# Statewide Policy Impact Assessment

## Proposed Blue Cross Blue Shield of Michigan Incident-to Billing Policy Changes

*A statewide survey of 2,769 behavioral health professionals and clients on the scope and consequences of the proposed policy change. Responses received from:*

| 689 | 1,856 | 224 | 2,769 |
|---|---|---|---|
| Limited licensed providers | Fully licensed providers & practice owners | Clients | Total respondents |

Prepared and conducted by the Michigan Mental Health Counselors Association (MMHCA) with the collaboration and support of:

National Association of Social Workers–Michigan (NASW-MI)
American Association for Marriage and Family Therapy (AAMFT)
Michigan Psychological Association (MPA)

**July 30, 2026**

Methodological note: All findings in this report are respondent-reported experiences and expectations. Because survey participation was voluntary, results should not necessarily be treated as statistically representative of the full professional population. The large respondent base - 2,769 individuals across three stakeholder groups, spanning four licensed professions, all practice settings, and communities throughout Michigan - and the consistency of findings across all three independent surveys strengthen the credibility of the patterns documented here. The absolute numbers represented here cannot be disputed and give these findings substantial credibility.

# Executive Summary

Blue Cross Blue Shield of Michigan (BCBSM) has announced changes to its commercial "incident-to" billing policy that will take effect in two phases: September 1, 2026 (Phase 1) and March 1, 2027 (Phase 2). To understand the impact of these changes on Michigan's behavioral health workforce and its clients, the Michigan Mental Health Counselors Association (MMHCA), the National Association of Social Workers – Michigan Chapter (NASW-MI), American Association for Marriage and Family Therapy (AAMFT) and the Michigan Psychological Association (MPA) conducted three statewide surveys in June/July 2026, receiving responses from 2,769 participants.

The findings document two simultaneous and reinforcing pathways through which this policy is likely to reduce behavioral health access in Michigan - one immediate, one structural and long-term.

## The Two-Track Impact

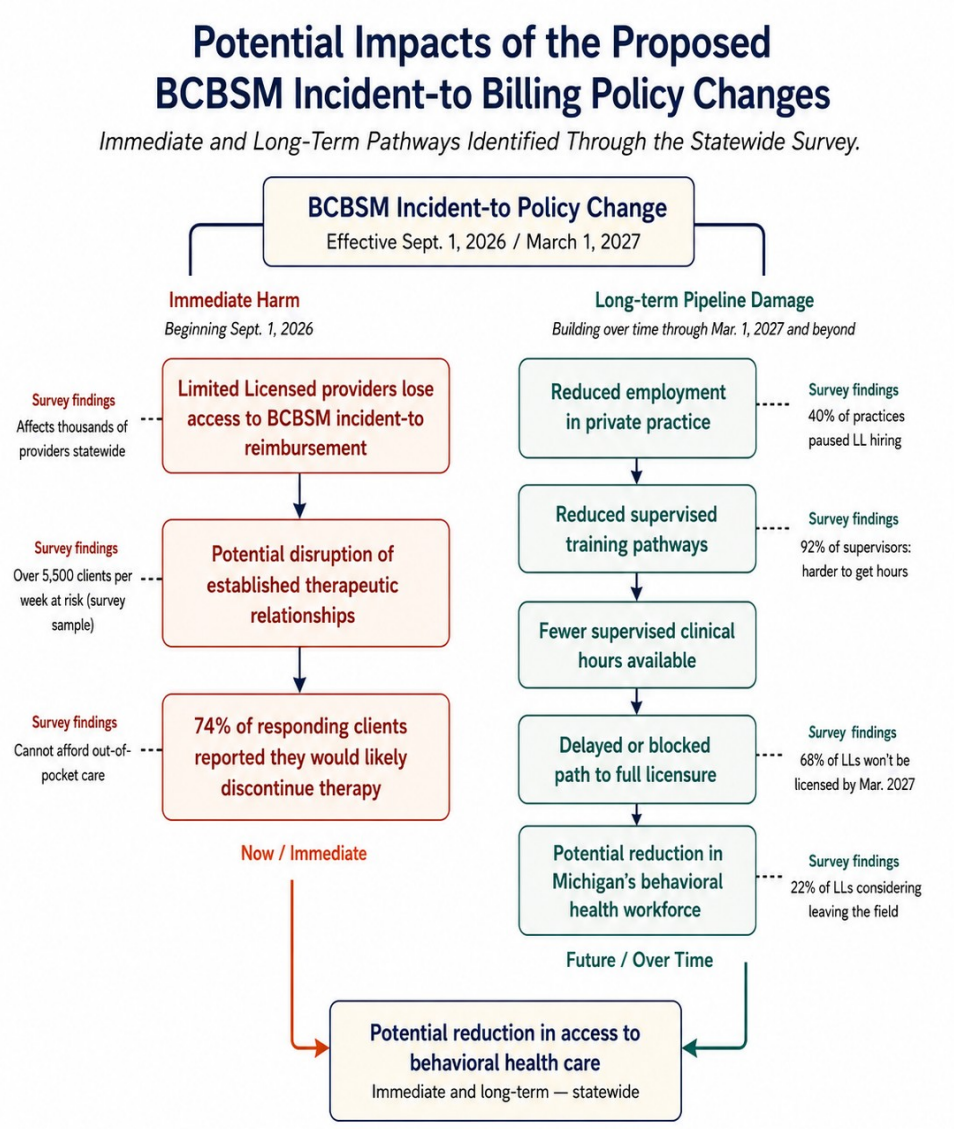


***Figure 1.*** Conceptual model summarizing two principal respondent-reported pathways through which the proposed BCBSM incident-to billing policy could affect Michigan's behavioral health workforce and access to care. The model integrates findings from the *quantitative* and qualitative survey analyses.

## Five Headline Findings

- **Thousands of clients face immediate disruption.** Survey respondents represent over 5,700 BCBSM clients seen weekly by limited licensed providers - including more than 1,000 in active crisis stabilization or safety planning. Responding practice owners report that fully licensed staff could absorb approximately 1,900 of an estimated 10,400 weekly LL-served BCBSM clients at their practices. The gap represents thousands of clients with no identified provider.
- **73% of clients would go without care.** When asked what they would do if their provider could no longer bill their insurance, 73% of client respondents said they would go without mental health care - either because they cannot afford out-of-pocket costs or because they do not expect to find another provider quickly. Only 3 respondents of 224 said they could afford out-of-pocket care without financial difficulty.
- **The workforce pipeline faces structural disruption.** 68% of limited licensed providers do not anticipate full licensure by March 1, 2027. Among supervisors, 92% reported the policy will make it harder for LLs to get required hours and will reduce employment options needed for licensure. 41% of practice owners have already paused hiring limited licensed clinicians.
- **Private practices cannot absorb the displaced clients.** 89% of fully licensed providers are already at or near full caseload capacity. Responding practices could absorb roughly one-fifth of the BCBSM clients currently served by limited licensed clinicians. 42% of practice owners said their practice would likely close or downsize significantly.
- **The impact is likely understated.** The surveys reached only current LARA licensees - not the incoming cohort of recent graduates currently applying for limited licenses. This new cohort, potentially several thousand individuals (last year over 2,500), will spend virtually their entire limited license period under this policy. Faculty from at least one Michigan graduate program report students considering leaving the state rather than begin supervised practice under the new policy.

*“This could literally mean someone’s life or death. I don’t mean that dramatically. I mean that seriously.”*

- Client respondent

***“We are not requesting simply a delay or further study. We are asking BCBS to keep the current framework as the permanent policy for limited licensed behavioral health clinicians in professional settings and to withdraw the elimination of incident-to billing in those settings. This new BCBSM policy will impose significant negative impact on patient care. Making the current system permanent has a neutral impact. Enhancing the number of providers would help, but this policy change does the opposite.***

- MMHCA / NASW-MI / AAMFT / MPA position

## Background

BCBSM has announced changes to its commercial incident-to billing policy effective in two phases. Beginning September 1, 2026, incident-to claims must use the SA modifier. Beginning March 1, 2027, providers eligible for direct participation must bill under their own National Provider Identifier (NPI), and providers holding what BCBSM describes as “provisional licensure” will no longer be eligible for incident-to reimbursement in professional practice settings.

BCBS specifically mentions that clinicians with limited licenses including limited licensed counselors (LLC), limited license Masters Social Workers (LMSWs), temporary limited license psychologists (TLLPs) and Limited License Marriage and Family Counselors (LLMFTs) will not be able to use incident-to billing pathways and will not be eligible for direct participation with BCBSM after March 1st, 2027 in a professional setting. However, they would be able to continue to use incident-to billing in a facility environment such as a Community Mental Health (CMH) agency, an outpatient psychiatric center (OPC) or inpatient psychiatric facility. The volume of positions in those settings does not meet the quantity of providers who would be forced out of private practice by this change.

This report documents the scope of that potential impact through three independent statewide surveys administered to the populations most directly affected.

## Methodology

Three surveys were developed and distributed jointly by MMHCA, NASW-MI, AAMFT and MPA during June 17–30, 2026. Data collection remains technically open but response volume has slowed substantially.

| Survey | Population | Respondents | Key question sets |
|---|---|---|---|
| Survey 1 | Limited Licensed Professionals (LLPC, LLMSW, LLMFT, tLLP) | 689 | Licensure timeline, client caseload, financial impact, consequences |
| Survey 2 | Fully Licensed Professionals & Practice Owners | 1,856 | Caseload capacity, supervision, workforce pipeline, practice sustainability |
| Survey 3 | Behavioral Health Clients | 224 | Access to care, continuity, financial barriers, impact of losing provider |

Methodological transparency: These surveys used voluntary, self-selected participation distributed via email to approximately 48,000 behavioral health professionals from the LARA licensure database, and endorsed by MMHCA, NASW-MI, AAMFT, MPA, and professional social media groups. The client survey was distributed through provider networks.

Because participation was voluntary, findings reflect the experiences and expectations of those who chose to respond and although it may not represent the full population, the cumulative impact on these respondents and their clients is undeniable. And, the consistency of findings across three independent surveys of three different populations strengthens confidence in the direction and magnitude of the patterns documented. All statistics are reported with valid N counts. Language throughout uses “respondents reported” and “findings suggest” rather than causal claims.

# Section 1: The Client Perspective

Survey 3 - 224 respondents

Although the smallest of the three surveys, client responses carry particular weight for policymakers and legislators: they come from people with no professional or financial stake in the outcome, describing their personal experience of accessing mental health care. 150 respondents were the client themselves; 38 were answered on behalf of a client such as a child. 87% are currently receiving mental health services. 84% carry BCBSM or BCN commercial insurance.

## Who Responded

| 87% | 84% | 47% | 33 |
|---|---|---|---|
| Currently receiving mental health services | Have BCBSM or BCN insurance | Currently seeing a limited licensed provider | Median age of person receiving services |

| Community type | Respondents |
|---|---|
| Small town or suburb | 91 (44%) |
| Mid-size city | 61 (29%) |
| Rural community | 30 (14%) |
| Large city or metro area | 27 (13%) |

## Access Barriers That Exist Before This Policy Takes Effect

Client respondents describe a system that is already difficult to navigate. The proposed policy would impose further restrictions on a workforce that is already insufficient to meet demand.

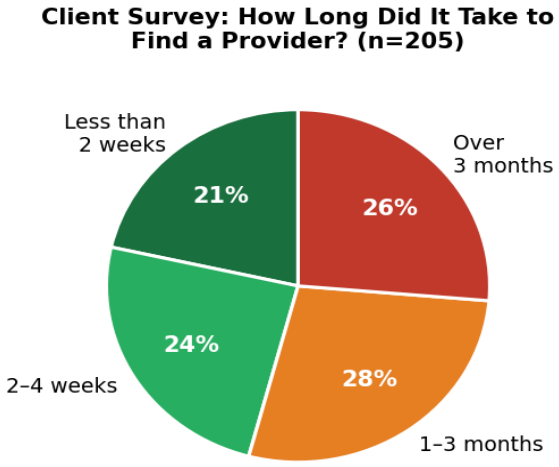


*Figure 2. How long did it take to find a mental health provider? (n=205)*

| 54% | 42% | 98% | 3 |
|---|---|---|---|
| Waited more than 1 month to find a provider | Have been unable to get care due to insurance | Say out-of-pocket care would be difficult or impossible | Respondents who could afford out-of-pocket care easily |

## What Clients Would Do if They Lost Their Provider

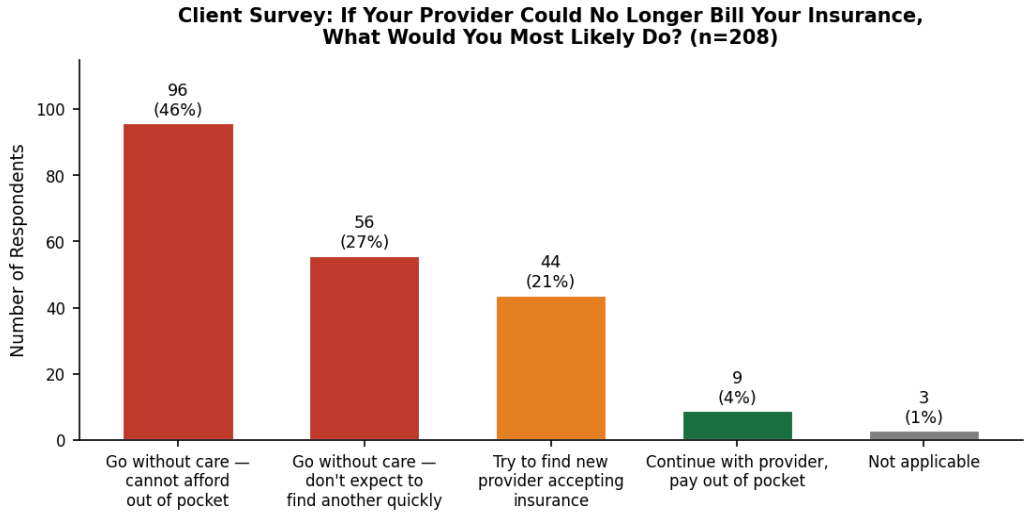


*Figure 3. If your provider could no longer bill your insurance, what would you most likely do? (n=208)*

Combined, 73% of client respondents said they would go without mental health care - 46% because they cannot afford out-of-pocket costs, and 27% because they do not expect to find another provider quickly. Only 3 respondents (1.4%) said they could afford out-of-pocket care without financial difficulty.

## In Their Own Words

The open-ended responses from clients are among the most powerful data in this report. Three themes dominate: the irreplaceability of established therapeutic relationships, the severity of existing access barriers, and the direct connection between losing care and crisis-level risk.

> *"My son suffers from OCD. We have been through three therapists before we found the one we have now. This woman has been life-changing for my son. We went from a child who couldn't leave my side to one who is having playdates and riding roller coasters. He trusts this woman like family. And now because she doesn't have the right letters after her name, my insurer won't cover her?"*
>
> - Client, parent

> *"Our child would end up in hospital."*
>
> - Client, answering on behalf of a child

> *"I began seeing my therapist when she held a limited license. My work with her over the last decade significantly changed my life for the better - I was able to graduate from university, go to graduate school, and develop healthy relationships."*
>
> - Client

> *"It already took me months to find my current provider. I live in a small town. There is only one therapy place that takes my insurance. I can't justify traveling 30 or more minutes for therapy."*
>
> - Client

> *"Policies that reduce the ability of supervised clinicians to serve BCBSM members will not reduce the need for mental health care - they will just reduce access to it. The result will be longer waitlists, fewer providers, and more people going without treatment when they need it most."*
>
> - Client

## Section 2: The Limited Licensed Provider Perspective

Survey 1 - 689 respondents - LLPC, LLMSW, LLMFT, tLLP

This survey targeted clinicians currently holding a limited license working in private practice or school-based settings. These are the providers whose billing status sits at the center of the proposed policy change.

### Who Responded

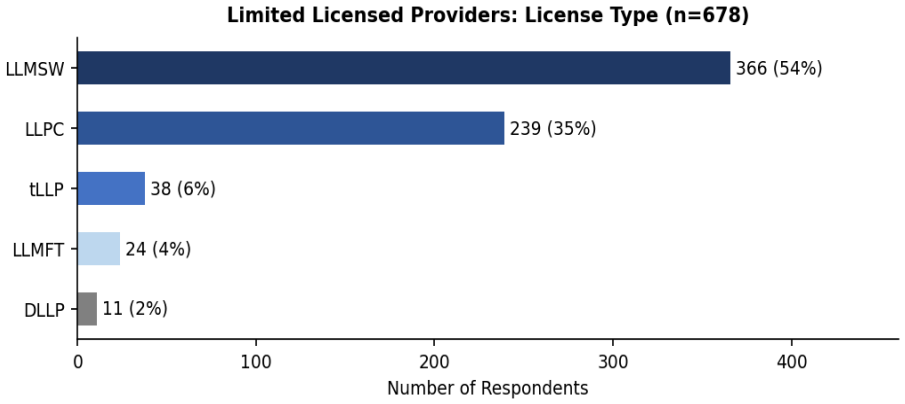


*Figure 4. Limited licensed respondents by license type (n=678)*

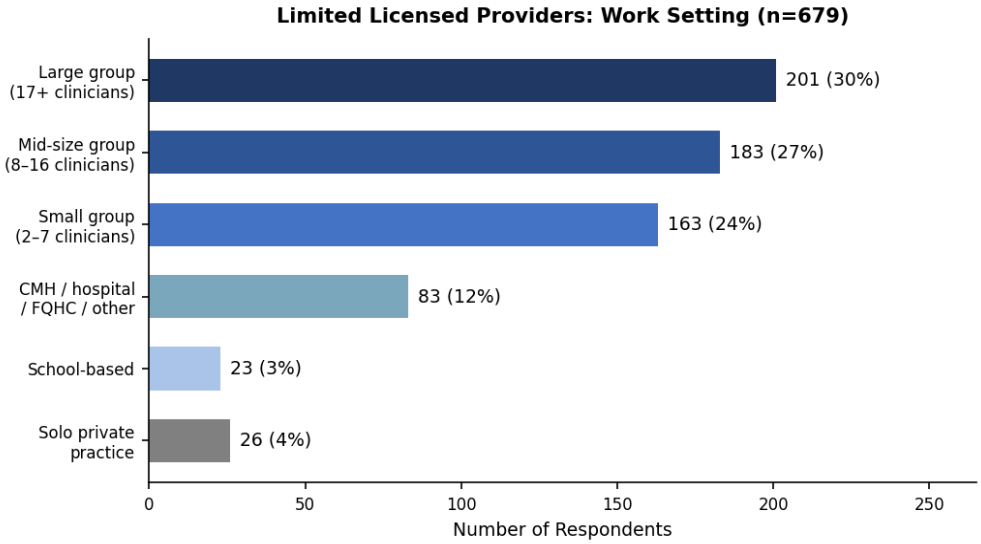


*Figure 5. Limited licensed respondents by work setting (n=689)*

## Licensure Timeline

A foundational question is how many limited licensed providers will have achieved full licensure before the March 1, 2027 implementation date. Findings suggest that most will not.

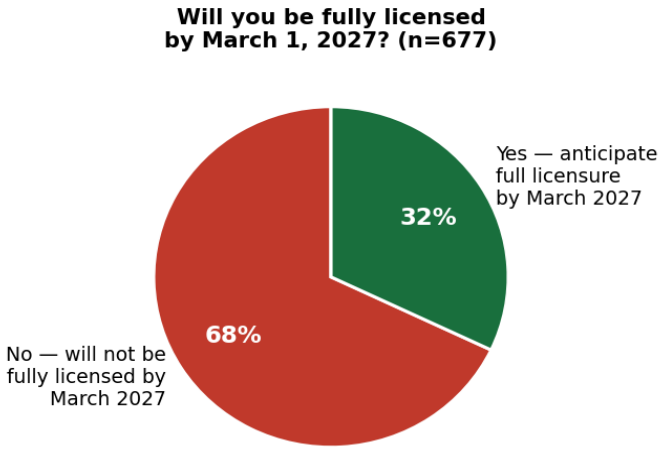


*Figure 6. Will you be fully licensed by March 1, 2027? (n=677)*

| 68% | 74% | 94% |
|---|---|---|
| Do not anticipate full licensure by March 2027 | Believe this policy will delay their path to licensure | Said yes or uncertain about licensure delay |

A note on related figures: 76% of respondents also selected licensure delay in the multiple-consequence chart below. That figure comes from a different question - a multiple-select list where licensure delay was one of several consequences respondents could identify alongside financial strain, employment disruption, and others. The two percentages measure the same concern from different angles and are mutually reinforcing, not contradictory.

## The Clients They Serve

| 5,762 | 3,177 | 1,035 | 55% |
|---|---|---|---|
| BCBSM clients seen weekly by LL respondents (n=564) | With serious or complex diagnoses (n=556) | In crisis stabilization or safety planning (n=540) | Median share of clinical income from BCBSM |

BCBSM clients represent a median of 55% of a limited licensed provider's total clinical income. For most respondents, this proposed policy is not a billing adjustment - it represents the potential elimination of more than half their professional income.

## Anticipated Immediate Consequences

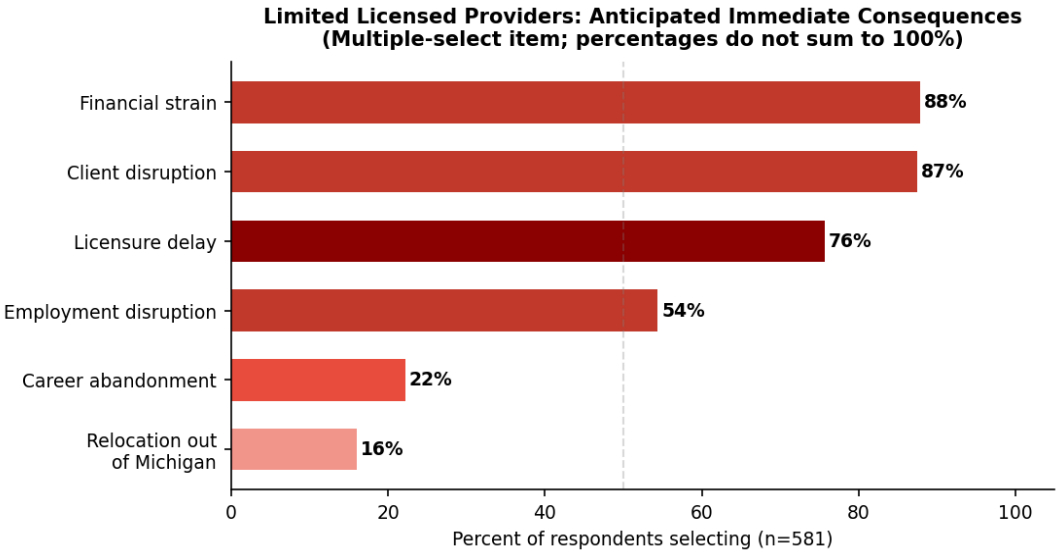


*Figure 7. Anticipated immediate consequences if policy takes effect (n=581; multiple-select item)*

This was a multiple-select item (respondents could choose more than one answer). The high rates across nearly every category suggest respondents anticipate cascading effects, not a single isolated disruption. Of particular note for workforce planning: **22% are actively considering leaving the mental health field entirely**, and **16% are considering leaving Michigan**.

Student loan debt compounds the financial picture. 74% of respondents carry graduate school debt. Among those who shared an amount (n=74), the mean was $68,242 (median $60,000). Several respondents describe six-figure debt taken on in anticipation of a career this policy would now undermine.

## In Their Own Words

Provider open-ended responses address two consistent arguments: that a limited license reflects a stage of career development rather than a level of competence, and that the supervision available in private practice settings is often more rigorous than what is available in facility settings.

> *"As a limited license clinician, I have already graduated with a Master's degree and completed two internships. Being a limited license clinician does not make someone less qualified or capable."*
>
> - Limited licensed provider

> *"My clinical supervisor reads and approves every clinical note I record. We meet several times per month. When clients learn there is a care team behind me, they are actually relieved. Fully licensed practitioners cannot always provide that."*
>
> - Limited licensed provider

> *"The only way to get fully licensed is through seeing clients. This change would effectively bottleneck and kill the mental health profession in Michigan. That is not hyperbole. It's reality."*
>
> - Limited licensed provider

> *"I have $160,000 in student loan debt and your policy is what greets me on the other side of eight years of school."*
> - Limited licensed provider

## A Population Not Yet Counted: The Incoming Graduate Cohort

The 689 respondents represent current LARA limited licensees only. They do not represent the cohort of recent graduates now applying for limited licenses for the first time. Because Michigan requires a minimum of two years under a limited license before full licensure, the majority of active limited licensed providers turns over approximately every two to three years. A new cohort - potentially several thousand individuals, based on last year's new licensees (over 2,500) - is entering the licensure process now and is not captured in any of the figures above.

This new cohort faces a distinctly difficult situation: they will spend virtually their entire limited license period operating under this policy from nearly their first day of supervised practice. Faculty from one Michigan graduate training program have reported that current students are actively considering leaving Michigan to begin their supervised hours in other states rather than practice under this policy. If accurate, this would represent a pre-emptive pipeline disruption that no survey of current licensees can measure.

*The size of the incoming cohort, the potential for graduate-level outmigration, and any effect on Michigan graduate program enrollment are beyond the scope of this survey. They are identified here as priority areas for follow-up inquiry. Taken together, they suggest the figures in this report represent a conservative lower boundary on the policy's total impact.*

# Section 3: The Fully Licensed Provider & Practice Owner Perspective

Survey 2 - 1,856 respondents

This survey reached fully licensed mental health professionals (LPC, LMSW, LLP, LP, LMFT) and practice owners and administrators across Michigan. 291 identified as practice owners or administrators and completed an extended section on practice-level impact. The average respondent has been licensed for 15 years (median 13) - these are established clinicians with deep familiarity with the workforce and billing environment.

## Capacity: The Absorption Problem

Whether fully licensed providers at capacity and cannot absorb clients displaced from limited licensed providers is a central operational question for this policy. The data consistently point in one direction. The question: Are you currently at or near caseload capacity?

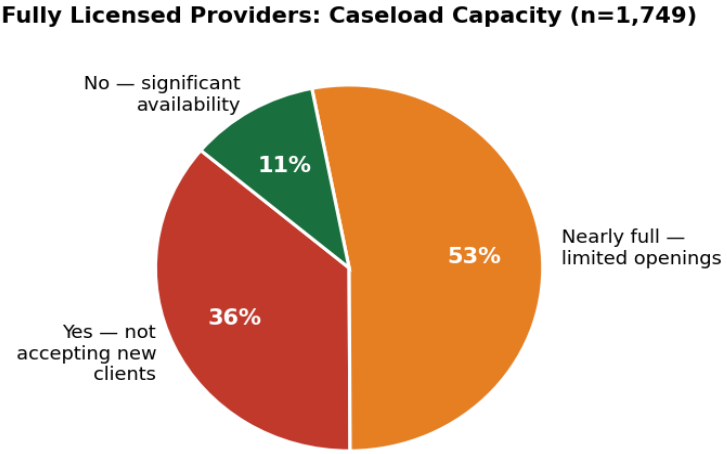


*Figure 8. Fully licensed provider caseload capacity (n=1,749)*

| 89% | 4.6 | ~10,422 | ~1,915 |
|---|---|---|---|
| Already at or near full caseload capacity | Average additional clients a licensed provider could absorb | BCBSM clients seen weekly by LLs in responding practices | Clients responding practices estimate fully licensed could absorb |

Responding practice owners reported that LL clinicians at their practices serve approximately 10,400 BCBSM clients weekly (n=243). The same owners estimated that fully licensed staff could realistically absorb approximately 1,900 of those clients (n=227). Because these figures come from different valid Ns, the gap is best expressed as a ratio: responding practice owners estimated their fully licensed staff could absorb roughly one-fifth of the BCBSM clients currently served by limited licensed clinicians.

## The Workforce Pipeline

Among the 491 fully licensed providers who currently supervise LLs for BCBSM incident-to billing, the assessment of the pipeline impact was near-unanimous:

| Pipeline impact | Respondents (n=491) |
|---|---|
| Will make it more difficult for LLs to get required hours | 454 (92%) |
| Will reduce employment options for LLs to reach full licensure | 455 (93%) |
| Will slow the number of people becoming fully licensed | 408 (83%) |
| No impact | 7 (1%) |

Practice owners collectively report their practices supervising 1,659 limited licensed providers through to full licensure over the past five years (n=266). This documents the private practice sector's concrete contribution to Michigan's behavioral health workforce development - a contribution this policy would substantially curtail.

92% of fully licensed respondents stated that private practice adequately prepares limited licensed clinicians for full licensure. This near-unanimous professional judgment from the supervisors responsible for that training directly challenges the implicit premise that facility-based supervision is preferable.

## Practice Sustainability

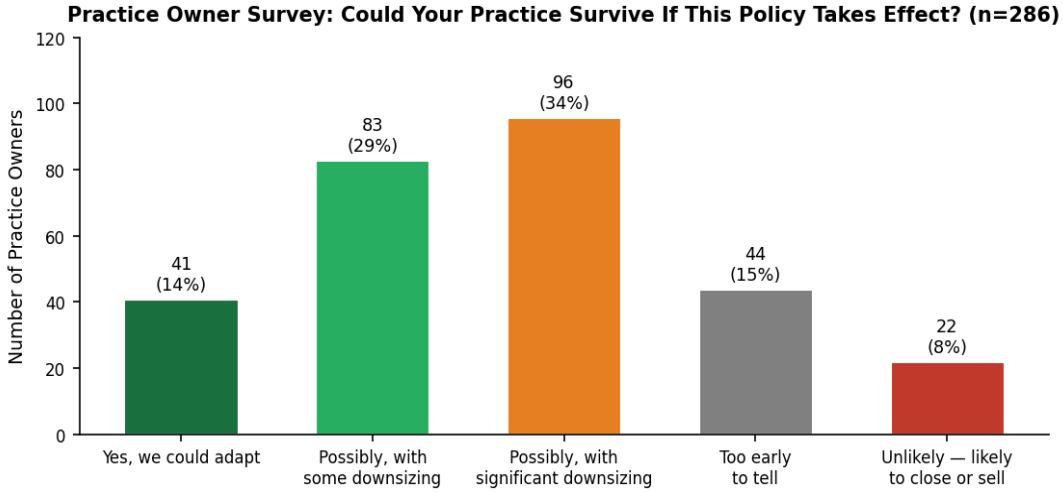


*Figure 9. Could your practice survive long-term if this policy takes effect as written? (n=286)*

| | | | |
|---|---|---|---|
| **41%** | **45%** | **239** | **34%** |
| Have already paused hiring limited licensed clinicians | Plan to employ fewer LLs if policy takes effect | Non-clinical staff positions potentially at risk | Mean % of practice revenue from BCBSM incident-to billing |

Only 14% of responding practice owners said they could adapt without downsizing. 8% said they would likely close or sell entirely. The combination of revenue exposure, existing hiring pauses, and near-full capacity across the licensed workforce creates conditions in which the policy's effects cannot be absorbed - they will be passed on to clients.

## In Their Own Words

*“We would see fewer kids. Longer waits for families. We anticipate more high-acuity referrals from ERs and PCPs.”*

- Practice owner

*“We already serve communities where access to mental health care is limited. Without the LLMSWs, there are certainly communities that will go without.”*

- Practice owner, rural Michigan

*“Current, real people with mental health conditions who have established trusting relationships with limited licensed providers could be forced out of those meaningful relationships in ways that are not medically recommended and, in worst cases, unsafe.”*

- Fully licensed provider

*“Our communities are the autistic, the ADHD, and the LGBTQIA+ community. You are hurting the autistic community especially, tremendously.”*

- Practice owner

## Section 4: Qualitative Analysis - Themes Across All Three Surveys

4,634 open-ended responses coded across 13 question sets

Open-ended responses from all three surveys were coded thematically using a five-theme framework. Themes are not mutually exclusive; many responses address multiple themes. The near-even distribution across all five themes is itself a finding: respondents did not cluster around a single concern. The policy is experienced as simultaneously threatening clients, clinicians, practices, the workforce pipeline, and the professional standing of limited licensed clinicians.

| 1,822+ | 1,637+ | 1,620+ | 1,582+ | 1,456+ |
|---|---|---|---|---|
| Theme 1: Access & Continuity | Theme 2: Workforce Pipeline | Theme 3: Practice Sustainability | Theme 4: Qualifications & Supervision | Theme 5: Messages to Decision-Makers |

### Theme 1: Access to Care and Continuity of the Therapeutic Relationship

The most frequently occurring theme across all question sets. Clients describe the therapeutic relationship as irreplaceable, not interchangeable. The idea of starting over is experienced not as inconvenience but as potential clinical setback - and for some, as a reason to abandon care entirely.

> *"It already took me months to find my current provider. There is only one therapy place in my town that takes my insurance. The idea that I would have to start over is devastating."*
> - Client

> *"I have several clients for whom this will be a very dangerous situation. They have significant clinical needs and there are no providers in the area taking new clients."*
> - Limited licensed provider

### Theme 2: The Workforce Pipeline

Raised by all three stakeholder groups independently. Limited licensed providers describe immediate barriers to accumulating the supervised hours required for full licensure. Supervisors and practice owners document the pipeline role of private practice. Clients connect the pipeline to their own future access to care.

> *"If I am unable to practice as a tLLP, I cannot work in my field until I go to internship. There is currently a three-year wait for internship applicants."*
> - Limited licensed provider, tLLP

> *"This isn't going to encourage people to get fully licensed - it's going to encourage them to quit."*
> - Client

### Theme 3: Practice Sustainability and Economic Impact

BCBSM clients represent a median of 55% of a limited licensed provider's clinical income. The economic exposure documented here is not marginal - for most respondents, this policy threatens their ability to remain in the profession.

*“I have spent over $100,000 on my graduate education and am two-thirds done with my supervised practice hours. This change will leave my clients with no access to therapy and destroy our business.”*
- Limited licensed provider

*“If this stays in place, our private practice that serves over 200 clients weekly in our small town may be forced to close. Our community mental health is backed up - clinicians there may only see clients once every three months.”*
- Practice owner

## Theme 4: Professional Qualifications and Supervision Quality

This is the most consistent argument in provider open-ended responses. Across hundreds of independent responses, providers articulate the same position: the “limited” in limited license reflects a stage of career development under supervision, not a level of competence. Many respondents note that the supervision provided in private practice is more rigorous than what is available in facility settings - a claim corroborated by 92% of fully licensed respondents who said private practice adequately prepares LLs for full licensure.

*“Clients seen by a limited licensed provider actually receive extra care because their cases are overseen by another fully licensed clinician. It would be devastating for a significant portion of the mental health community to lose access to limited licensed professionals.”*
- Limited licensed provider

*“I get more high-quality supervision at private practice than I ever got at a non-profit facility or CMH.”*
- Fully licensed provider

## Theme 5: Messages to Decision-Makers

A significant portion of provider responses articulate a constructive ask: delay, clarify, create a credentialing pathway, and don’t reduce services to clients. Both providers and clients independently raise the argument that reducing access to outpatient preventive mental health care will simply increase costs through emergency department utilization, psychiatric hospitalization, and medical care for mental-health-related physical conditions.

*“As a small business owner, being able to provide a robust benefit package to my employees is vital. Reducing mental health coverage hinders my ability to recruit and retain talent. Denying access to necessary medical care is callous. I sincerely hope BCBSM reconsiders their updated policy as it will devastate their beneficiaries and harm Michiganders."*
- Client

*“*"These services are a major help to many people. They help prevent real physical and financial harm both to their patients and to others. Mental health care prevents violent tragedies and increases the abilities of the workforce. We should be expanding access to care, not limiting it."
*- Client*

*“*"If client access to outpatient mental health services is limited, mental health care will likely lead to reactive care instead of preventative care. I expect IOP, PHP, urgent care, ER, and hospital admission rates will likely rise — which will cost BCBS substantially more money than covering preventative outpatient care provided by limited licensed clinicians."
- Fully Licensed Provider

# Section 5: Cross-Cutting Findings

Observations that span all three surveys and all five themes

## 1. Convergence across three independent populations

The three surveys were completed independently by people with different roles, different professional interests, and different stakes in the outcome. Yet the same five themes appear in consistent proportions across all three groups. Clients raise access concerns. Limited licensed providers raise pipeline and qualification concerns. Practice owners raise sustainability concerns. And all three, in their messages to decision-makers, describe the same underlying risk: a policy intended to improve quality of care will instead reduce access to care at a time when the existing access crisis is already severe.

This convergence is one of the strongest signals in the data. It is not a single group advocating for its own interests. It is three different populations describing the same problem from three different vantage points.

## 2. The therapeutic relationship as a clinical asset

Client responses consistently describe the therapeutic relationship - the specific bond between a client and a particular provider - as clinically essential. This is consistent with the research literature on therapeutic alliance as a predictor of outcomes. Clients describe providers who have finally “gotten” them, who have carried the most painful parts of their story, who have helped them reach specific clinical milestones. Disrupting these relationships is not experienced as a billing adjustment. It is experienced as a clinical event.

## 3. The rural amplification effect

Rural respondents appear across all three surveys and consistently describe a compounded version of the access problem. In metropolitan areas, a disrupted client may eventually find another provider, though waits will grow. In rural Michigan, there is often no alternative - no facility-based option, no reliable telehealth connection, no other provider accepting their insurance within a reasonable distance. Rural responses carry a particular urgency that aggregate statistics do not fully capture.

> “Please keep allowing limited license practitioners to bill insurance. It is so hard to find quality mental health services in rural areas and telehealth has been a godsend for people like me. I wouldn't be able to afford to continue to receive care if insurance didn't cover it.”
> - Client, rural Michigan

> "I work in a rural community where clients have very limited options for therapy, and I specialize in children which is even more limited. In my office and community there is nowhere for them to go except to terminate the therapeutic relationship if BCBS makes this decision."
> - Limited licensed provider

## 4. Children and adolescents as a vulnerable sub-population

References to children, adolescents, and youth mental health appear throughout all three surveys. Child therapy is already scarcer than adult therapy, and wait times are longer. Children’s therapeutic progress is particularly sensitive to the disruption of established relationships. Several client responses describe children and adolescents with active suicidal ideation or self-harm history

whose therapeutic relationships are now at risk. In addition, often Limited License professionals and those earlier in their career are more “in touch” with younger clients.

*"My highschooler has significant depression and, prior to working with the LLPC, suicidal ideation. The counselor helped to a point where SI hasn't been an issue in 16 months."*
- Client, parent.

"My son suffers from OCD. We have been through three therapists before we found the one we have now. This woman has been life-changing for my son. We went from a child who couldn't leave my side to one who is having playdates and riding roller coasters. He trusts this woman like family. And now because she doesn't have the right letters after her name, my insurer won't cover her services? I'm disgusted and enraged."
- Client, parent

"My 3-year-old daughter was banging her head against the wall and other hard surfaces whenever she was upset. Nearly hourly. Until we found a therapist that would see young children and helped us identify ways to calm her. She is gifted - she began reading at 2 years old - so we didn't qualify for any services available to children with disabilities. Without mental health services my gifted child would be unable to attend daycare and either my husband or I would have to quit working."
- Client, parent

"I am a therapist who works with both adults and children. Many of my youngest clients have waited months to get in to see me - because child therapists in Michigan are already in critically short supply. This policy change means those kids lose their provider, and will be sent back to the end of a waitlist that may be six months to a year long, if they can find someone at all. For a child, therapy only works when there is trust - and building that trust with a therapist takes time, consistency, and safety. Abruptly removing that trusted adult from a child's life isn't just a disruption to treatment. It can be its own trauma."
- Limited licensed provider

"Our region in Michigan is facing a teen suicide epidemic. This policy will limit the ability for competent, trained clinicians to serve the communities who need services the most."
- Clinician/administrator

"We are a child and adolescent clinic so this will impact hundreds of children in Oakland County. Many families cannot afford self-pay services."
- Practice owner

## 5. The downstream cost argument

Multiple providers and clients independently and without prompting raise the argument that reducing access to outpatient preventive mental health care will increase utilization of more expensive services: emergency departments, inpatient psychiatric facilities, and medical care for conditions driven by untreated mental health needs. There is already a shortage of those services throughout the state, especially in more remote areas. There is a documented shortage of inpatient psychiatric facilities in Michigan. This argument was not prompted by any survey question. Its spontaneous and independent appearance across hundreds of responses in all three surveys suggests it reflects a genuine and widespread belief about the downstream increased financial consequences of this policy.

## Section 6: What We Are Asking

A constructive request for dialogue and review

The findings in this report document that, as currently written, this policy will cause serious and lasting harm to both the providers and the clients it is intended to serve. We are asking BCBSM to work with us to find a path forward that achieves its stated goals of improving quality of care without those consequences.

Specifically, we are requesting:

1. A stakeholder meeting with BCBSM provider relations leadership to review these findings and discuss alternatives that protect access to care while meeting BCBSM's stated quality of care goals.
2. A delay in implementation of the March 1, 2027 requirements pending resolution of the credentialing pathway question and a review of the workforce impact documented here.
3. A direct credentialing pathway for limited licensed providers to participate with BCBSM commercial plans, consistent with their state licensure and supervised status.
4. Legislative review of the policy's impact on Michigan's behavioral health workforce pipeline, particularly as it relates to rural access and the development of future fully licensed clinicians.

Our position: This policy, as currently written, eliminates or severely restricts the ability of thousands of licensed clinicians to serve BCBSM commercial members in private practice settings. It does so at a time when Michigan's behavioral health workforce is already insufficient to meet demand, when thousands of existing clients have no readily available alternative provider, and when the incoming generation of early-career clinicians is watching to decide whether Michigan is a viable place to build their careers.

The same findings that document the harm also point to a solution: a direct credentialing pathway for limited licensed providers, combined with a delay in implementation sufficient to allow that pathway to be established. We are ready to engage in that conversation.

## Appendix: Survey Administration Detail

| Item | Detail |
|---|---|
| Survey period | June 17 – June 30, 2026 (data collection remains open; response volume has substantially slowed) |
| Survey platform | Google Forms |
| Primary distribution | Email invitation to approximately 48,000 behavioral health professionals using publicly available LARA licensure information |
| Additional distribution | MMHCA, NASW-MI, AAMFT, MPA, closed professional social media groups |
| Client survey distribution | Distributed primarily through behavioral health providers to reach individuals receiving BCBSM services |
| Data analysis | Conducted by MMHCA; reviewed internally by NASW-MI, AAMFT and MPA |
| Confidentiality | All responses are anonymous; aggregate data only is reported; no individual responses are identified |
| Open-ended responses | Reproduced verbatim with minor edits for clarity only where noted; fully de-identified |

Survey 1 (Limited Licensed Professionals) included questions covering: license type, work setting, community served, anticipation of full licensure by March 2027, weekly caseload by payer, clients with serious diagnoses or in crisis stabilization, income share from BCBSM, awareness of facility-based alternatives, student loan debt, and anticipated immediate consequences. It included four open-ended question sets.

Survey 2 (Fully Licensed Professionals & Practice Owners) included questions covering: license type, work setting, years licensed, caseload capacity, absorption capacity, current supervision of LLs, projected pipeline impact, and practice-level financial and operational impact. Practice owners completed an extended section on LL caseloads, revenue exposure, staff impact, hiring plans, and practice survival. It included eight open-ended question sets.

Survey 3 (Behavioral Health Clients) included questions covering: respondent type, geographic location, age, insurance status, current service status, knowledge of provider license type, time to find a provider, prior access barriers, anticipated response to provider loss, and out-of-pocket affordability. It included three open-ended question sets.

For questions regarding this report or the underlying data, contact MMHCA at MMHCABOARD@MMHCANOW.ORG.