaries with the rights required as recipient rights under Chapter 7 of the Mental Health Code, MCL 330.1700 *et seq*. Additional contract functions mandate the right to mediation, person-centered planning, pre-release plans, and the CMHSP's right to ensure that disciplinary action is taken against those who violate beneficiaries' rights under MCL 330.1722(1).

Providers entering into these contracts include more than just hospitals, but may include providers of rehabilitation services, members of law enforcement, and other individuals or entities that interact with those who face mental health crises in the CMHSP's geographic area. Provider contracts accounted for approximately $9 million of the $21 million budget for Centra Wellness Network, a CMHSP serving Manistee and Benzie counties. Those funds are essential for meeting the CMHSP's statutory duties, especially in situations requiring crisis intervention. The CMHSP directors testified that the contracts were necessary for them to perform the functions mandated by Michigan law. This is especially significant in the context of the CMHSP's responsibility under MCL 330.1438 to those who present with an emergency. Multiple contracts are necessary because recipients must be given a choice of physician or mental health professional "in accordance with the policies of the [CMHSPs]." MCL 330.1713.

Medicaid funds are necessary to enable CMHSPs to furnish the administrative, assessment, and service-identification functions mandated by MCL 330.1226(1)(a). Some of those costs are required by statute. For example, CMHSPs must "select a physician, a registered nurse with a specialty certification issued under [MCL 333.17210], or a licensed psychologist to advise the [CMHSP] on treatment issues." MCL 330.1226(1)(m). With respect to the spreading of this cost, Michigan law permits CMHSPs to "[s]hare the costs or risks, or both, of managing and providing publicly funded mental health services with other [CMHSPs] through participation in risk pooling

arrangements, reinsurance agreements, and other joint or cooperative arrangements as permitted by law." MCL 330.1226(2)(e). In addition, the Mental Health Code allows CMHSPs to "[e]nter into agreements with other providers or managers of health care or rehabilitative services to foster interagency communication, cooperation, coordination, and consultation." MCL 330.1226(2)(f).

This prominently plays out in the situation when a person presents at a community mental health facility with the need for inpatient psychiatric treatment. Preadmission screening remains a responsibility of the CMHSPs even under the RFP, but CMHSPs cannot carry out that function unless they are allowed to provide the managed care functions designated exclusively to the PIHPs in the RFP. Without the ability to enter into contracts incentivized through payments to hospitals and other providers of services to people who present for involuntary or voluntary admission, the CMHSP cannot adequately serve those people. In emergent situations, neither the CMHSP nor the provider knows whether the individual is covered by Medicaid at the time of the screening, so the ability of the CMHSP to guarantee payment at the time of admission is crucial. Moreover, if the individual is a child, the CMHSP must undertake a search for the child's parent or guardian prior to admission, and the source of funding is unclear in that situation.

Wrap-around services are another area that CMHSP directors described as a crucial part of their work in serving their communities, and something that requires them to serve in a managed-care capacity, rather than as a provider. To be sure, CMHSPs have sources of funding other than Medicaid, such as commercial insurance, Medicare, general funds, or various grants. But CMHSP directors explained that they do not always know whether a person who presents for care qualifies for funding from any of those sources.

Marissa Grove, who serves as a solicitation manager at DTMB, explained the process for issuing an RFP. She explained that DTMB has three options for revising an issued RFP. It can issue a notice of deficiency, it can issue an amendment to the RFP, or it can pull back the RFP if major problems exist. Here, five amendments have already been made to the RFP. The RFP sets the terms of the contract, and both the contract terms and the RFP are subject to change after the bid is accepted, even if there is a change that cancels the RFP.

Raymie Postema, the MDHHS Director of the State Office of Recipient Rights, testified that she had concerns about the RFP and its potential negative impact on the protection of recipient rights throughout the state. CMHSPs are statutorily required to train and enforce recipient rights, so transferring that responsibility to the successful bidders for PIHP roles impedes that process.

Aneza Smith-Butterwick, the MDHHS's subject-matter expert for substance use disorder (SUD) in the context of the RFP, explained that SUD services are governed by the Mental Health Code, and they must be provided by a CMHSP or a regional entity. The RFP allows for more than one entity in a single geographic region if the entities bid together, but a public university cannot receive block-grant funds for SUD services.

Kristen Morningstar, the MDHHS Bureau Administrator, who served as program manager for procurement at the MDHHS, stated that managed-care functions are a core feature of the RFP, and those functions cannot be delegated, so CMHSPs cannot contract with a provider for managed-care services. Morningstar was unsure how CMHSPs could fulfill their statutory duties under MCL 330.1309 and MCL 330.1422. Several others with authority at the MDHHS, including Postema, raised concerns about the RFP and compliance with Michigan law. Postema commented that SUD services cannot be managed under the RFP if a PIHP is not a regional entity or a CMHSP.

Leslie Asman from the Bureau of Legal Affairs offered reasons for the RFP. Specifically, she mentioned introducing competitive procurement, the possibility of the federal government not renewing a waiver for the Medicaid program, and concerns about administrative duplication. At present, seven of the ten existing PIHPs delegate functions to CMHSPs. Asman testified that the RFP resolves conflicts of interest because it places the payor role solely in the hands of the PIHPs, not the CMHSPs, which act as providers of some services. She also described the operation of the PIHPs and the system established by the RFP. How this will take place in terms of operations has yet to be determined, but because the MDHHS has experience in carrying out operations without details set in advance, Asman had no concerns about that matter. Therefore, defendants asked the Court to place its imprimatur on the existing RFP by awarding them summary disposition.

II. LEGAL ANALYSIS

Defendants sought summary disposition under MCR 2.116(C)(8) and (10), and plaintiffs responded by asking for similar relief under MCR 2.116(I)(2). What remains unresolved after the Court's October 14, 2025 opinion and order is a single issue under MCR 2.116(C)(10) and MCR 2.116(I)(2). A motion requesting summary disposition under MCR 2.116(C)(10) "tests the *factual sufficiency* of a claim." *El-Khalil v Oakwood Healthcare, Inc*, 504 Mich 152, 159-160; 934 NW2d 665 (2019). Summary disposition under MCR 2.116(C)(10) may be awarded only if "there is no genuine issue of material fact." *Id.* Such a genuine issue of material fact exists "when the record leaves open an issue upon which reasonable minds might differ." *Id.* The remaining issue here is whether the RFP conflicts with the Mental Health Code, and particularly MCL 330.1206(1), which assigns certain functions to CMHSPs, rather than PIHPs. Several significant conflicts exist.

The RFP does not obligate the PIHPs selected through the bidding process to give priority to CMHSPs for the "comprehensive array of mental health services appropriate to conditions of

individuals who are located within its geographic service area," except pre-admission screening for inpatient hospital services, which the CMHSPs are statutorily mandated to provide "regardless of an individual's ability to pay." MCL 330.1206(1). More importantly, the RFP bars successful bidders for PIHP roles from paying CMHSPs for services provided through contracts with service providers. This conflicts with numerous provisions of the Mental Health Code, which recognizes that CMHSPs must provide certain services and ensure recipients of those services receive various rights either directly from the CMHSPs or through contracts with other service providers.

Indeed, each of the mental health services that CMHSPs are required, "at a minimum," to provide pursuant to MCL 330.1206 requires CMHSPs to develop a network of providers (through contractual relationships) to furnish services to Medicaid beneficiaries, to carry out eligibility and coverage verification for Medicaid beneficiaries, and to engage in activities to improve health care quality. Crisis stabilization and response, for example, requires CMHSPs to maintain a network of providers to react with flexibility and in a short timeframe. See MCL 330.1206(1)(a). Recipient rights services are incentivized through financial contracts that give CMHSPs authority to conduct the necessary investigations into beneficiaries' complaints. See MCL 330.1206(e). And mental-health advocacy and prevention activities that inform and educate with the "intent of reducing the risk of severe recipient dysfunction" are closely related, if not identical, to activities that improve health-care quality. See MCL 330.1206(g). Those duties are imposed on the CMHSPs regardless of whether or not the recipients are Medicaid beneficiaries and, in fact, directors of the CMHSPs commented that they often do not know whether those seeking services are eligible for Medicaid. Medicaid funding is such a significant portion of the budgets of CMHSPs that it is impractical, if not impossible, for CMHSPs to differentiate Medicaid beneficiaries from others to whom they are statutorily obligated to provide mental-health services. CMHSPs must provide services regardless

of an individual's ability to pay, MCL 330.1208(4), and CMHSPs are statutorily authorized to bill Medicaid or other appropriate payers for the services. MCL 330.1202(2).

That obligation extends far beyond the duties identified in MCL 330.1206. The CMHSPs' statutory duty to provide preadmission screening requires the CMHSPs to have flexibility to enter into financial contracts with service providers above and beyond inpatient hospital admissions to address the complex needs of individuals to whom they provide services. Their contracts must be negotiated in advance because preadmission screening must be available seven days a week, 24 hours a day. MCL 330.1409(1). Moreover, the duties following the screening require coordination with other entities involved in each person's care. MCL 330.1409(5), (7). Services following pre-admission screening may include hospitalization, or if the person does not meet the requirements for hospitalization, the CMHSP instead must "ensure the provisions of follow-up counseling and diagnostic and referral services if needed." MCL 330.1427. Individuals determined not clinically appropriate for inpatient placement must be directed to clinically appropriate levels of care that may include outpatient services or a residential treatment center. MCL 330.1409(7). Medicaid funding is crucial to the CMHSPs' ability to carry out those statutory mandates because it depends on the maintenance of a provider network.

Numerous provisions of the Mental Health Code require CMHSPs to contract with service providers. Those provisions include recipients' rights to request mediation and receive individual prerelease plans for appropriate community placement as well as plans for aftercare services. MCL 330.1206a; MCL 330.1209a(1), (2), (3). Also, CMHSPs must enter into interagency agreements for a collaborative program to provide mental-health treatment and assistance to qualifying people involved in the criminal justice system. MCL 330.1207a(3).

Finally, CMHSPs' contracts with providers ordinarily include a provision authorizing the CMHSPs to carry out investigations and take disciplinary actions to ensure that the recipient rights provisions in Chapter 7 of the Mental Health Code are carried out. The RFP's prohibition of PIHPs delegating that function to CMHSPs through financial contracts conflicts with Michigan law.

III. CONCLUSION

For the reasons explained above, defendants' motion for summary disposition beyond the award in the Court's October 14, 2025 opinion and order is denied, and the Court hereby issues a declaratory pronouncement that the RFP, as drafted, impermissibly conflicts with Michigan law in numerous respects, especially insofar as the RFP restricts CMHSPs from entering into financial contracts for the purpose of funding CMHSPs' managed-care functions. However, the Court will not yet issue injunctive relief that directs defendants to amend or pull back the RFP.[4] Defendants must decide, in the first instance, how to address the conflicts between Michigan law and the RFP that the Court has identified.

IT IS SO ORDERED.

This is not a final order. It does not resolve the last pending claim or close the case.

Date: January 8, 2026

Hon. Christopher P. Yates (P41017)
Judge, Michigan Court of Claims

[4] Michigan law disfavors injunctive relief against state agencies and officials except in cases where declaratory relief has failed. See *Davis v Detroit Fin Review Team*, 296 Mich App 568, 614; 821 NW2d 896 (2012). Consequently, the Court will stay its hand unless and until defendants prove unable or unwilling to fulfill their obligations under this Court's declaratory pronouncement.