

Southwest Michigan

B E H A V I O R A L H E A L T H

Substance Use Disorder Oversight Policy Board (SUDOPB)

Southwest Michigan Behavioral Health

5250 Lovers Lane, Suite 200, Portage, MI 49002

Monday, January 26, 2026

4:00-5:30

Draft: 1/20/26

- 1. Welcome and Introductions (R. Hazelbaker)**
- 2. Public Comment**
- 3. Agenda Review and Adoption (R. Hazelbaker) (d) pg.1**
- 4. Financial Interest Disclosure and Conflict of Interest Handling (A. Strasser)**
 - None
- 5. Consent Agenda (R. Hazelbaker)**
 - November 17, 2025 Meeting Minutes (d) pg.2
- 6. Board Actions**
 - Officer Elections (R. Hazelbaker)
- 7. Board Education**
 - a) Michigan Profile for Healthy Youth (MiPHY) (A. Malta, Jen Bloomfield, and Angela Blood Starr) (d) pg.5
 - b) Fiscal Year 2026 YTD Financials (G. Guidry) (d) pg.19
 - c) PA2 Utilization Fiscal Year 2026 YTD (G. Guidry) (d) pg.20
 - d) FY25 SUD Behavioral Health Treatment Episode (BH TEDS) Admission Data (J. Smith) (d) pg.22
 - e) Problem Gambling (L. Smithson) (d) pg.37
 - f) Riverwood PA2 Budget Change (J. Smith) (d) pg.44
- 8. Communication and Counsel**
 - a) Legislative and Policy Updates (M. Todd)
 1. Court of Claims PIHP Procurement Ruling (d) pg.45
 2. SAMSHA Grant Funding
- 9. County Updates**
- 10. Public Comment**
- 11. Adjourn**

The meeting will be held in compliance with the Michigan Open Meetings Act

Southwest Michigan BEHAVIORAL HEALTH

Substance Use Disorder Oversight Policy Board (SUDOPB) Meeting Minutes

November 17, 2025

4:00 – 5:30 pm

Draft: 11/18/25

Members Present: Randall Hazelbaker (Branch County); Richard Godfrey (Van Buren County); RJ Lee (Cass County); Matt Saxton (Calhoun County); Paul Schincariol (Van Buren County); Marsha Bassett (Barry County); Jared Hoffmaster (St. Joseph County)

Members Absent: Rayonte Bell (Berrien); Alex R. Ott (Berrien); Jonathan Current (Kalamazoo County) Dominic Oo (Calhoun County); Allyn Witchell (Kalamazoo County)

Staff and Guests Present:

Mila Todd, Interim Executive Officer, SWMBH; Joel Smith, Substance Use Treatment and Prevention Director, SWMBH; Garyl Guidry, Chief Financial Officer, SWMBH; Amy St. Peter, Clinical Grants Specialist, SWMBH; Lily Smithson, Gambling Disorder Specialist, SWMBH; Michelle Jacobs, Senior Operations Specialist and Rights Advisor, SWMBH; Anastasia Miliadi, SUD Treatment Specialist, SWMBH; Emily Flory, Strategic Initiatives Project Manager, SWMBH; Erin Hetrick, SUD Treatment Specialist, SWMBH; Alena Lacey, Chief Clinical Officer, SWMBH; Cate Pederson, Interim Quality Manager

Welcome and Introductions

Randall Hazelbaker called the meeting to order at 4:01 pm. Introductions were made.

Public Comment

None

Agenda Review and Adoption

Second Marsha Bassett

Motion Carried

Board Actions

2026 SUDOPB Meetings

Consent Agenda

Motion Matt Saxton moved to approve the 9/15/25 meeting minutes as presented.

Second Motion Carried

Jared Hoffmaster

Board Education

Fiscal Year 2025 YTD Financials

Garyl Guidry reported as documented, highlighting numbers for Medicaid, Healthy Michigan, MI Child, Block Grant, PA2 and PA2 carryforward. Discussion followed.

PA2 Utilization Fiscal Year 2025 YTD

Garyl Guidry reported as documented noting that PA2 utilization will continue to increase due to grant funds ending. Discussion followed.

Recovery Self-Assessment Survey

Cate Pederson reported as documented, summarizing history, results, participation rates, analysis and observations. Discussion followed.

Block Grant Update

Joel Smith noted that a wait list started in August of 2025, and a finite number of consumers will come off that wait list by the end of November.

CCBHC Data Visibility

Joel Smith stated that effective 10/1/25 SWMBH no longer has oversight over CCBHCs and therefore will not have access to CCBHC data which will change next year's report.

Communication and Counsel

Legislative Updates

Public Policy and Legislative Updates

Mila Todd noted the following:

- 8/4/25 RFP and Statement of work was released. RFP eliminates existing PIHPs and creates 3 new entities.
- Geographic constraints prevent SWMBH from bidding on the RFP.
- State responded to lawsuit (760-page response). Multiple law firms representing the plaintiffs and multiple Attorneys General named as the State's counsel.
- 9/12/25 plaintiffs' reply brief in support of motion for preliminary injunction due.
- 9/16/25 Case conference with Judge Yates.
- 9/22/25 plaintiffs' response brief in opposition to the State's motion is due.
- 9/26/25 State's reply brief is due.
- SWMBH received legal advice to submit a bid to the RFP within SWMBH constraints. RFP bid due 10/6/25. SWMBH is developing a bid to the RFP to meet legal obligations.
- 10/9/25 Hearing resulted in a partial loss and a partial win for SWMBH. The Judge ruled that there is a genuine issue of material fact.
- 12/8/25 hearing scheduled to review issues of fact with the Judge set to rule after the hearing

meaning.
Discussion followed.

2025 SUDOPB Attendance Report

Michelle Jacobs noted the attendance report for 2025 will be included in each month's packet per County Administrator request.

County Updates

Barry County issued an RFP for the Opioid Settlement dollars. 5 applications were received and Barry plans to use the settlement dollars in full for the time noted.

St. Joseph issued an RFP for the Opioid Settlement dollars. 5 applications were received.

Van Buren County is using some of their Opioid Settlement dollars for specialty courts and prevention programs.

Public Comment

None

Adjourn

Randall Hazelbaker adjourned the meeting.

Meeting adjourned at 5:04pm

Michigan Profile for Health Youth - MiPHY

SUD Oversight Board Meeting - January 2026



Jen Bloomfield

Regional School Health Coordinator

Van Buren Intermediate School District

Serving Berrien, Cass, and Van Buren Counties



Angela Blood Starr

Regional School Health Coordinator

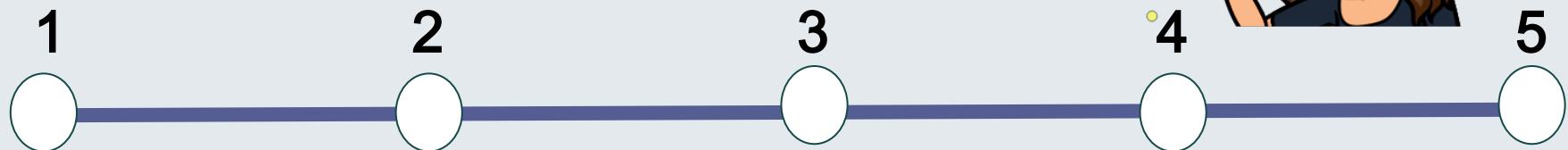
Calhoun Intermediate School District

Serving Barry, Branch, Calhoun, Kalamazoo, & St. Joseph



THINK PAIR SHARE

On a scale of 1 to 5



“MiPHY...what’s
that? Never
heard of it.”

“I know about the
MiPHY and its
implementation.”

“I’ll take over the
presentation
from here.”

How familiar are you with the **Michigan Profile for Healthy Youth (MiPHY)** survey?

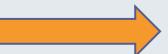
Michigan Profile for Healthy Youth (MiPHY)

- Data on student health behaviors including risk and protective factors
- Used for data-driven decision making

www.michigan.gov/miphy



It's an Implementation Year

- Survey cycle = Sept 15, 2025  June 5, 2026
- Grades 7th, 9th, 11th
- Typically 145-175 questions
- Takes around 30 minutes to complete
- Online



MiPHY Basics

- Schools register and self manage the process through the MiPHY administration website (Michigan School Health Survey System)
- Data is collected through a secure survey website
- Confidential, anonymous, and voluntary for students
- No cost to districts

MiPHY provides student results on these health risk behaviors:



Alcohol, Tobacco, and Other Drug Prevention



Food and Nutrition



Personal Health and Wellness



Physical Activity



Safety



Sexual Health



Social, Emotional, and Mental Health



Violence Prevention

MiPHY vs. MiPHY Basic

- MiPHY contains all questions including sexual behaviors, suicide and depression
- MiPHY Basic does NOT ask questions about sexual behaviors, suicide and depression



MiPHY Benefits

- Provides data to the schools and community on the most pressing issues teens face for data-driven decision making
- Aligns with school improvement initiatives and MICIP with focus on the Whole Child
- Helps bring grant dollars into the community
- Comprehensive survey reduces need to conduct multiple surveys and is a more efficient way to gather data



MiPHY Reports

- **Rapid Reports**

- Buildings and district can access results in 2-4 business days after closing the survey at the MiPHY administration site

- **Multiple Reports**

- Building - only district has access*
- District - only district has access*
- County - public access (not shared until June)

*Inability to reveal district's data ¹⁴



Michigan Profile for Healthy Youth: 2023-2024

Calhoun

MiPHY Regional Demographics Summary High School

The Michigan Profile for Healthy Youth (MiPHY) was completed by 7,9 and 11 grade students in Michigan. The results in this report reflect student survey responses from high schools that voluntarily participated in your county and may not be representative of all high schools in the county. Characteristics of the participating districts and buildings are as follows:

Michigan Profile for Healthy Youth District Participation			
Participating Districts ¹	#	Total Districts in County	% Participating Districts
Public	6	11	54.5%
Public Districts with Private School	5	7	71.4%
Public School Academy	0	6	0.0%
Total²	6	17	35.3%

Michigan Profile for Healthy Youth Building Participation		
Participating Buildings	Total Buildings in County ³	% Participating Buildings
Public	7	28
Private	0	12
Public School Academy	0	3
Total	7	31
		22.6%

SWMBH Region Data - High School

Alcohol, Tobacco, and Other Drugs Past 30-Day use

- Rank the following drugs in order from most used (1) to least used (4)

electronic vapor product	1 - 10.7%
alcohol	3 - 9.7%
marijuana	2 - 10.2%
painkillers such as OxyContin, Codeine, Vicodin, or Percocet	4 - 3.2%

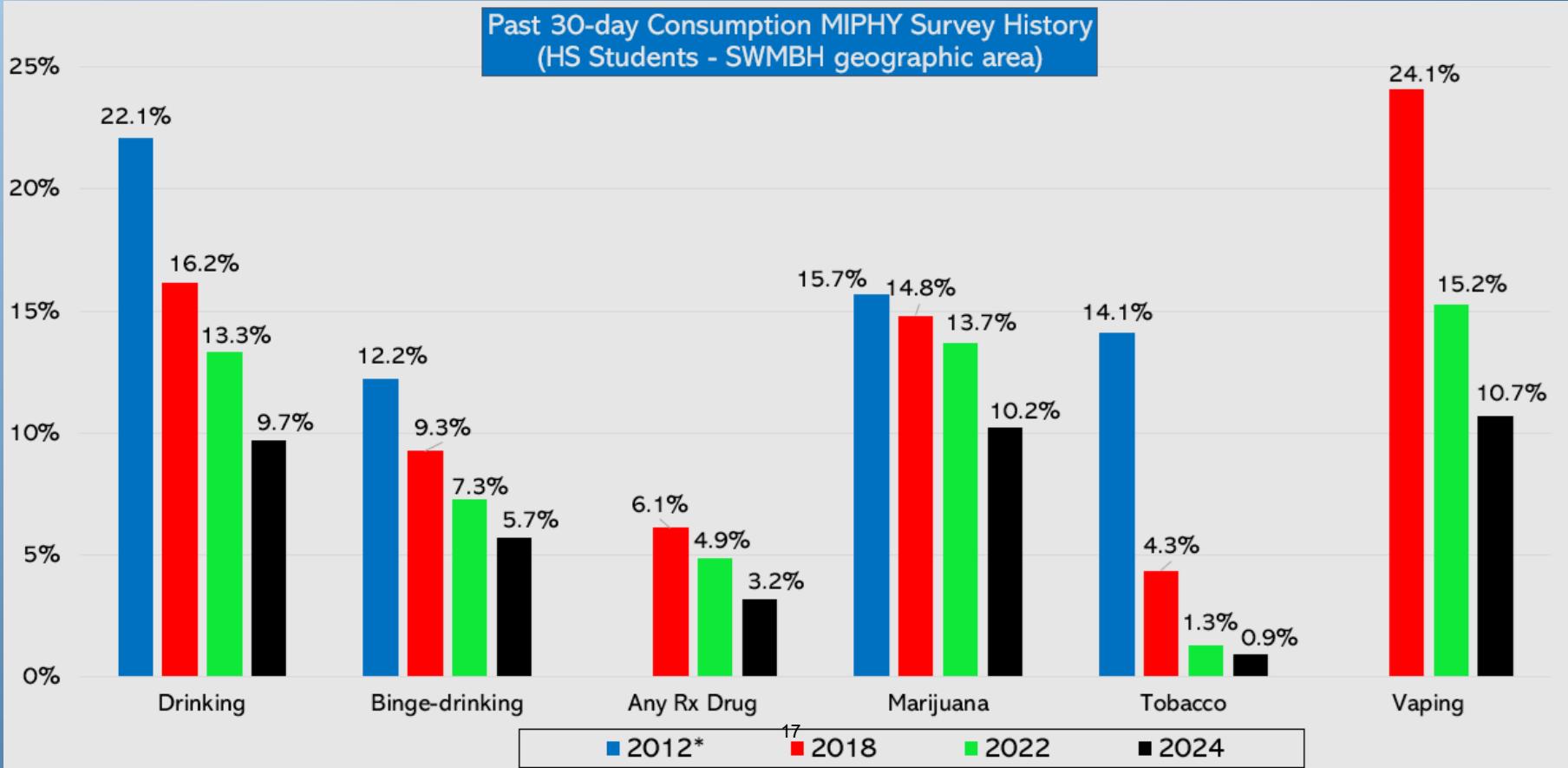
SWMBH Region - MiPHY Survey Comparison (2018 - 2022 - 2024)

<u>Past 30-day use/consumption (HS)</u>	2018	2022	2024
Any alcohol drinking	16.2%	13.3%	<u>9.7%</u>
Binge drinking	9.3%	7.3%	<u>5.7%</u>
Opioid Med abuse (OxyContin, Codeine, Percocet, Tylenol III, etc.)	4.2%	3.5%	<u>3.2%</u>
Psycho stimulant med abuse (Ritalin, Adderall, etc.)	3.7%	2.5%	<u>1.9%</u>
Any Rx med abuse	6.1%	4.9%	<u>4.1%</u>
Marijuana use	14.8%	13.7%	<u>10.2%</u>
Cigarette smoking	4.3%	1.3%	<u>1.2%</u>
E-Cig/Vaping	24.1%	15.2%	<u>10.7%</u>
Parent Talk with student regarding alcohol/drugs	79.3%	78.4% ¹⁶	<u>75.7%</u>

SWMBH Region	N	%
Race / Ethnicity # MiPHY Survey participants (HS)		
Amer. Indian	55	1%
Arab/ Chaldean	65	1%
Asian	128	2%
Black	459	8%
Hispanic/ Latino	1,047	19%
White	3,655	68%
Total	5,409	

MIPHY Retrospect of HS “past 30-day consumption” by HS Students in the SWMBH Region

* 2012: First MiPHY Survey Cycle





Intentional Close

One Takeaway I am Going to Try...

Thinking about what you heard and learned today, what is one takeaway?

A takeaway can be an idea, a strategy, a tool, or an action step.

THINK PAIR SHARE



	A	D	E	F	G	H	I	J	K												
1	Substance Use Disorders Revenue & Expense Analysis Fiscal Year 2026																				
2	For the Fiscal YTD Period Ended 11/30/2025																				
4	MEDICAID					Healthy MI															
5	Budgeted YTD Revenue		Actual YTD Revenue		YTD Expense		Fav (Unfav)		Budgeted YTD Revenue		Actual YTD Revenue		YTD Expense		Fav (Unfav)						
7	Barry	40,366	22,070	2,435	19,635	60,883	42,872	8,138	34,733												
8	Berrien	152,034	86,096	8,700	77,396	241,995	185,087	20,413	164,673												
9	Branch	42,501	24,988	0	24,988	56,580	41,721	1,459	40,262												
10	Calhoun	168,418	94,386	71,500	22,886	227,524	159,342	137,693	21,649												
11	Cass	47,252	25,581	50,107	(24,525)	73,633	48,305	109,814	(61,510)												
12	Kazoo	214,256	131,609	40,720	90,890	356,827	258,344	87,534	170,810												
13	St. Joe	60,435	30,481	4,721	25,760	94,356	59,012	10,655	48,357												
14	Van Buren	78,511	44,812	0	44,812	115,180	75,699	4,721	70,978												
15	DRM	603,270	355,893	604,670	(248,777)	842,917	712,129	1,101,111	(388,982)												
17	Grand Total	1,407,043	815,916	782,851	33,065	2,069,895	1,582,510	1,481,538	100,971												
19	BLOCK GRANT					BLOCK GRANT BY COUNTY															
20	EGRAMS		Budgeted YTD Revenue		Actual YTD Revenue		YTD Expense		Fav (Unfav)		County		Actual YTD Revenue		YTD Expense		Fav (Unfav)				
21	SUD Block Grant		573,797	463,212	463,212	0	Barry	0	0	0	Berrien	8,530	8,530	0	0	0	0				
22	Community Grant	83,150	15,607	15,607	0	Berrien	292	292	0	Branch	292	292	0	0	0	0	0				
23	WSS	195,274	152,914	152,914	0	Calhoun	94,827	94,827	0	Cass	801	801	0	0	0	0	0				
24	Prevention	64,399	21,826	21,826	0	Cass	99,395	99,395	0	Kazoo	99,395	99,395	0	0	0	0	0				
25	Admin/Access	20,882	9,936	9,936	0	St. Joe	18,086	18,086	0	St. Joe	18,086	18,086	0	0	0	0	0				
26	State Disability Assistance	33,333	11,927	11,927	0	Van Buren	13,581	13,581	0	Van Buren	13,581	13,581	0	0	0	0	0				
27	Gambling Prevention	233,333	83,813	83,813	0	DRM	383,303	383,303	0	DRM	383,303	383,303	0	0	0	0	0				
28	State's Opioid Response 3	15,833	13,787	13,787	0	Admin/Access	20,956	20,956	0	Admin/Access	20,956	20,956	0	0	0	0	0				
29	Partnership for Advancing Coalition	667	0	0	0																
30	Substance Use Disorder - Tobacco 2	36,867	0	0	0																
31	Alcohol Use Disorder Treatment	16,667	0	0	0																
32	Recovery Incentives Infrastructure	25,000	0	0	0																
33	Healing and Recovery Community Engageme																				
34																					
35	Mental Health Block Grant	33,333	15,487	15,487	0																
36	Transitional Navigators	21,667	21,866	21,866	0																
37	Veterans Navigator	41,667	52,271	52,271	0																
38	Behavioral Health Disparities	0	0	2,525	(2,525)																
39	Admin/Access																				
40																					
41	Grand Total	1,395,867	862,646	865,171	(2,525)																
42																					
43	PA2					PA2 Carryforward															
44	Budgeted YTD Revenue		Actual YTD Revenue		YTD Expense		Fav (Unfav)		Prior Year Balance		Current Utilization		Projected Year End Balance								
45	Barry	95,425	15,301	3,080	12,221	Barry	804,479	12,221	816,700	Berrien	820,919	37,802	858,721	Branch	595,883	11,950	607,834	Calhoun	193,794	23,895	217,689
46	Berrien	415,751	67,357	29,554	37,802	Berrien	541,276	13,543	554,820	Branch	2,110,723	36,058	2,146,781	Cass	81,228	13,543	93,737	Kazoo	2,110,723	36,058	2,146,781
47	Branch	76,484	11,950	0	11,950	Branch	397,237	(1,183)	396,054	Calhoun	623,433	29,081	652,514	Cass	126,259	22,824	149,083	St. Joe	397,237	(1,183)	396,054
48	Calhoun	368,456	63,140	39,245	23,895	Calhoun	6,087,745	163,368	6,251,113	Van Buren	176,265	29,081	195,346	Kazoo	750,823	125,567	875,390	St. Joe	126,259	21,641	147,900
49	Cass	81,228	13,543	0	13,543	Cass	176,265	29,081	195,346	Van Buren	176,265	29,081	195,346	Kazoo	750,823	125,567	875,390	St. Joe	126,259	21,641	147,900
50	Kazoo	126,259	21,641	22,824	(1,183)	Kazoo	176,265	29,081	195,346	Van Buren	176,265	29,081	195,346	St. Joe	126,259	21,641	147,900	Berrien	176,265	29,081	195,346
51	St. Joe	176,265	29,081	0	29,081	St. Joe	176,265	29,081	195,346	Van Buren	176,265	29,081	195,346	Berrien	176,265	29,081	195,346	Branch	176,265	29,081	195,346
52	Van Buren	176,265	29,081	0	29,081	Van Buren	176,265	29,081	195,346	Calhoun	176,265	29,081	195,346	Kazoo	176,265	29,081	195,346	Cass	176,265	29,081	195,346
53																					
54	Grand Total	2,090,691	347,580	184,212	163,368																



Public Act 2 (PA2) Utilization Report
Fiscal Year 2026

Program	FY26 Approved Budget	Utilization FY26 November 2025	PA2 Remaining	YTD Utilization
Barry	207,833	11,326	153,734	5%
Barry County - Adult Specialty Court	32,215	1,099	31,116	3%
Barry County - Peer Recovery Coach	49,920	7,148		14%
BCCMHA - Outpatient Services	49,920	3,080	46,840	6%
BCCMHA-Prevention Services	75,778	-	75,778	0%
Berrien	512,616	29,554	483,062	6%
Abundant Life - Healthy Start	77,700	12,625	65,075	16%
Berrien MHA - Riverwood Jail Based Assessment	16,085	-	16,085	0%
Berrien County - Treatment Court Programs (DTC)	90,000	-	90,000	0%
Berrien County - Trial Courts (Intake/Assessment Coordinator)	62,564	-	62,564	0%
CHC - Jail Services	8,000	11	7,989	0%
CHC - Carol's Hope	42,000	1,771	40,229	4%
CHC - Wellness Group	6,000	-	6,000	0%
CHC - Star of Hope Recovery House	60,000	15,148	44,852	25%
Sacred Heart - Butternut	25,267	-	25,267	0%
Berrien County Health Department - Prevention Services	125,000	-	125,000	0%
Branch	123,884	1,481	122,403	1%
Pines BHS - Outpatient Treatment	30,000	1,481	28,519	5%
Jail Based Clinician	93,884	-	93,884	0%
Calhoun	407,016	39,245	367,771	10%
Calhoun County 10th Dist Sobriety Treatment Court	114,499	16,095	98,404	14%
Calhoun County 10th Dist Veteran's Treatment Court	6,013	37	5,976	1%
Calhoun County 37th Circuit Drug Treatment Court	215,313	14,946	200,367	7%
Haven of Rest-Haven Life Recovery Program (Men's)	20,000	4,000	16,000	20%
Calhoun County Juvenile SUD Services	26,191	-	26,191	0%
Michigan Rehabilitation Services - Calhoun	25,000	4,167	20,833	17%
Cass	216,592	-	140,401	0%
Woodlands - Meth Treatment & Drug Court Outpatient Services	86,521	-	86,521	0%
Woodlands BHN-Family Education Group	8,880	-	8,880	0%
Woodlands Case Management Outreach	45,000	-	45,000	0%
Woodlands-Prevention Services	76,191	-	76,191	0%
Kalamazoo	1,119,099	119,403	999,696	11%
CHC - New Beginnings	77,627	19,332	58,295	25%
CHC - Bethany House	56,154	9,319	46,835	17%
ISK - Oakland Drive Shelter	42,000	7,000	35,000	17%
8th District Sobriety Court	29,590	-	29,590	0%
8th District General Probation Court	14,850	-	14,850	0%
8th District Mental Health Recovery Court	4,950	-	4,950	0%
9th Circuit Problem Solving Courts	80,003	-	80,003	0%
CHC - Adolescent Services	21,876	-	21,876	0%
KCHCS Healthy Babies	87,000	-	87,000	0%
ISK - Opiod Overdose Response Program (OORP)	168,818	-	168,818	0%
ISK - Homeless Emergency Response System (FUSE)	33,600	5,600	28,000	17%
ISK - Mental Health Services Court	100,000	16,667	83,333	17%
Michigan Rehabilitation Services - Kalamazoo	17,250	2,875	14,375	17%
Mothers of Hope	60,000	29,894	30,106	50%
Recovery Institute - Recovery Coach	115,000	12,192	102,808	11%

Program	FY26 Approved	Utilization FY26	PA2	YTD
	Budget	November 2025	Remaining	Utilization
CHC - Prevention	29,381	11,824	17,557	40%
Prevention Works - ATOD	100,000	-	100,000	0%
Prevention Works - Task Force	25,000	-	25,000	0%
Gryphon Gatekeeper - Suicide Prevention	20,000	1,700	18,300	9%
Gryphon Helpline/Crisis Response	36,000	3,000	33,000	8%
St. Joseph	165,392	15,422	149,970	9%
CHC - Hope House	57,325	9,319	48,006	16%
3B District - Drug/Alcohol Testing	37,040	-	37,040	0%
3B District - Sobriety Courts/Ignition Interlock	3,276	-	3,276	0%
Pivotal (CMH) - Court Ordered Drug Testing/Assessments	44,000	6,104	37,896	14%
Pivotal (CMH) - Prevention	23,751	-	23,751	0%
Van Buren	204,454	22,408	182,046	11%
Van Buren CMHA- Substance Abuse Treatment	88,007	-	88,007	0%
Van Buren County-Specialty Courts and Pretrial Services	71,466	22,408	49,058	31%
Van Buren CMHA - Prevention	44,981	-	44,981	0%
Totals	2,956,886	238,840	2,675,273	8%

Behavioral Health Treatment Episode Data Set (BH TEDS)

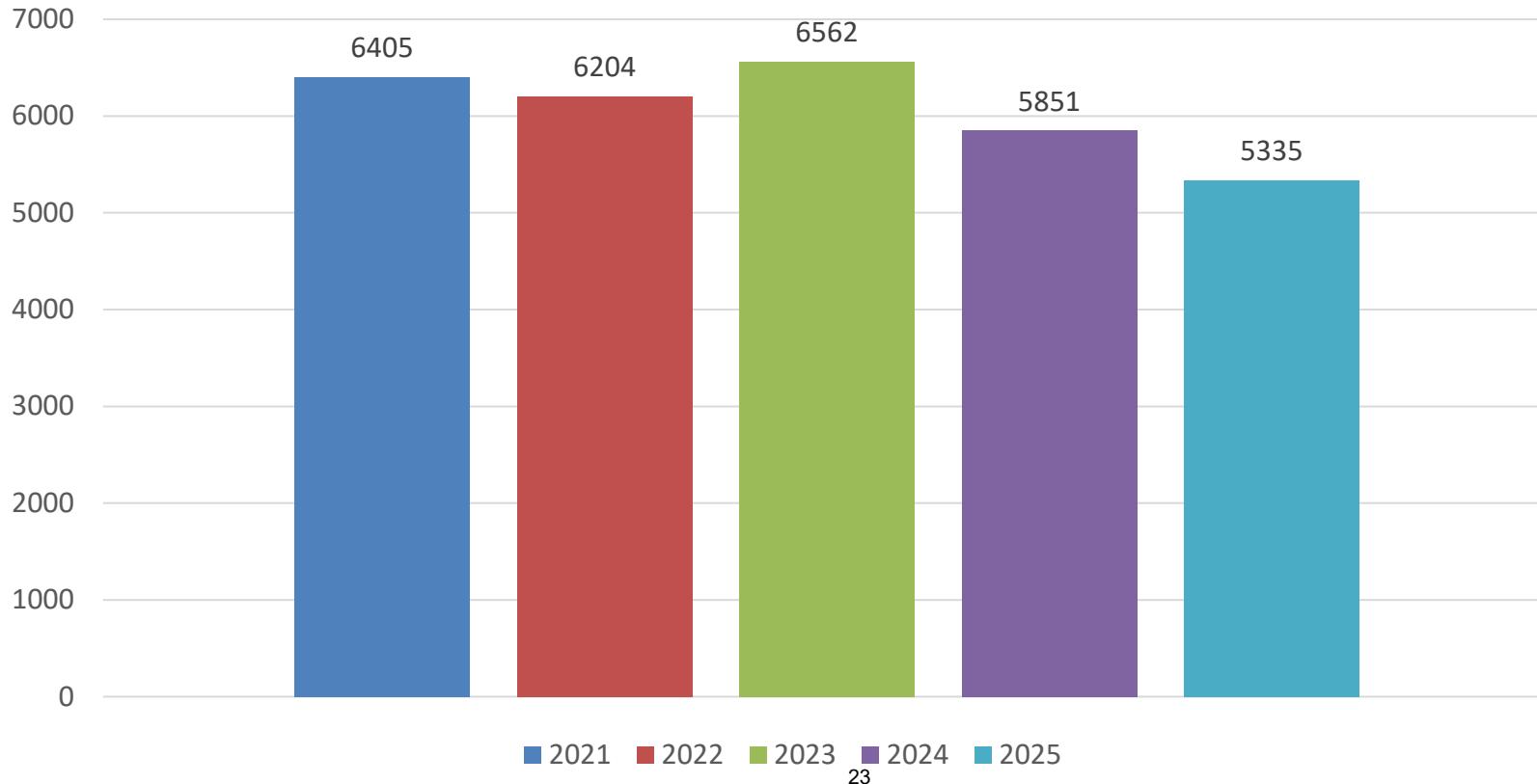
Admission Data:
Fiscal Year 2025



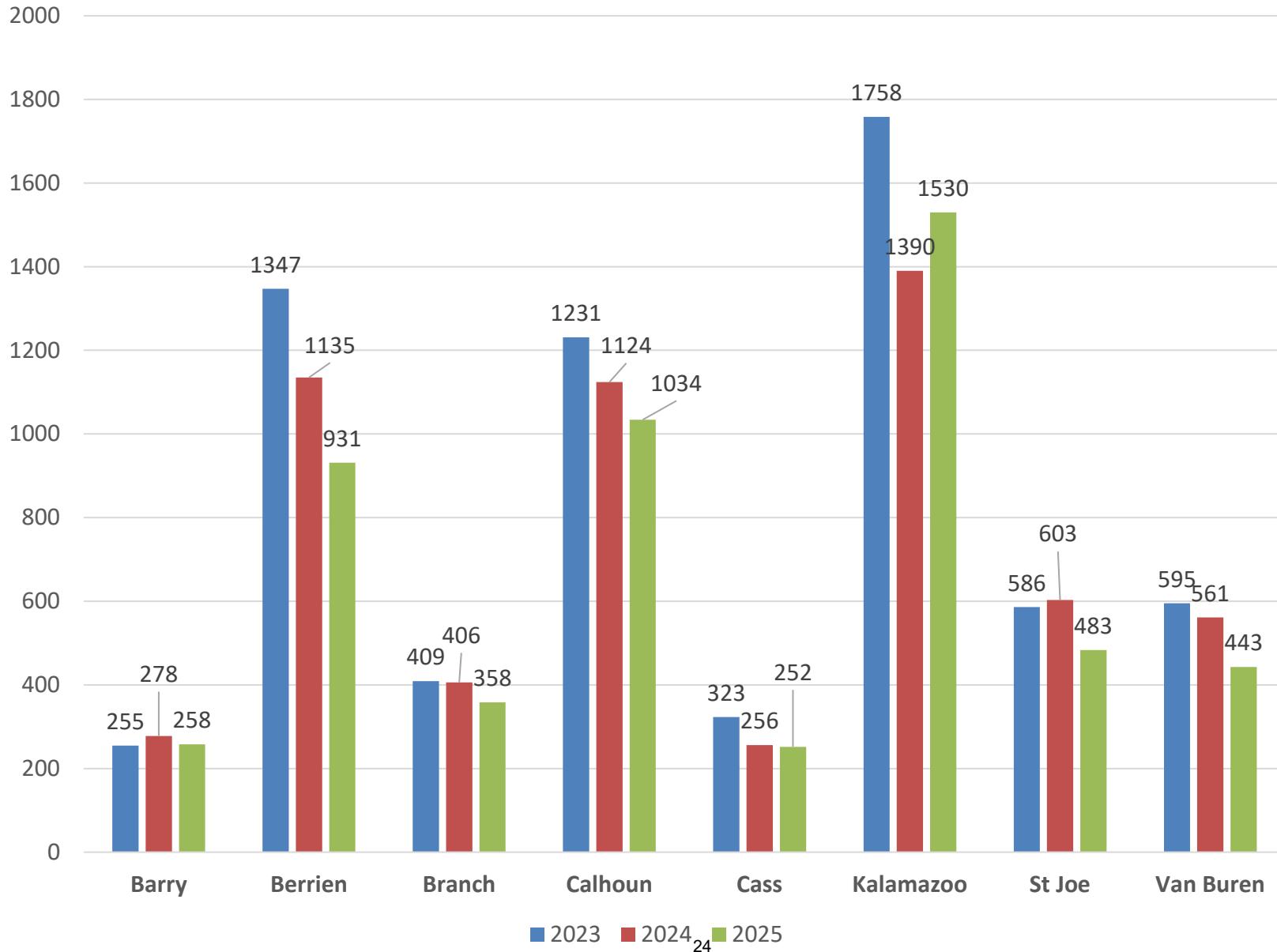
Overview:

As required by the MDHHS contract, a Behavioral Health Treatment Episode Data Set (BH-TEDS) is completed for every admission to SUD treatment. In fiscal year (FY) 2025, the SWMBH region had **5,335** treatment admissions to service. This count includes all customers for all levels of care. For example, if a customer went to detoxification services first and then to outpatient services, they would be counted twice (two separate services). County specific information is based on the customer's county of residence.

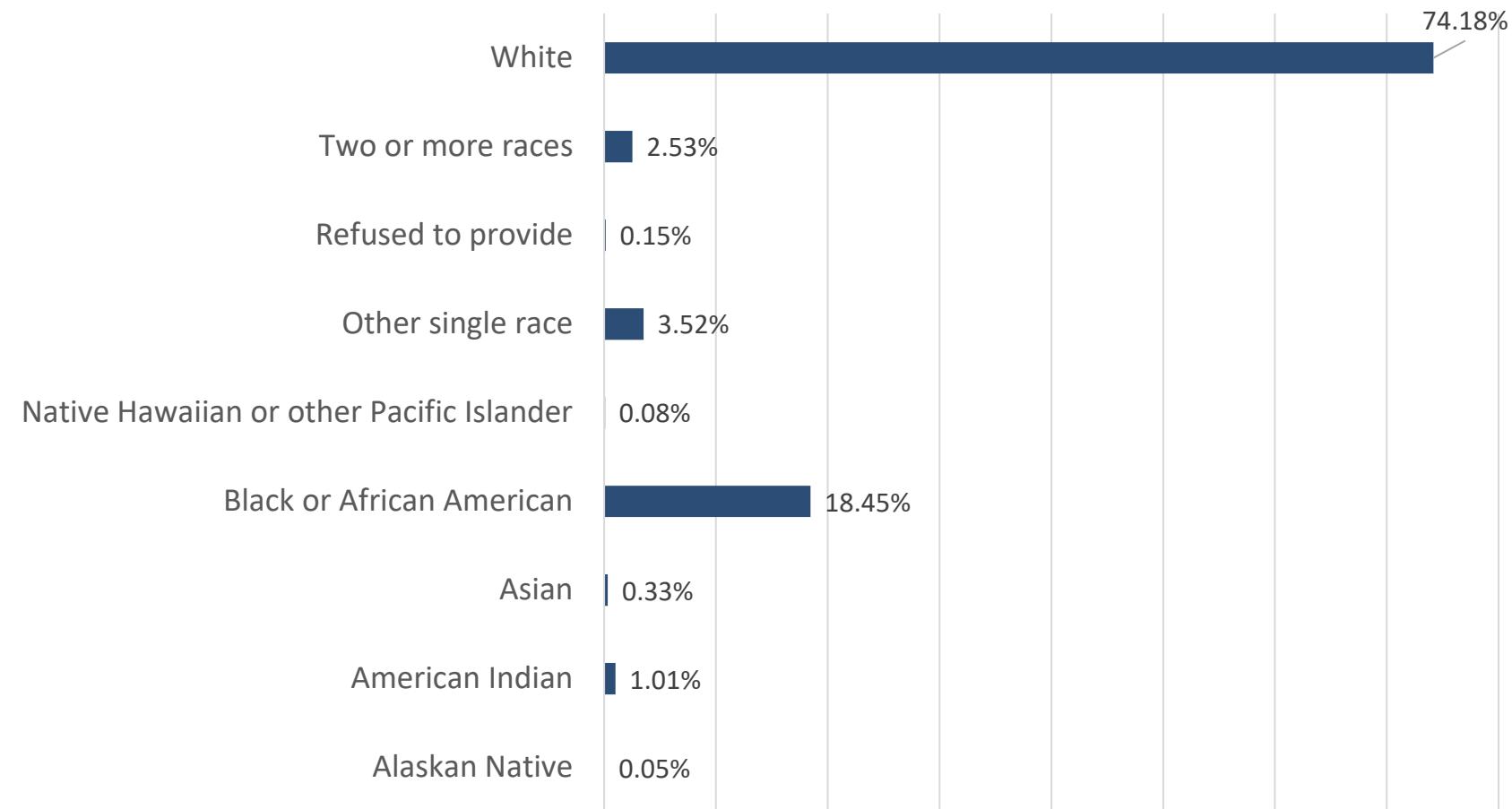
Total Treatment Admissions - SWMBH



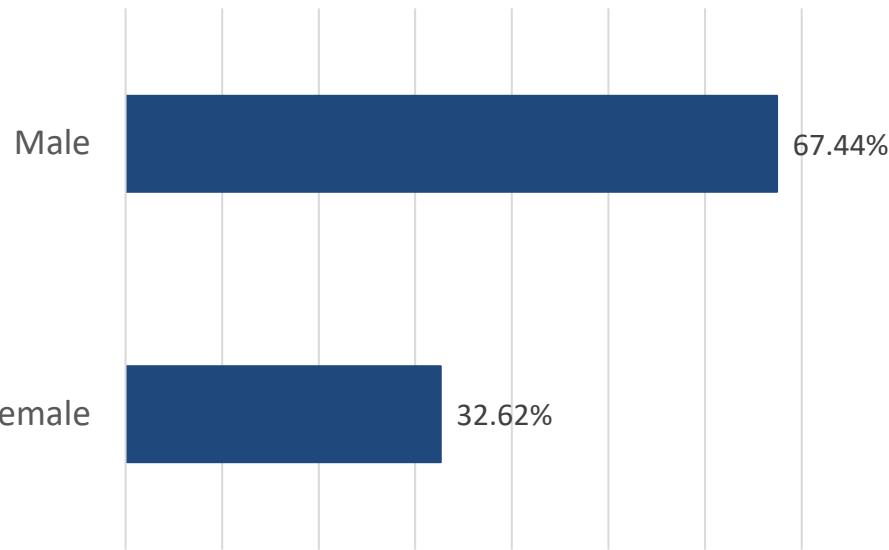
Treatment Admissions by County



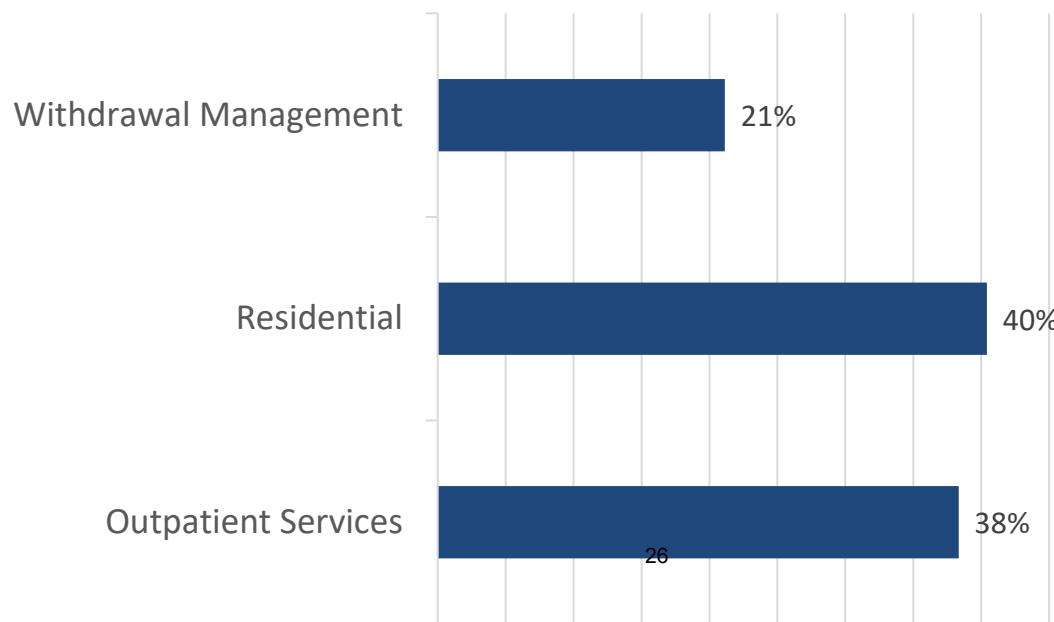
SWMBH Region: Race



SWMBH Region: Gender

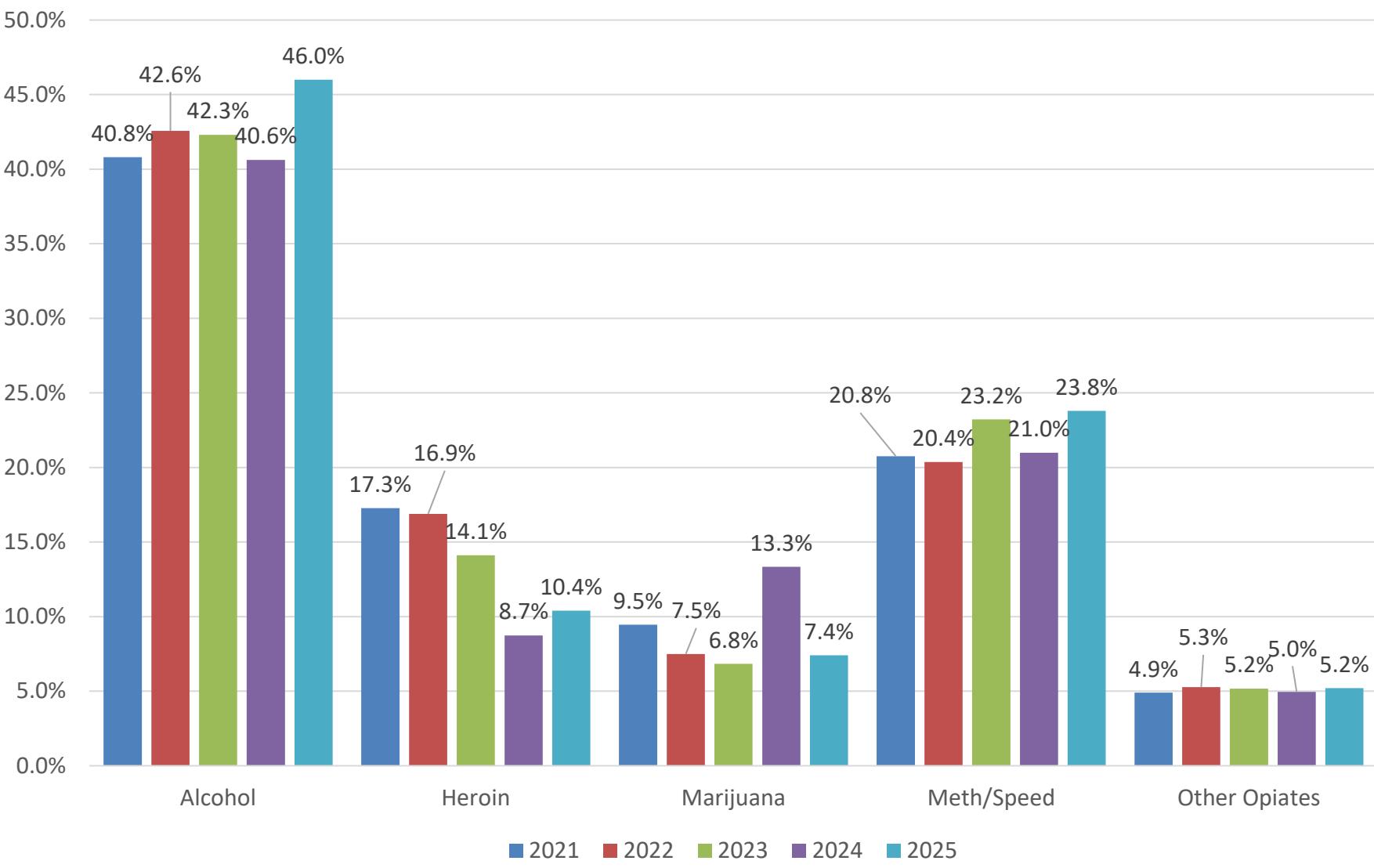


SWMBH Region: Treatment Service Setting

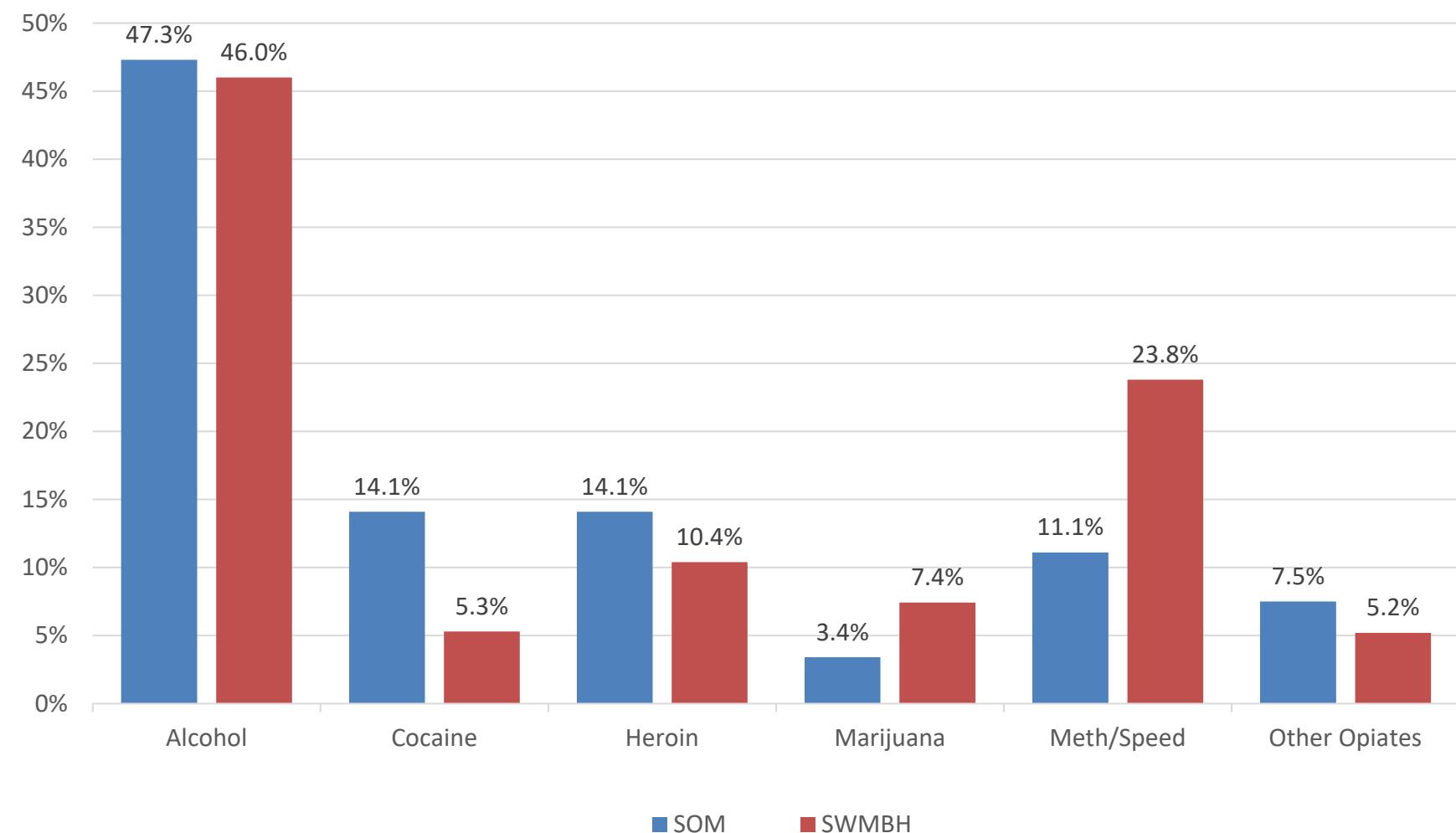


SWMBH Region

Primary Substance of Abuse at Admission

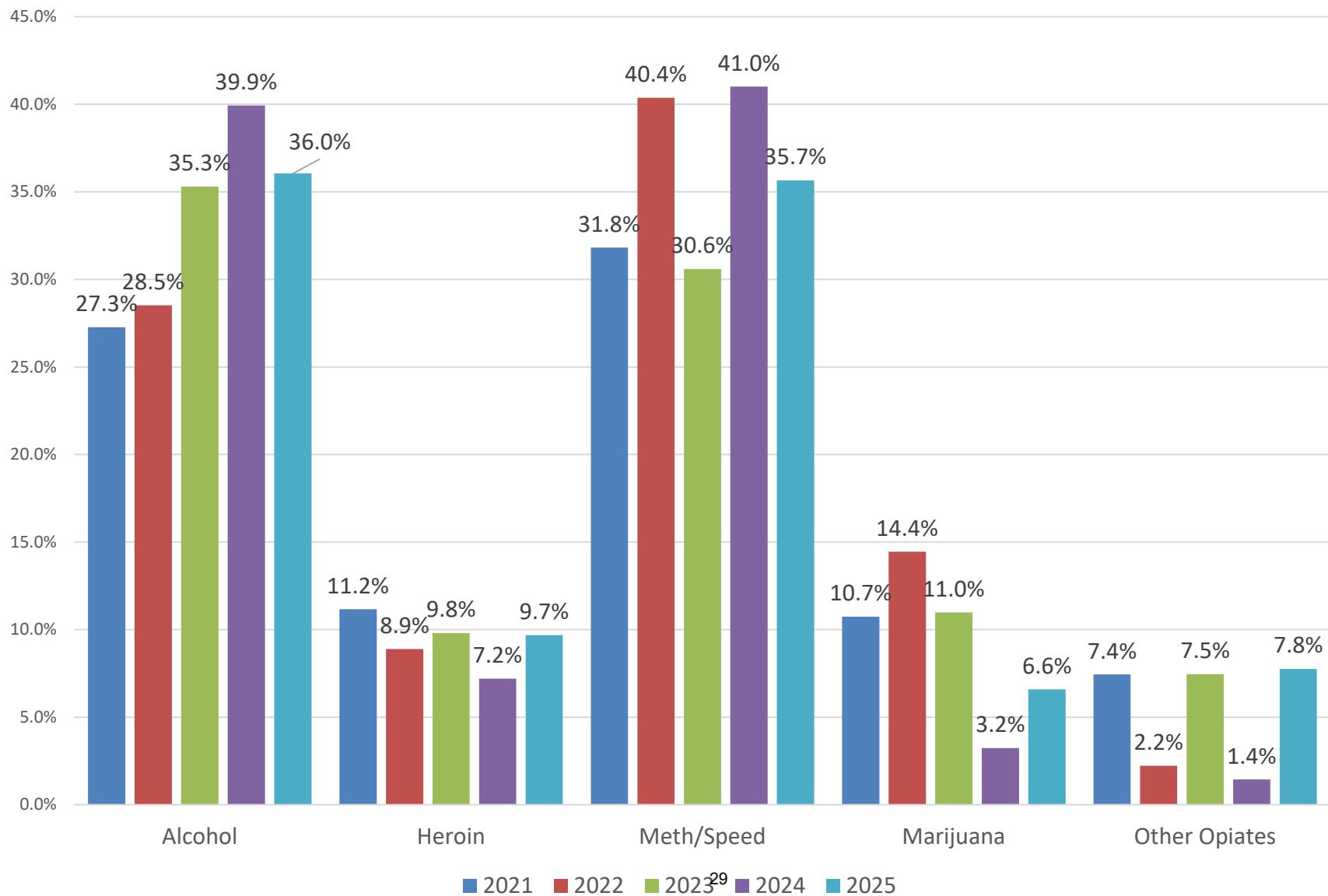


State of Michigan/SWMBH Region Primary Substance of Abuse at Admission



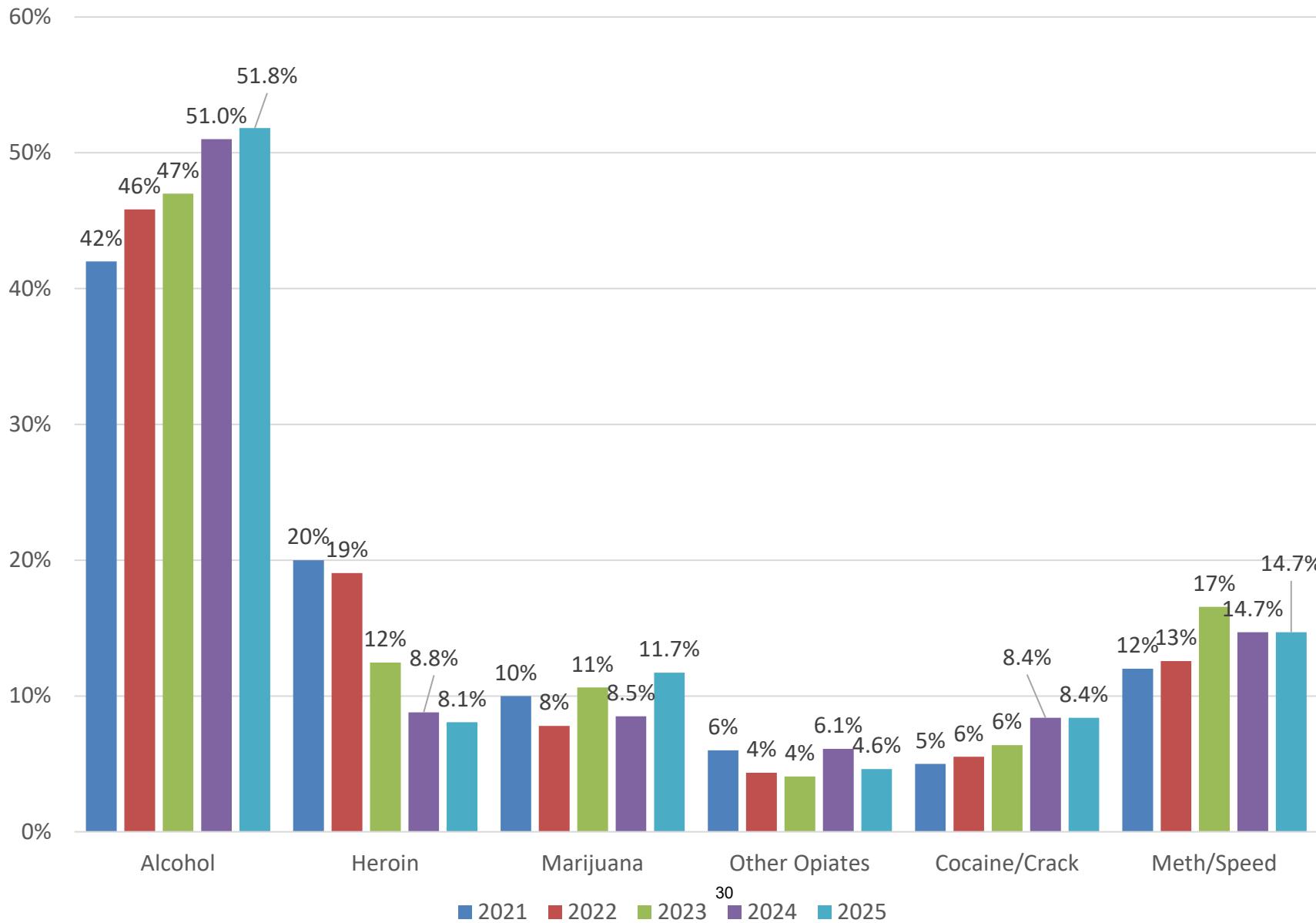
Barry County

Primary Substance of Abuse at Admission



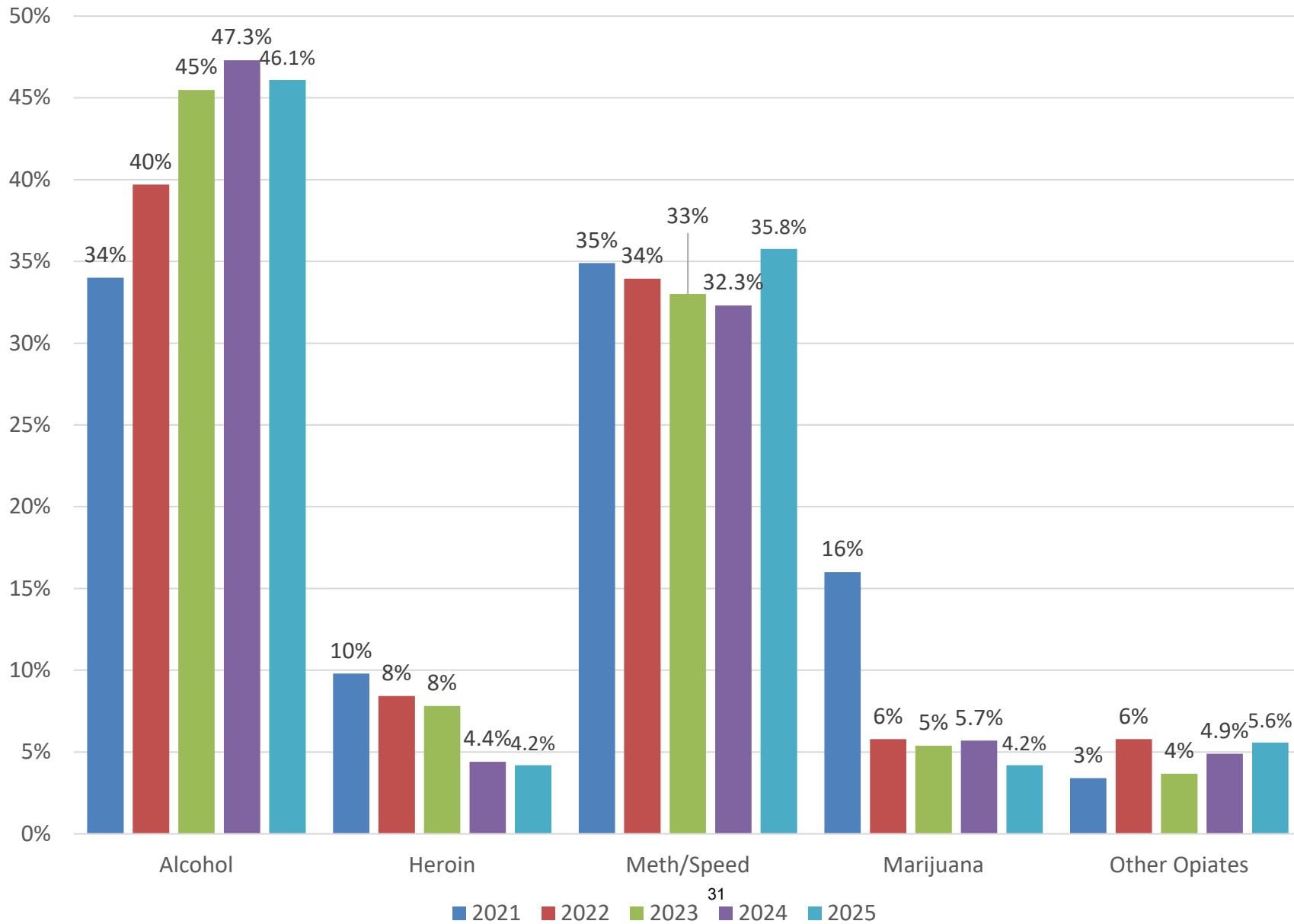
Berrien County

Primary Substance of Abuse at Admission



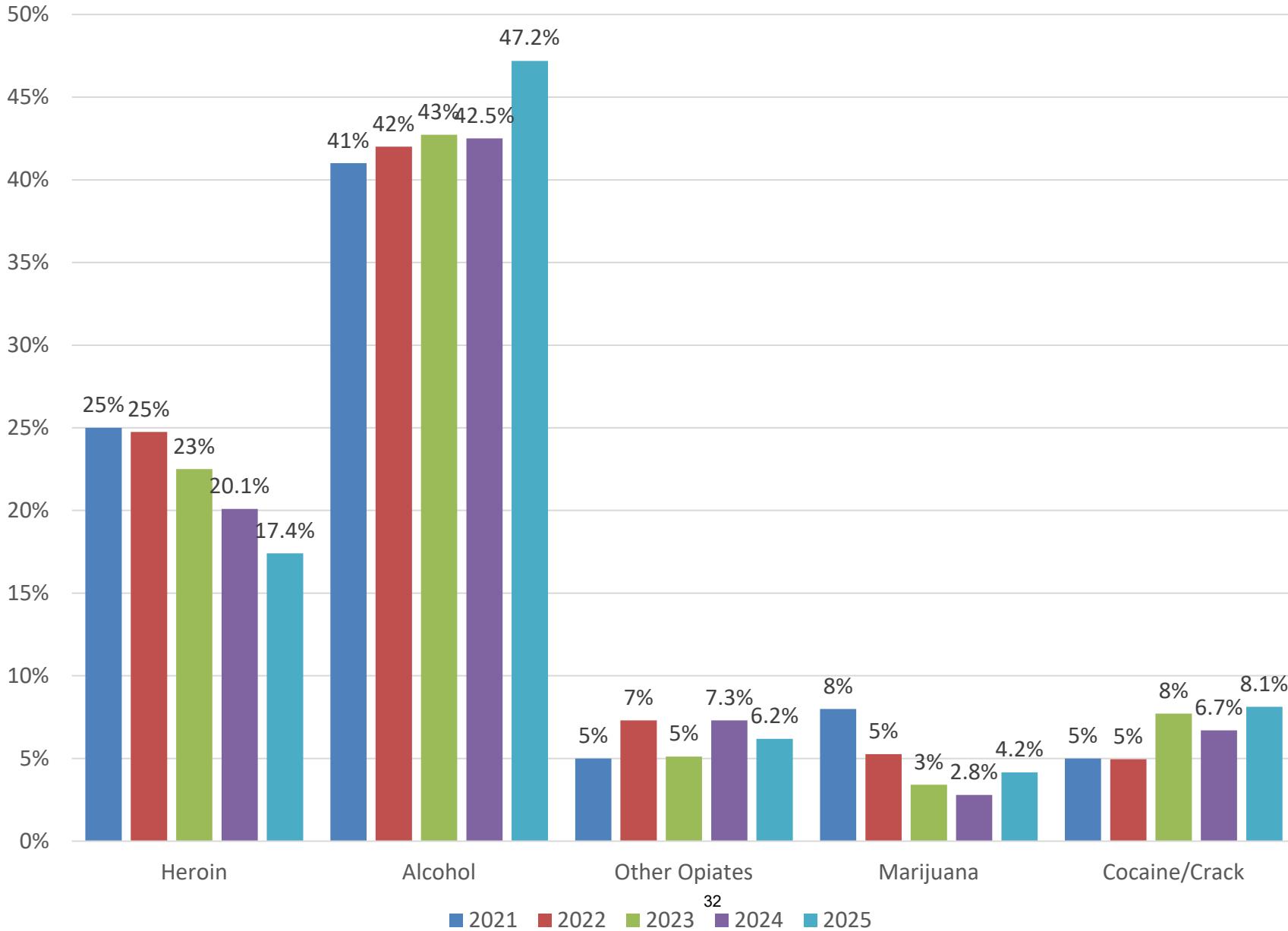
Branch County

Primary Substance of Abuse at Admission



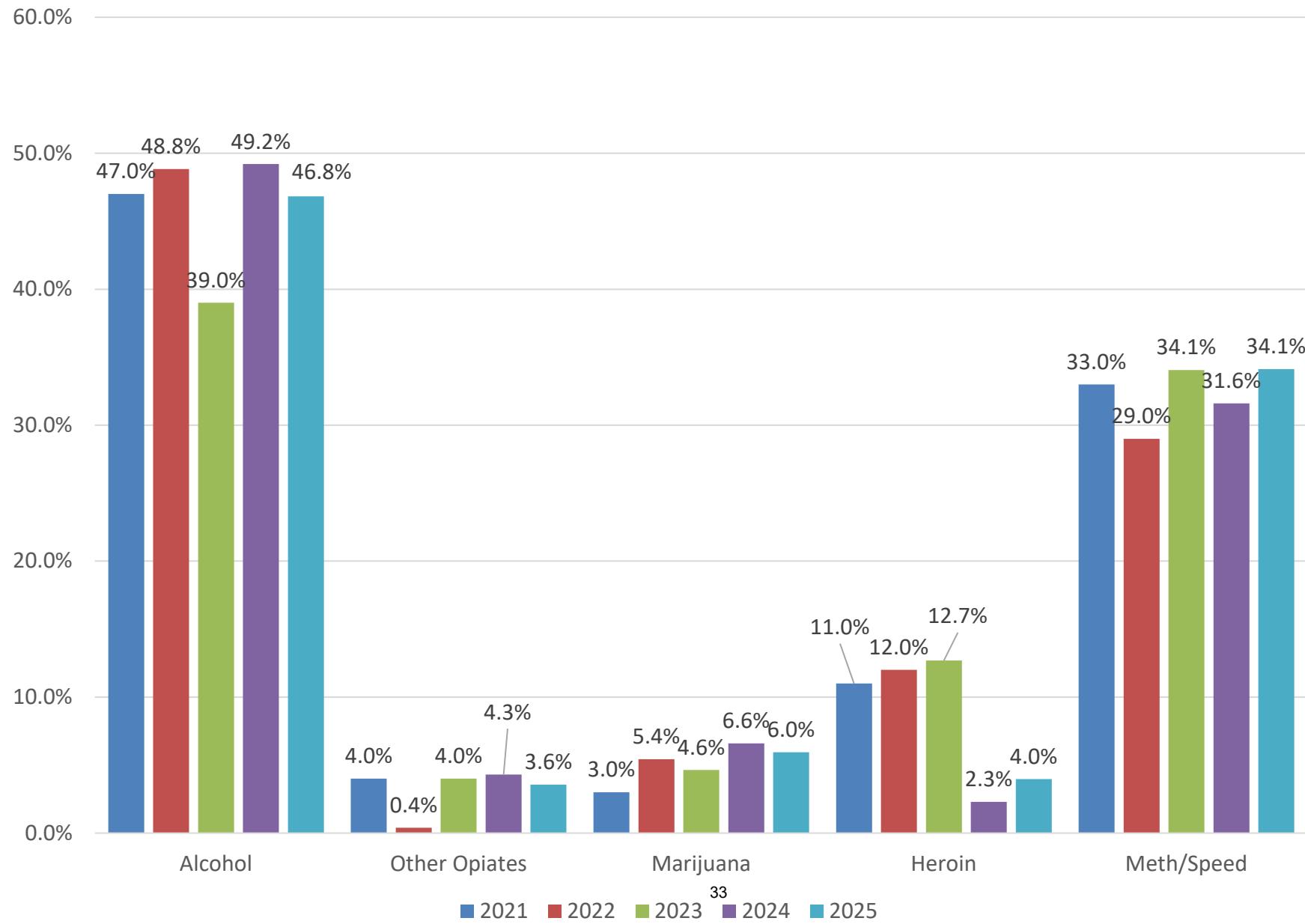
Calhoun County

Primary Substance of Abuse at Admission

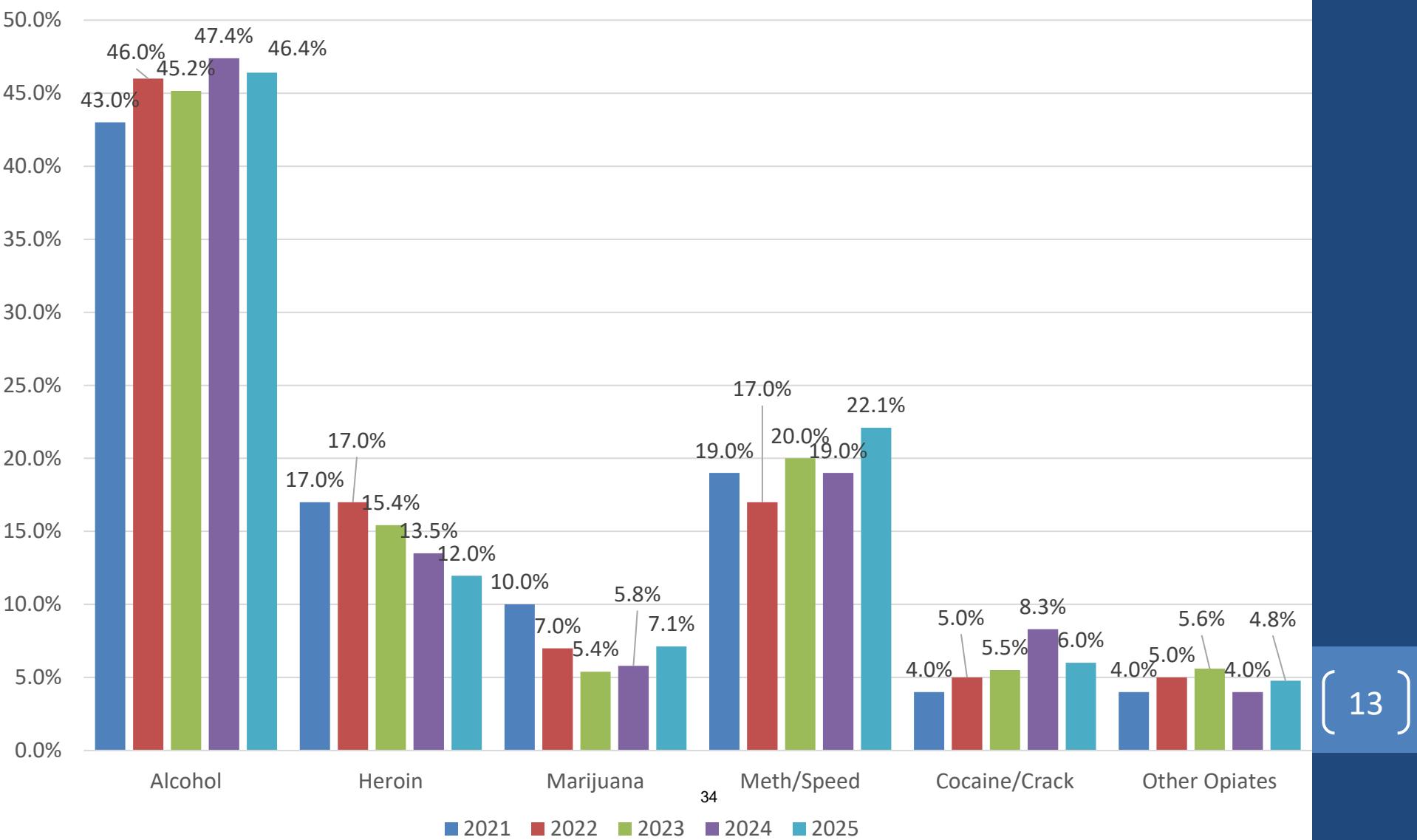


Cass County

Primary Substance of Abuse at Admission

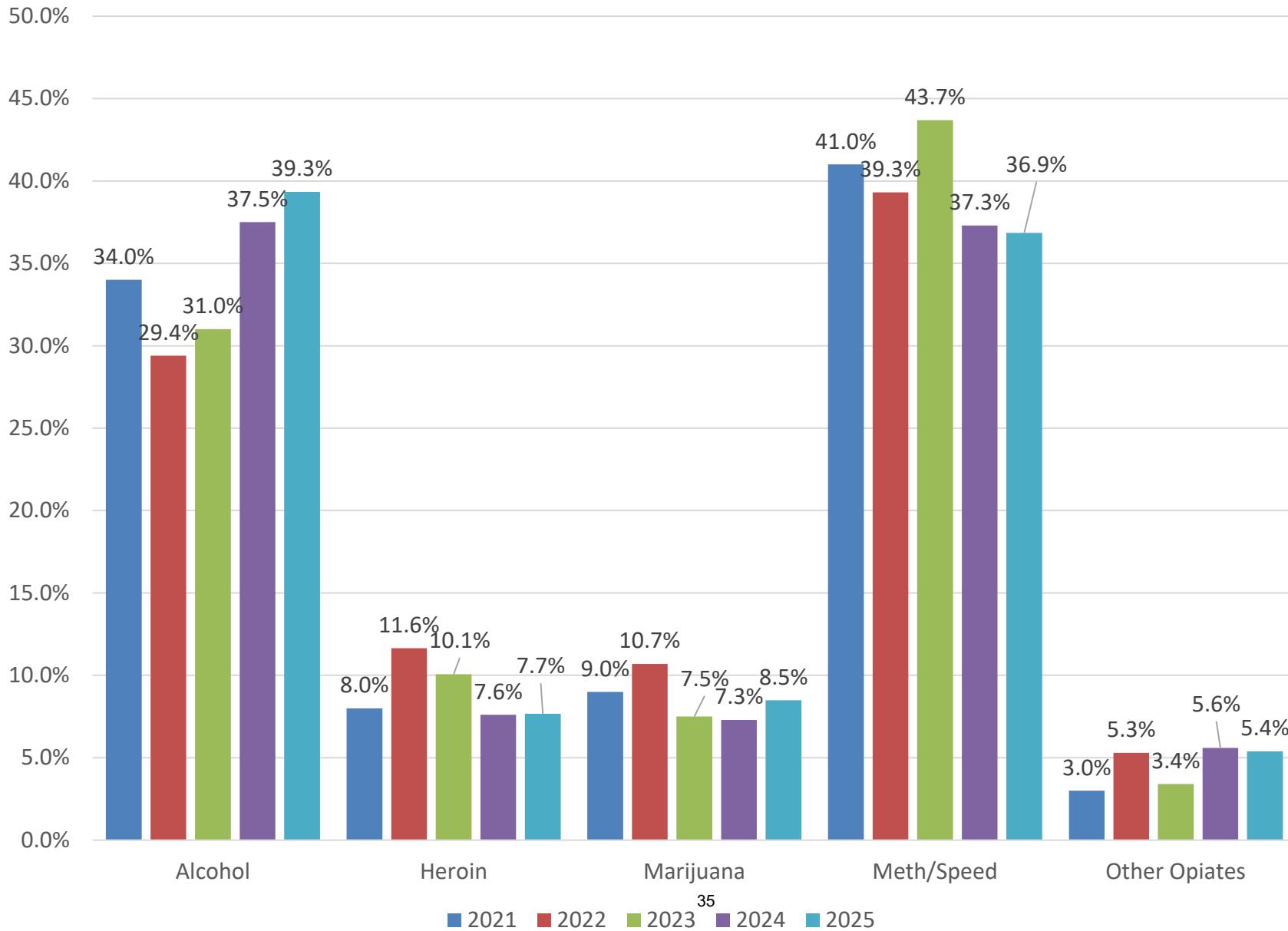


Kalamazoo County Primary Substance of Abuse at Admission



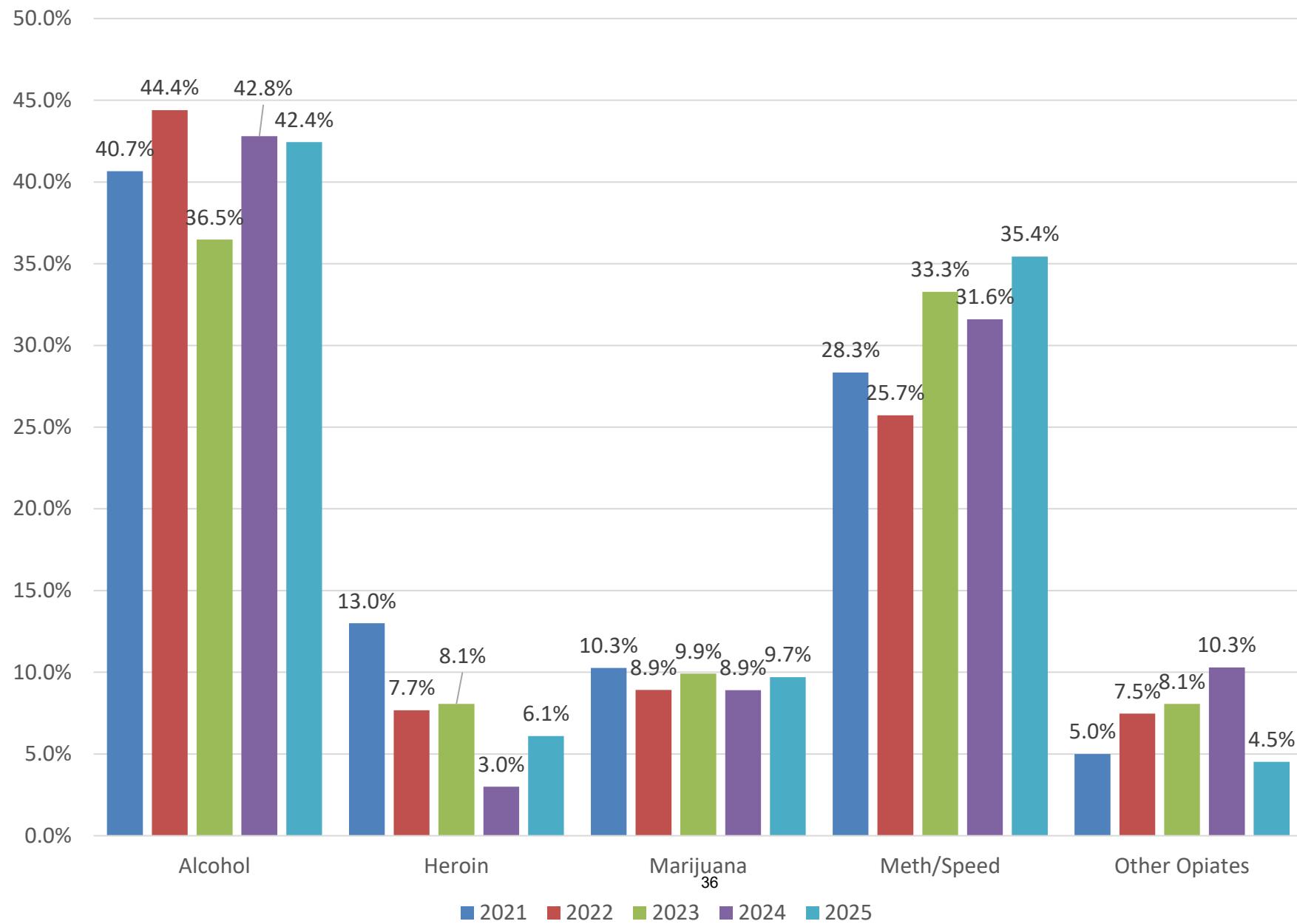
St Joe County

Primary Substance of Abuse at Admission



Van Buren County

Primary Substance of Abuse at Admission



Problem Gambling Program: Overview and NODS Screening Results



Overview:

- **Problem Gambling Grant through MDHHS:**
 - Screening for problem gambling at request for service contact
 - Implement Prevention campaigns
 - Educate communities on risk of Problem Gambling
- **Screening at SWMBH Call Center and other SWMBH SUD Access Points:**
 - National Opinion Research Center (NORC) Diagnostic Screen for Gambling Problems (NODS):
 - NODS CLiP (Loss of Control, lying, and preoccupation) three question brief screen:
 1. Have there ever been periods lasting 2 weeks or longer when you spent a lot of time thinking about your gambling experiences or planning out future gambling ventures or bets?
 2. Have you ever tried to stop, cut down, or control your gambling?
 3. No Have you ever lied to family members, friends, or others about how much you gamble or how much money you lost on gambling?
 - If yes to any of the three questions, move on to the full NODS Screening: 17 questions to determine potential level of severity of problem gambling.

Campaigns:

- Spring Campaign: April-May
- Summer Campaign: July-August
 - Billboards (KZoo area)
 - Over 8 million views
 - Social media ads
 - Facebook, Snapchat, Instagram
 - Streaming
 - Spotify, Apple Music, iHeart
- Target Audience
 - Young males/college students, 18-24yr



Campaigns:



Especially
when betting
on sports.



WinThemBack.org



40

Especially
when betting
on sports.



WinThemBack.org



(4)

Education:

- Goal is to increase awareness and educate on harms of gambling
- Presentations
 - Focuses on populations affected, characteristics of gambling disorder/problem gambling, harm reduction strategies
 - Task Forces, Coalitions, Area Agencies on Aging, Rotary, Recovery-Oriented Systems of Care, School-based groups



Michigan-Based Resources

[Problem Gambling Resources](#)

- Michigan Problem Gambling Helpline has trained and experienced counselors available 24/7 to support you or your loved one in finding the help they need.
 - Dial 1-800-270-7117 to talk to a counselor.
 - They can provide resources, conduct a screening assessment, and refer you or your loved one to treatment or support groups in your area.
- [Gamblers Anonymous](#)
 - GA is group of men and women that struggle with compulsive gambling and meet regularly to share their experiences, support each other and help others into treatment and recovery.
 - Battle Creek, MI (In-person)
 - Thursdays, 6:30pm EST
 - Alano Club, 1125 W. Territorial Road, Battle Creek, MI 49015
 - W. Bloomfield, MI (Virtual)
 - Wednesdays, 7:00pm EST
 - Zoom Link

Reasons for Gambling and Gaming



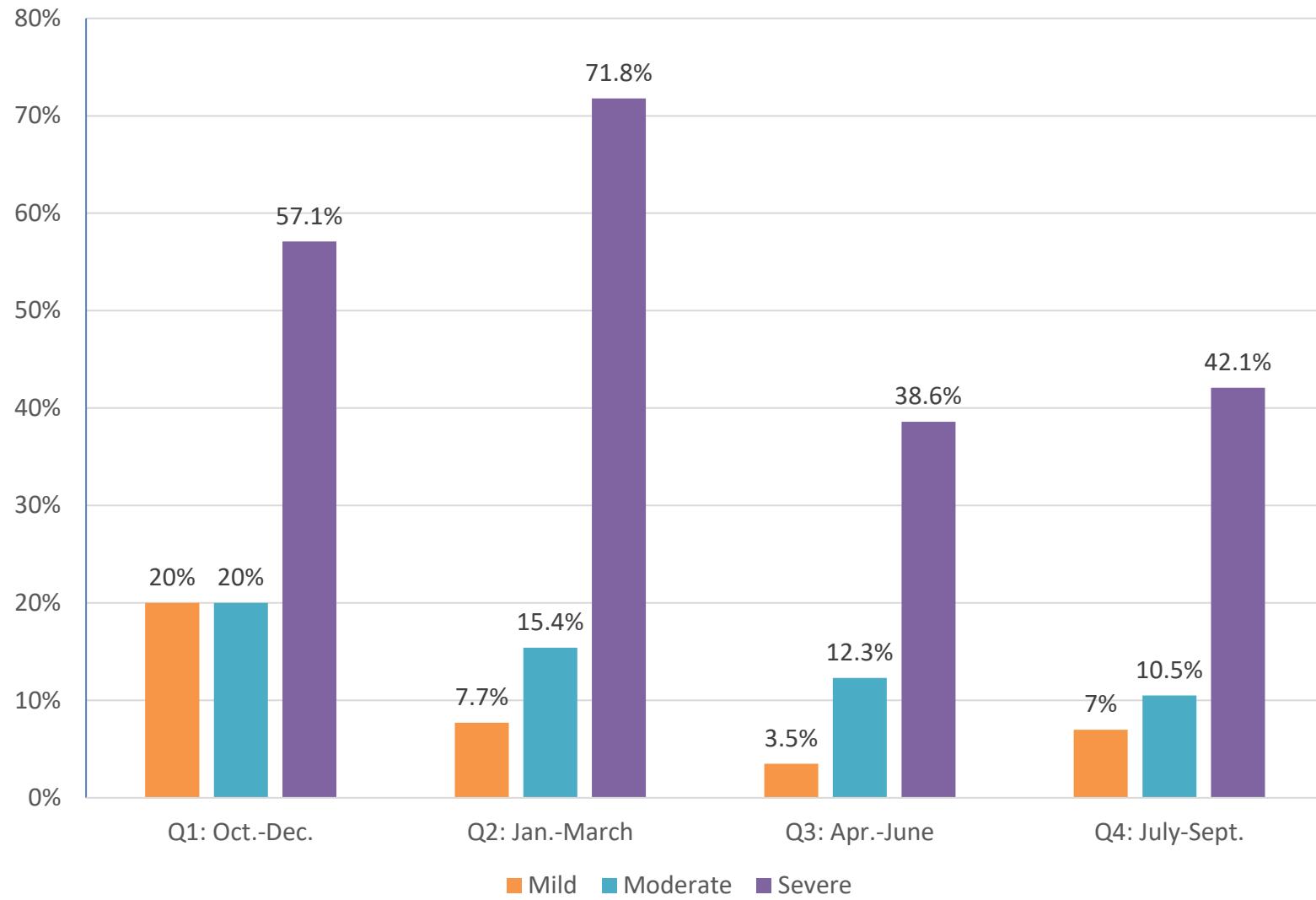
Gaming

- It's fun!!
- Social Connectedness
- Escapism/Distraction
- Challenge
- Educational

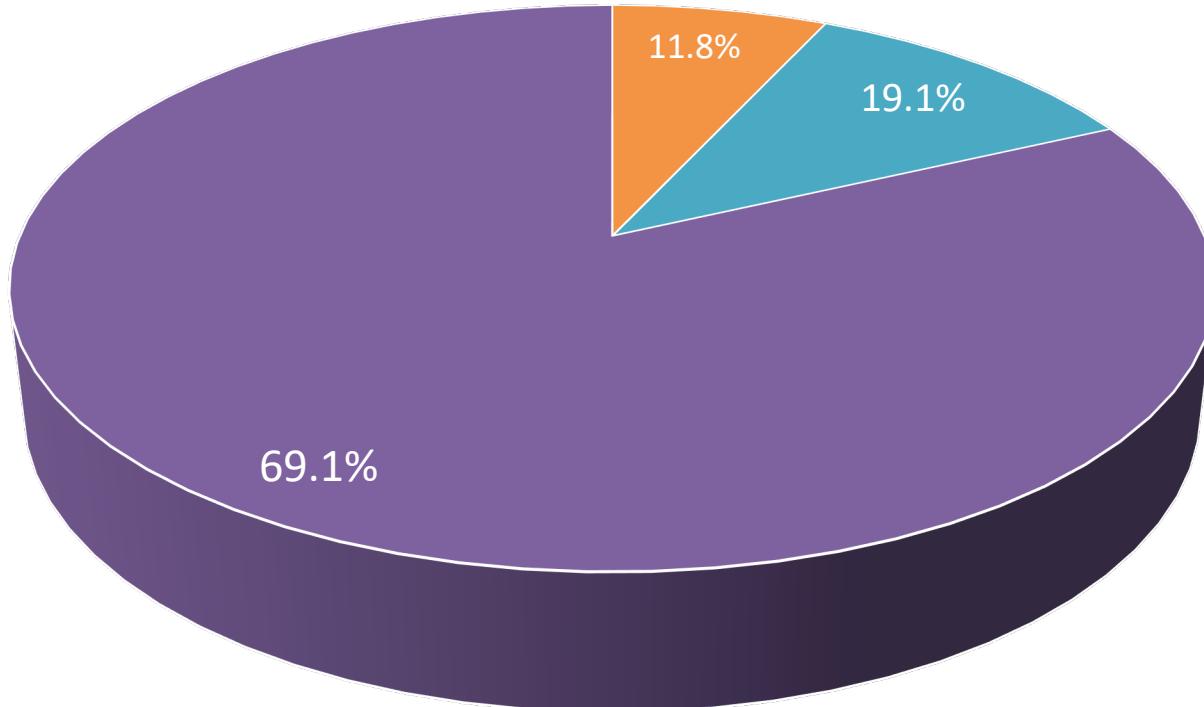
Gambling

- It's fun!!
- Social Connectedness
- Escapism/Distraction
- Challenge
- Glamorous

NODS Results per Quarter:



NODS Screening Results FY25:



■ Mild ■ Moderate ■ Severe

3,813 CLiPs Administered

136 NODS Administered (3.6%)

FY26 Riverwood: PA2 Jail Assessments and Intensive Outpatient Programming Incentives

Summary: Riverwood has requested to modify line-item amounts for their jail assessments and IOP incentives. Total funding remains the same.

Original

11. OTHER EXPENSES (Specify)		Amount
Jail Assessments for non-covered misdemeanor clients @ cost/assessment.		1,685.00
Incentives for IOP - limit \$75/person		14,400.00
11. TOTAL OTHER EXPENSES		\$ 16,085.00
12. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-11)		\$ 16,085.00
13. INDIRECT COSTS		** SWMBH'S Maximum I/C**
PUBLIC ACT 2 - PA2	5% \$ -	
- Please Select -	5% \$ -	
- Please Select -	5% \$ -	
	\$ -	
	INDIRECT RATE	0.00%
13. TOTAL INDIRECT COSTS		\$ -
14. TOTAL EXPENDITURES FUNDED (Sum of Lines 12-13)		\$ 16,085.00

Amended Budget:

11. OTHER EXPENSES (Specify)		Amount
Jail Assessments for non-covered misdemeanor clients @ cost/assessment.		10,110.00
Incentives for IOP - limit \$75/person		5,975.00
11. TOTAL OTHER EXPENSES		\$ 16,085.00
12. TOTAL DIRECT EXPENDITURES (Sum of Totals 1-11)		\$ 16,085.00
13. INDIRECT COSTS		** SWMBH'S Maximum I/C**
PUBLIC ACT 2 - PA2	5% \$ -	
- Please Select -	5% \$ -	
- Please Select -	5% \$ -	
	\$ -	
	INDIRECT RATE	0.00%
13. TOTAL INDIRECT COSTS		\$ -
14. TOTAL EXPENDITURES FUNDED (Sum of Lines 12-13)		\$ 16,085.00

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

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

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

Hon. Christopher P. Yates

Defendants.

/

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

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.

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

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.
- (b) Identification, assessment, and diagnosis to determine the specific needs of the recipient and to develop an individual plan of services.
- (c) Planning, linking, coordinating, follow-up, and monitoring to assist the recipient in gaining access to services.
- (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 CMHSPs 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.