MHA Michigan Health & Hospital Association | Leading Healthcare

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Nov. 21, 2025

RE: 2545-BH Medicaid Health Plan (MHP) Provider Mental Health Assessment Requirements for Comprehensive Health Care Program (CHCP) Enrollees

On behalf of the Michigan Health & Hospital Association (MHA) and its 128 member hospitals and health systems, we appreciate the opportunity to provide feedback on the Michigan Department of Health and Human Services (MDHHS) Mental Health Framework and the proposed policy **2545-BH: Medicaid Health Plan (MHP) Provider Mental Health Assessment Requirements for Comprehensive Health Care Program (CHCP) Enrollees**.

The MHA and its member hospitals support the MDHHS' commitment to improving integration between Community Mental Health Service Providers (CMHSPs) and MHPs, ensuring that beneficiaries experience no wrong door when accessing care. We also appreciate the MDHHS' stated assurance that there will be no penalties for providers during the initial implementation period. However, as currently structured, the framework's training, billing and operational requirements create significant barriers that may unintentionally restrict access and strain an already overextended behavioral health workforce. **The MHA and its member hospitals have serious concerns that this policy, if implemented as written, will significantly decrease access to mental health services for Medicaid patients.**

If this policy is implemented as currently written, the MHA implores the MDHHS **to remove the pre-admission screening requirement** that requires hospitals to wait until CMHs have completed before moving forward with care. The pre-admission screening requirement has been a challenge for hospitals for years, as data shows the CMHs very rarely complete the assessment within the three-hour time frame. If all providers must implement the two new assessment tools outlined in the policy, **the pre-admission screening requirement should be removed entirely**. If this requirement is not removed, providers would be completing three assessments before delivering care. This would be the opposite of good public policy and would further delay timely access to care.

Implementation Timeline and Training Capacity

The framework's retroactive effective date of Oct. 1, 2025, combined with a December 2025 policy publication date, has caused confusion about when providers must start complying with the policy. Training availability remains severely limited, with many sessions canceled or fully booked immediately, making it difficult for providers to complete the required training. **The MHA recommends all communications materials be updated to reflect an Oct. 1, 2026 implementation date.**

The MDHHS should clarify whether providers who serve both youth and adult populations will be required to complete training and certification for both the MichiCANS and LOCUS tools, as the expectation is not explicitly stated in the proposed policy. Providers shared that the trainings take 10-13 hours to complete (plus two additional hours for supervisors) and – under the current policy – must also pass a certification test to use either assessment tool. This adds significant administrative burden for providers. **The MHA strongly encourages the MDHHS to eliminate the credentialing and testing requirement entirely and instead require only completion of the training.** Providers already hold the clinical licensure and expertise necessary to determine levels of care; these training tools are intended to familiarize them with the mechanics of the tool, **not to assess clinical competency**.

Many hospitals and outpatient providers have reported that the time required, particularly for psychiatrists and other prescribers, is not operationally feasible given workforce shortages and rising demand for mental health services. One inpatient psychiatric facility estimates it will cost more than $750,000 to take providers out of clinical rotation to complete the required trainings. This is not financially sustainable for hospitals and providers. **In addition, the MHA strongly encourages the MDHHS to expand access to training opportunities.** There are currently not enough trainings being offered to meet demand and providers have reported they are routinely cancelled. This results in disruptions in care delivery that would otherwise be allocated to critical patient cases. Hospitals and providers require flexibility to determine the most efficient and clinically appropriate pathway for assessment completion. Providers estimate that compliance will result in hundreds of thousands of dollars in training, lost productivity and additional administrative costs per system during the first year – with ongoing costs for reassessments and staff turnover.

Additionally, providers continue to report challenges with duplicate documentation between electronic medical records systems (EMRs) and the MDHHS' systems that are not integrated, creating additional administrative work for providers. It also remains unclear whether CMHs have begun using the tools or if implementation will differ across systems, leading to uncertainty about consistency and coordination between CMHs and hospitals.

Recommendations:

- Delay full enforcement until training capacity and certification infrastructure are sufficient statewide.
- Allow phased or role-specific implementation, prioritizing direct behavioral health clinicians over physicians who primarily manage medications.
- Permit alternative pathways (e.g. system-led training, asynchronous learning modules or equivalency recognition) to minimize disruption in care delivery.
- Clarify how "no penalty" enforcement will operate during the transition period to give providers regulatory assurance. Offer funding offsets or directed payments to mitigate training and administrative costs.
- Ensure that documentation platforms are compatible with EMRs to prevent duplicate data entry and improve care coordination.
- Eliminate credentialing and certification testing requirements and instead require only completion of the training. Providers are already clinically qualified to determine levels of care and the testing requirement adds burden without improving quality of care.

- Create a self-paced, on-demand training option (e.g. recorded modules that can be completed during cancellations or non-clinical time) to allow for greater flexibility and reduce the need for providers to clear entire clinic schedules for live sessions.

Clarification of Assessment Scope and Use

Providers are uncertain about when and how the new assessments must be completed. Current policy language indicates that reassessment is only required when there is a *change in condition*, but this leaves ambiguity, such as whether an inpatient admission or partial hospitalization referral constitutes such an event. Patients receiving behavioral health treatment will have a *change in condition* frequently. **Asking providers to complete the assessment every time this occurs is not feasible and will lead to complexities in care delivery for patients and unnecessary cost increases for care**.

The MHA also encourages the MDHHS to clarify the new requirement for Rural Health Clinics (RHCs). Page 4C references that these tools will be *mandatory for RHCs*. This requirement was not previously communicated, and health systems that operate multiple RHCs require clear guidance on applicability, training expectations, and an attainable implementation deadline. Many rural hospitals do not provide inpatient psychiatric services or behavioral health services. **Requiring RHCs to comply with this policy as written is not feasible and will cause more confusion among providers and payers.**

<u>Recommendations:</u>

- Define the specific circumstances that trigger an initial or repeat assessment (e.g. inpatient admission, level-of-care change or discharge).
- Exempt RHCs from this policy.
- Provide written guidance on how the tools intersect with CMH, CCBHC, and pre-admission screening processes to prevent redundancy.

Evidence Base, Tool Selection, and Patient Impact

Providers continue to question the rationale for selecting Michigan's (MichiCANS) and LOCUS and whether these tools remain evidence-based in their current forms. MichiCANS is a modified version of the validated Child and Adolescent Needs and Strengths (CANS) tool. Clinicians across the state are concerned the alterations that were made to the original version may impact reliability and comparability with other state's data. Further, adding these assessments into the patient visit will impact visit times. There has been no published analysis of the expected time required to complete either tool or the potential impact on patient engagement and visit length. Providers report the assessment take more than 40 minutes to complete. This is a significant amount of time to add onto patient care visits and will have notable impacts on care delivery. Again, the MHA recommends the MDHHS reconsider this policy as written.

<u>Recommendations:</u>

- Release a technical justification for tool selection and describe the validation process ensuring continued evidence base and reliability.

- Estimate how long it takes to complete each tool and how it affects the number of patients providers can see and their experience during visits.
- Consider conducting pilot testing or phased rollouts to identify operational challenges and patient impacts before implementing statewide.

Access, Workforce and System Alignment

Requiring all qualified mental health providers to complete the MichiCANS and LOCUS training and, implement them with each Medicaid patient is a significant change to the delivery of behavioral health care in Michigan. The list of qualified mental health providers is exhaustive and burdensome for healthcare professionals that already have the training and education to provide high-quality behavioral health care. We believe asking psychiatrists to be trained in these tools and administering them routinely to patients is unnecessary.

Further, these requirements do not align with hospital best practices. For example, one of the state's largest health systems does not use Medicaid credentialed social workers (MSWs) in the emergency department setting as their costs are rolled into the hospital facility fees. The proposed policy change would require all MSWs to receive required the MDHHS training, assess patients, and bill for the assessment. The MHA strongly encourages the MDHHS to narrow the list of qualified mental health providers that must comply with this policy. **While we acknowledge that enabling providers to perform assessments internally could reduce reliance on CMHs and speed access, the policy's current scope risks overwhelming already strained clinical capacity.**

<u>Recommendations:</u>

- Engage both MHPs and provider systems in developing a unified implementation strategy that supports access while maintaining consistency in screening responsibilities.
- Decrease the provider types that must comply with this policy

Data Transparency and Policy Evaluation

During stakeholder conversations, the MDHHS has not yet provided data on how many individuals fall into the "gray area" between CMHSP and MHP responsibility that this Framework seeks to address. Without that data, it is difficult to determine whether the scope of statewide implementation is proportional to the problem. **The MHA and its member hospitals feel this is a statewide policy that is being implemented to address a small number of cases, where the MHP and PIHP disagree about who is responsible for coverage and payment.** The MHA is concerned about potential administrative burdens associated with two sets of health plans covering patients' behavioral health needs, each with their own unique prior authorization programs.

<u>Recommendations:</u>

- Publish a quantitative analysis identifying the population currently affected by coordination gaps, along with the projected costs and benefits of universal implementation.

- Establish a responsibility matrix identifying which services are covered by the MHP and which are covered by the PIHP. This will resolve issues where providers are not paid while separate plans dispute responsibility.
- Convene a joint provider–payer–state advisory group to refine rollout strategy, evaluation metrics, and performance measures related to access, timeliness and provider participation.
- Restrict health plans' ability to implement prior authorization programs for vulnerable patients who need vital behavioral health services. Behavioral health providers receive extensive training to deliver appropriate and evidence-based care. They are also required to participate in continuing education to maintain their license.

Conclusion

The MHA appreciates the MDHHS for the opportunity to comment on this proposed policy. However, we have concerns about the implications of this policy, if implemented as proposed. **The MHA and its member hospitals believe this change will further exacerbate the bifurcated public and commercial behavioral health system in Michigan. We do not require these types of assessments of processes when providing care for physical health needs**. Many hospitals and health systems anticipate having to narrow their Medicaid patient panels or reassign care to smaller, trained subgroups of providers to implement the Mental Health Framework.

The MHA received communications through our website portal that private practices are considering not accepting Medicaid insured patients altogether. **The MHA strongly encourages the MDHHS to reconsider this policy in its current form, as the risk to decreasing Medicaid access for patients with behavioral health needs is immense, which is a significant risk during the current climate.** The MHA welcomes the opportunity to work directly with the MDHHS on a revised policy and is willing to convene hospital behavioral health leaders to provide input and create other potential solutions.

Thank you for considering our feedback on behalf of Michigan's hospitals and health systems. Questions can be directed to Lauren LaPine-Ray at llapine@mha.org.

Sincerely,

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