

Dear Ms. Morningstar & MDHHS Leadership,

On behalf of the Michigan Health & Hospital Association (MHA) and our member hospitals and health systems, thank you for the department's continued engagement regarding implementation of the Mental Health Framework (MHF). Over the past year, the MHA has collected feedback from acute care hospitals and health systems, freestanding inpatient psychiatric facilities, physician leaders, and hospital financial executives on the Mental Health Framework, specifically policies [MMP 26-01](#) and [MMP 26-30](#).

The MHA and member hospitals and health systems support the shared goal of improving access, care coordination and outcomes for Medicaid beneficiaries. **However, the MHF, as written today, has significant challenges, all of which clinical leaders and the MHA feel are still unresolved and must be addressed before the October 1st implementation date.** The MHA respectfully requests that the Michigan Department of Health and Human Services (MDHHS) delay the Oct. 1 implementation until the following unresolved issues are addressed.

Unresolved Issue 1: Lack of Implementation Clarity

Providers continue to report uncertainty regarding specific implementation requirements, timelines, operational expectations, and enforcement mechanisms. Members have indicated that key questions remain unanswered, making it difficult to prepare systems, workflows, staffing models, and technology infrastructure for compliance.

Requested Action: The MHA requests that MDHHS issue an L-letter providing formal, comprehensive implementation guidance for providers for the MHF. The L-letter should clearly identify the requirements currently in effect, the components that have been delayed, applicable timelines and enforcement expectations, and the responsibilities of providers, Medicaid Health Plans (MHPs), Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Service Providers (CMHSPs). It should also resolve inconsistencies among existing policy bulletins, FAQs, webinars and health plan communications.

Unresolved Issue 2: Assessment Duplication and Clinical Workflow Concerns

Providers have requested additional guidance regarding the setting in which assessments should be completed and billed, including whether they will always be treated as outpatient services and whether a PIHP may be responsible for an assessment conducted in an outpatient setting. Questions also remain about whether an assessment must be completed by the patient's treating provider or may be assigned to a designated clinician who has limited familiarity with the patient.

MDHHS has clarified that a valid MichiCANS or LOCUS completed by another qualified provider within the previous 12 months should generally be accepted. However, the framework does not fully address duplication between the required tools, existing hospital clinical assessments, CMHSP pre-admission screening and CMHSP intake and eligibility processes. Additionally, nothing requires an MHP or PIHP to accept the score that a hospital-based provider generates on a MichiCANS or LOCUS assessment.

Hospitals also need clearer direction regarding who is responsible for completing an assessment after a patient stabilizes following an emergency department visit, psychiatric hospitalization or crisis episode. This clarification is critical for providers to be able to implement the policy effectively and for payers to pay claims accurately. Similar questions remain for prescriber-only practices in which patients receive medication management but do not routinely see a therapist or social worker.

Requested Action: The MHA requests that MDHHS publish a statewide workflow identifying where assessments may be conducted, which providers may complete them, which claim types and billing codes should be used, and which payer is responsible. The department should also establish clear standards for designated assessors,

Brian Peters, Chief Executive Officer

including the level of familiarity and interaction with the patient needed to complete a clinically reliable assessment.

Unresolved Issue 3: Added Administrative and Technology Burden

Hospital electronic health records are not integrated with the systems used to submit MichiCANS and LOCUS results. MichiCANS must be entered into CareConnect360, while many providers must use a separate LOCUS website. The LOCUS platform available to unaffiliated providers is entry-only, requiring providers to separately save assessment records for their files. These processes create additional logins, duplicate data entry and difficulty tracking whether an assessment has been completed or is due for annual reassessment.

Behavioral health clinicians at Michigan's largest inpatient psychiatric hospital have piloted the assessments and reported that one assessment, done correctly, adds an additional 45-60 mins to a patient encounter. This is substantially longer than the approximately 25 minutes reflected in the department's comparison-rate methodology. Although assessment services are billable, the comparison rates are not mandatory, and payment may vary among MHPs and PIHPs. A billable code also does not account fully for training expenses, lost productivity and reduced appointment capacity. This added time is significant in reducing clinical care time and access to care.

Requested Action: The MHA requests that MDHHS establish a streamlined process for providers to submit, retrieve and track assessments and provide support for necessary technology changes. The department should also evaluate the time and resources required to administer the assessments, issue clear and consistent reimbursement guidance, and establish a process for addressing unpaid or denied assessment claims.

Unresolved Issue 4: Uncertainty on Workforce Capacity and Access Implications

MDHHS has indicated that organizations may train a smaller group of designated staff rather than every eligible clinician. However, this approach may conflict with guidance suggesting that the assessment should be completed by a provider who knows the patient well. A designated assessor may require substantially more time to collect the information needed to complete an accurate assessment, while requiring treating clinicians to administer the tools would impose significant training demands and reduce their availability for direct patient care.

These concerns are particularly significant in rural and underserved communities, where behavioral health providers are already limited and patients may wait months for services. Additional training and assessment responsibilities could further reduce appointment capacity and discourage providers from continuing to participate in Medicaid.

Requested Action: The MHA requests that MDHHS clarify the qualifications, patient contact and clinical information a provider must have to complete a reliable assessment. The department should establish an operationally feasible model that preserves clinical accuracy without requiring every treating clinician to complete extensive training.

Unresolved Issue 5: Lack of Payer Accountability and Coverage Responsibility

Although assessment results do not currently change payer responsibility while the related coverage changes are delayed, providers need clear guidance regarding how the future model will operate. It remains unclear whether all inpatient and outpatient behavioral health services will shift to the payer identified through the assessment, whether PIHPs will become responsible for outpatient services they have not traditionally covered, and whether references to PIHP responsibility include services administered or paid through CMHSPs.

Providers are also concerned that a patient's condition and assessment result may change frequently. If each new result can change payer responsibility, billing departments may have to repeatedly determine where claims should be submitted, creating additional denials, rebilling and delays in payment. The assessment itself may not resolve existing disputes if MHPs and PIHPs can still disagree about when responsibility transferred or whether a particular score accurately reflects the patient's needs.

Requested Action: The MHA requests that MDHHS publish a complete service-level payer-responsibility matrix explaining when assessment results will affect coverage, which entity is responsible for inpatient and outpatient services, when a change in responsibility becomes effective, and how reassessments will affect claims already authorized or in progress. MDHHS should also establish a single payment and dispute-resolution process that protects providers and patients from denials, rebilling and disruptions when payer responsibility changes or remains disputed.

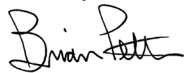
Given the number and significance of these unresolved issues, the MHA respectfully requests that MDHHS delay any remaining Oct. 1, 2026 implementation and compliance deadlines until the department has issued the requested L-letter, clarified assessment and billing workflows, defined payer responsibilities, and demonstrated that affected organizations are operationally prepared. The MHA would welcome creating a new workgroup comprised of MHA members hospitals to identify current workflows, challenges faced, and the workable solutions outlined above that resolve the identified goals. MHA would welcome MDHHS' involvement in this workgroup. If MDHHS goal is to ensure plans are correctly assigned coverage and payment responsibility through this process and their requirements are delayed without a future target implementation date, the provider requirements should also be delayed, with implementation of their requirements tied to plan requirements.

Implementation has already been paused for payers. **The MHA respectfully requests the MDHHS to do the same for providers.** It is critical to note that 2027 is fast approaching, which brings the new Medicaid redetermination process required by H.R.1. Requiring providers to also participate in the MHF during an already challenging time for Medicaid beneficiaries is a significant risk. It is the MHA's position that we should be making it easier for both providers to deliver care to Medicaid beneficiaries while making it easier for Medicaid beneficiaries to receive their care. **The MHF as currently written does neither of those things.**

The MHA remains committed to working collaboratively with MDHHS to improve care coordination and access to behavioral health services. We welcome continued dialogue regarding these concerns and opportunities to identify solutions that advance the department's goals while minimizing disruption to providers and patients. Questions can be directed to MHA staff [Lauren LaPine-Ray](#) and [Jason Jorkasky](#).

Thank you for your consideration.

Sincerely,



Brian Peters
CEO

cc: Meghan Groen
Amy Epkey
Penny Rutledge