MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Quality Assessment Performance Improvement Program Evaluation

Year End Report FY 2025

Approval History:

Entity	Approval Date
Approved by MCCMH Board of Directors	02/25/2026

Contents

Introduction

The Macomb County Community Mental Health (MCCMH) Prepaid Inpatient Health Plan (PIHP) is required by the Michigan Department of Health and Human Services (MDHHS) to maintain a Quality Assessment and Performance Improvement Program (QAPIP). The final approval of the QAPIP lies with MCCMH's Governing Body, its Board of Directors. The previous QAPIP remains in effect until the new one is finalized. The final QAPIP will be disseminated to the Board, the Citizen Advisory Council, and the MCCMH Provider Network. The QAPIP will be posted on the MCCMH website and provided to the public upon request.

Board input and approval are necessary components of the QAPIP. The Board will receive quarterly progress updates on focus areas of the QAPIP through various presentations on the specific projects identified in the QAPIP. MCCMH's QAPIP Evaluation is not all-inclusive as there are many improvement activities ongoing throughout the organization.

Organizational Quality Structure

The QAPIP is managed by the MCCMH Quality Committee. The Quality Committee ensures that MCCMH's mission and strategic plan are woven into all policies and procedures across the network. The Committee oversees the various subcommittees and functions of the MCCMH QAPIP. The Committee identifies and addresses specific issues in need of remediation and reviews ongoing activities of the various subcommittees. Grievances and appeals are tracked, and the trends are reported to the Quality Committee. The Committee also reviews input from persons served utilizing satisfaction surveys, forums, and other forms of stakeholder input. All committee meeting minutes are continuously monitored and integrated into the overall Quality Improvement Program. Formal actions related to the QAPIP are taken to the Board at least annually through the QAPIP report.

The Committee's objectives are to improve quality, maximize clinical outcomes, reduce costs, and increase efficiency in service delivery. Through collaboration amongst the departments, the Quality Committee is responsible for oversight of ongoing implementation of quality indicators, processes, and outcomes across MCCMH as defined through the goals of the QAPIP.

QAPIP Work Plan Evaluation

Key Performance Indicators

MCCMH has been utilizing Key Performance Indicators (KPI) for Behavioral Health as outlined by MDHHS. MCCMH monitors updates to Michigan's Mission-Based Performance Indicator System (MMBPIS) codebook as published by MDHHS. Updates occurred in preparation for FY26; however, those updates do not impact FY25 KPI. Effective FY25 Q3, MDHHS requested to only receive PIHP-level data and is no longer requesting quarterly CMHSP data.

Standards for KPI performance were based on the 2025 codebook guidelines. No changes to performance rates occurred during FY25. Indicators 1, 4a, and 4b maintained the standard of 95% or greater. Indicator 10 maintained a standard of 15% or less. Indicator 2 has

2 established standards of 57% and 62% or above. Indicator 2e similarly has 2a established standards of 68.2% and 75.3% or above. Once a PIHP meets the initial standard, it is expected to continue making efforts to reach the high standard. Indicator 3 standards are set at 72.9% and 83.8%. Once the 2nd percentile is met, a PIHP's performance is expected to maintain or exceed the same levels.

The above indicators measure the domains of Access, Efficiency, and Outcomes. The standards previously mentioned are based on population and indicator-specific selection and exception methodology. From these set standards, MCCMH has developed internal processes and validation activities to ensure data is valid and reliable. Strategies to ensure the systemic ongoing collection and analysis of valid and reliable data through MCCMH's electronic medical record (EMR) system (FOCUS) and interactive dashboard development are collaborative efforts among key departments within MCCMH. Departmental collaboration includes Quality, Information Systems, and Clinical Informatics. MCCMH has used a combination of validation activities, including primary source verification, member-level detail file reviews, and ensuring that source code is up to date, to ensure reports are pulling information as expected by MDHHS.

This data is reported to MDHHS according to established timelines and formats. MDHHS develops and distributes quarterly PIHP Performance Indicator Reports based on statewide performance measure data submission.

In September of 2025, MDHHS announced a new format for data file sharing and a reduction in the number of indicators measured by PIHP. Indicators 2a and 2e will remain to be reported to MDHHS by PIHPs on a quarterly basis. Indicator 3 will continue to be monitored by MDHHS; however, the PIHPs do not have a responsibility to report that measure unless otherwise specified by MDHHS.

MCCMH also maintains internal standards to monitor and analyze data collection. Data is reported to the Quality Committee and leadership for review and recommendations to address any areas falling below the desired benchmark. When negative outliers occur, MCCMH analyzes the cause and develops remedial and improvement strategies. MCCMH will continue to monitor indicators 1, 3, 4a, and 10 despite MDHHS no longer requiring PIHP-level data. MCCMH views access to treatment as an essential part of improvement strategies, and indicator 1 is essential to monitoring timeliness of access to care. Indicators 4a and 10 both monitor time to appointment following hospitalization and rehospitalization rates, respectively. Both metrics are essential in MCCMH's understanding of its networks' ability to engage with members to provide care and keep them out of the hospital.

Improvement Strategies

MCCMH utilizes data to make informed decisions about structural process improvements. The strategies implemented allow MCCMH to proactively make changes based on trends and to reactively request updates at the provider level to ensure data completeness.

MCCMH has implemented close monitoring initiatives with indicators 2 and 3. This represents a shift from quarterly retroactive reporting to MDHHS. Provider agencies are now required to proactively review upcoming appointment information weekly, which aligns with indicators 2 and 3. These weekly queries allow MCCMH to notify provider agencies of scheduling gaps and allow provider agencies to reschedule appointments that are outside of the required time frame.

MCCMH periodically audits its internal logic structure to assess data integrity and validity. During those audits, several logic errors/bugs were identified during FY 2025. Those logic errors were reported to MCCMH's EHR Vendor for prompt fixes. One logic error incorrectly identified members as dual eligible (both Medicaid and Medicare). This error caused MCCMH to report data to MDHHS, which was incomplete in nature. The logic error was corrected, and accurate data was sent to MDHHS. Another error reported was the duration of dispositions. The logic error caused MCCMH's performance for indicator 1 to drop below the benchmark in the third quarter.

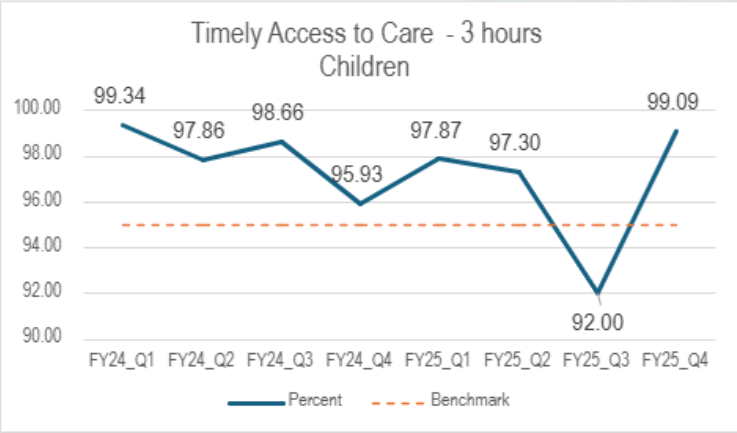
MCCMH completed a root cause analysis (RCA) in the member-level detail file. MCCMH implemented a change to the logic audit procedure, which allowed MCCMH to have a completed and more granular picture of each indicator and systemic shortcoming.

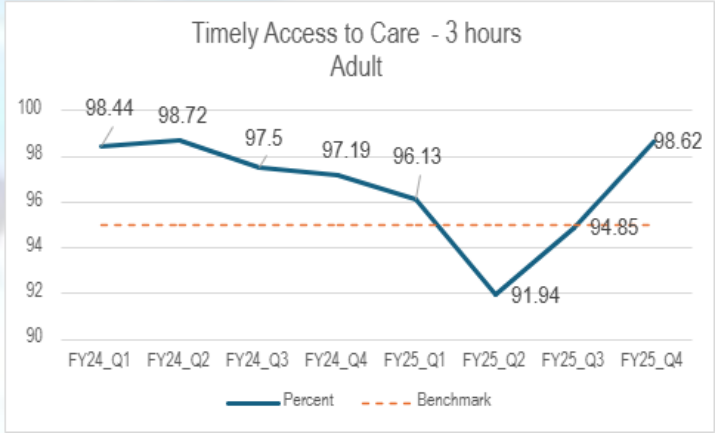
MCCMH implemented EHR changes specifically aimed at reducing the information gap between hospital providers and administrative staff at the PIHP. The EHR changes specifically impacted indicator 10. The changes request more information from hospital discharge planners, including whether a member is being discharged to an in-network or out-of-network provider, member service refusals, leaving against medical advice, or ongoing out-of-network treatment services. These changes improve data entry completeness, requiring fewer manual changes by staff and more timely follow-up metrics.

MCCMH utilizes qualitative provider feedback and quantitative monitoring of data to make recommendations. MCCMH utilizes one-to-one provider meetings to review KPI performance. MCCMH met individually with agencies whose performance was below the established standards. MCCMH encouraged agencies whose performance improved and was sustained to share strategies and success stories with other agencies during the monthly Quality Provider meetings. These presentations encouraged collaboration between agencies and prompted successful strategy changes. Strategy changes included increased use of interactive dashboards to monitor rehospitalizations.

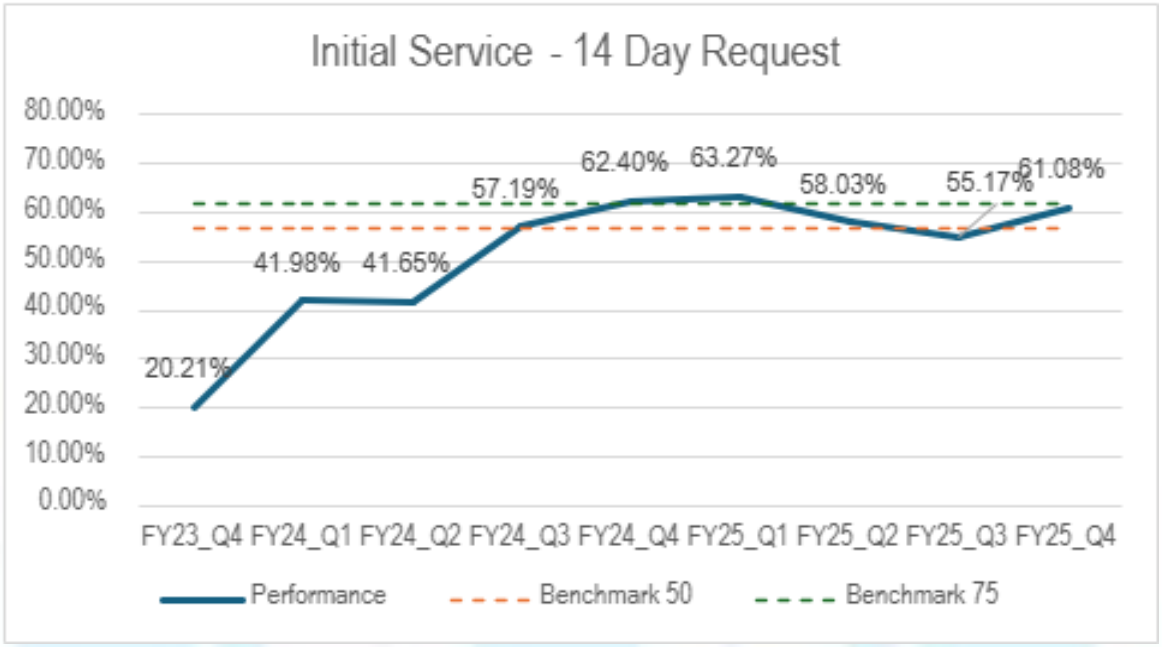
Performance Indicator Overview

Indicator #1
Benchmark: 95%: Met
The percentage of persons served during FY 2025 receiving pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.



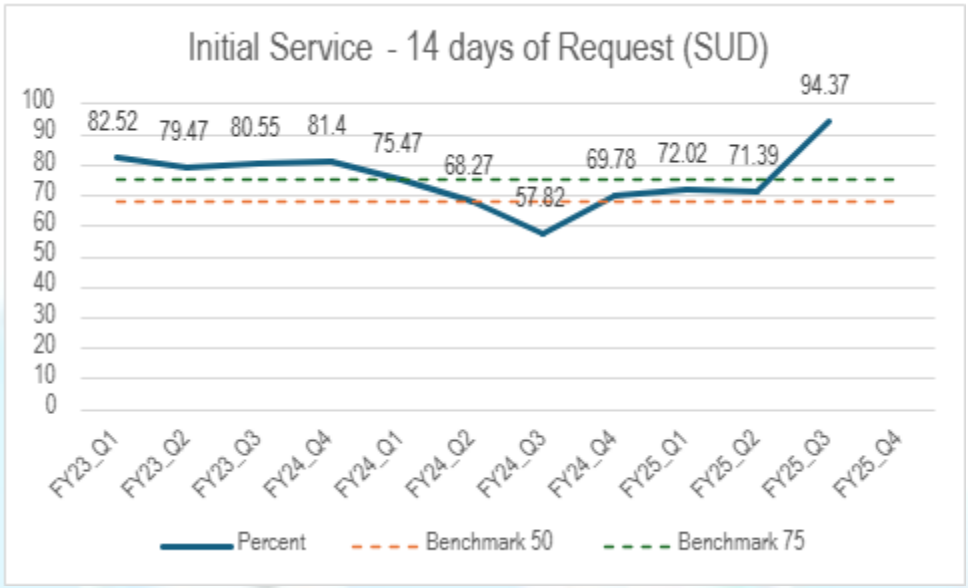


Indicator #2
Benchmark: 57%: Met
The percentage of new persons during the quarter who receive a completed biopsychosocial assessment within fourteen (14) days of a non-emergency request for service. There is improvement from Q3 to Q4, leaving MCCMH within 1 percent of meeting the 75th percentile.



Indicator #2e
Benchmark: 68.2%: Not Met
The percentage of new persons during the quarter receiving a face-to-face service for treatment or support within 14 calendar days of a non-emergency request for service for persons with substance use disorders (SUD).

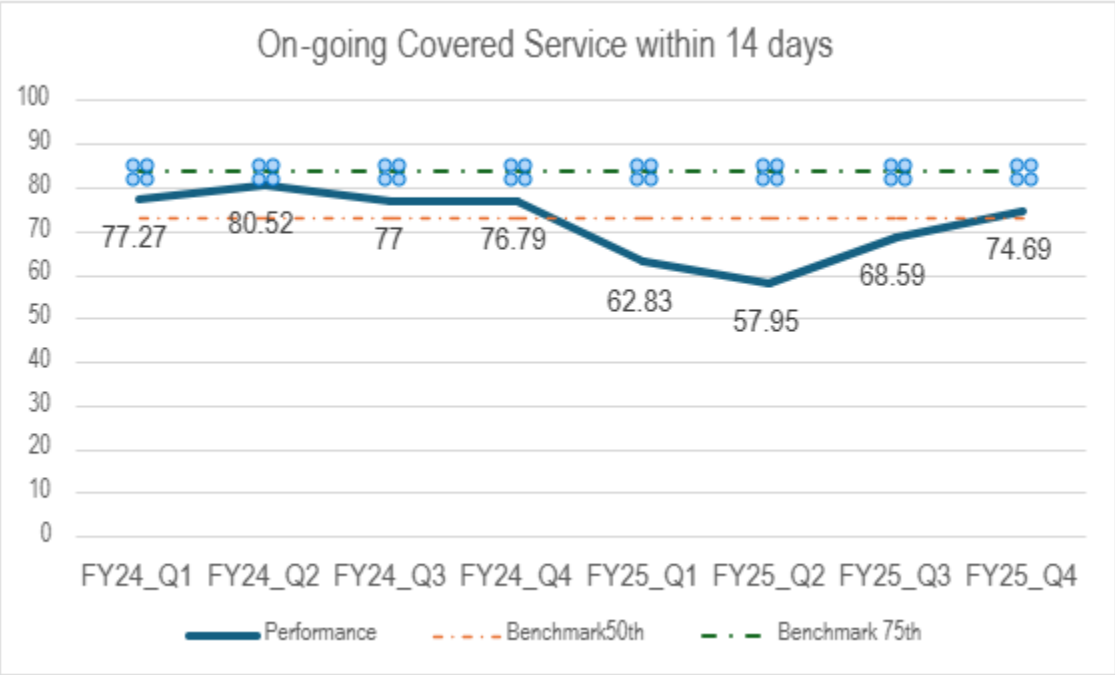
This indicator is calculated by MDHHS' Behavioral and Physical Health and Aging Services Administration (BPHASA) based on quarterly information reported to MDHHS by MCCMH. This indicator was below the benchmark for the first three quarters in FY 2025. However, MCCMH completed a review by the provider and found out that one provider with high numbers was reporting incorrectly. Training was provided, and this has led to a significant increase in performance.



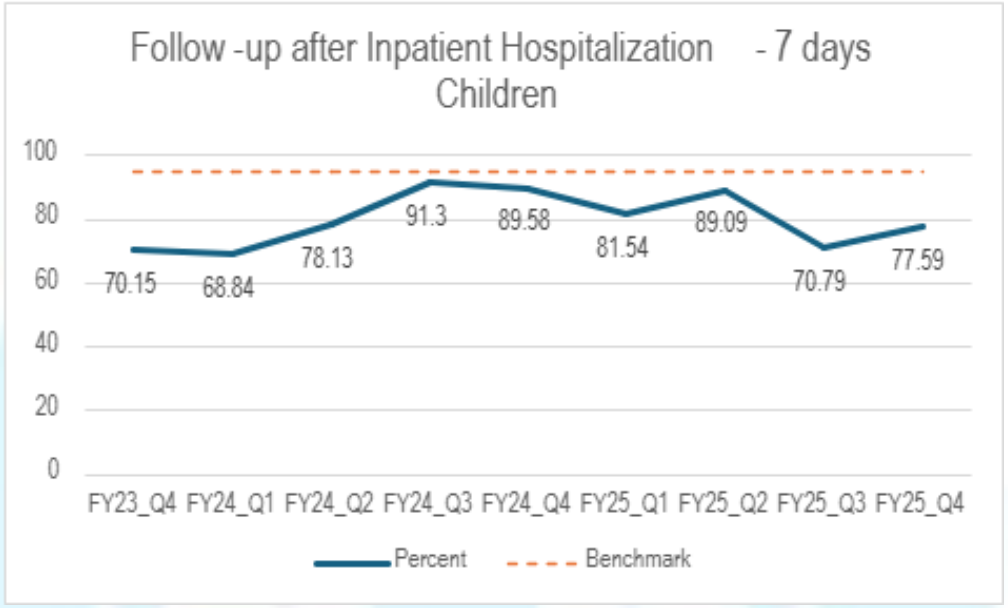
Indicator #3

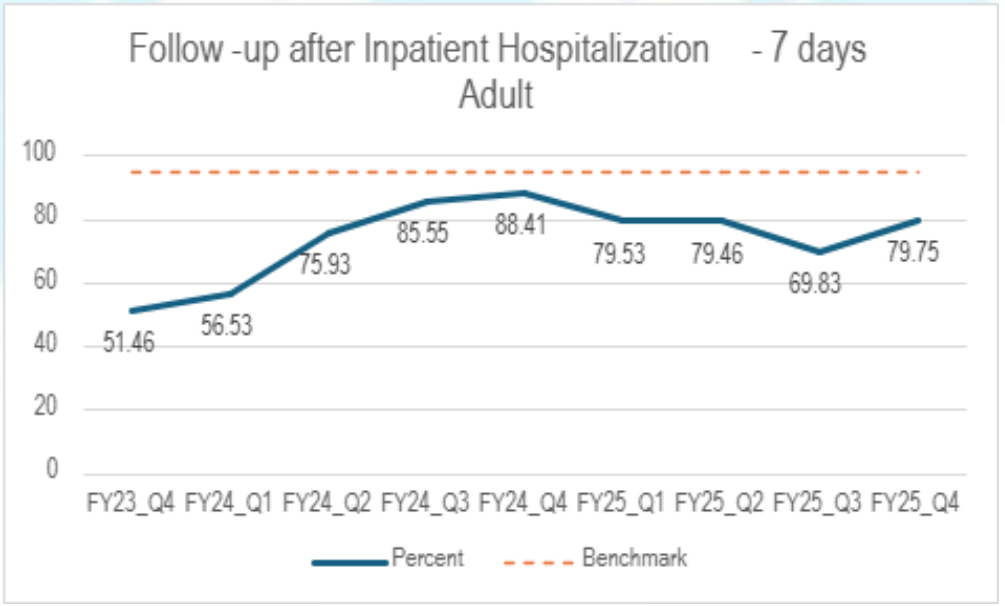
Benchmark: 83.8% (75th percentile): Not Met

The percentage of new persons during the quarter who started any medically necessary ongoing covered service within 14 days of completing a non-emergent biopsychosocial assessment. Based on internal tracking, MCCMH has consistently seen an increase in Q3 and Q4.

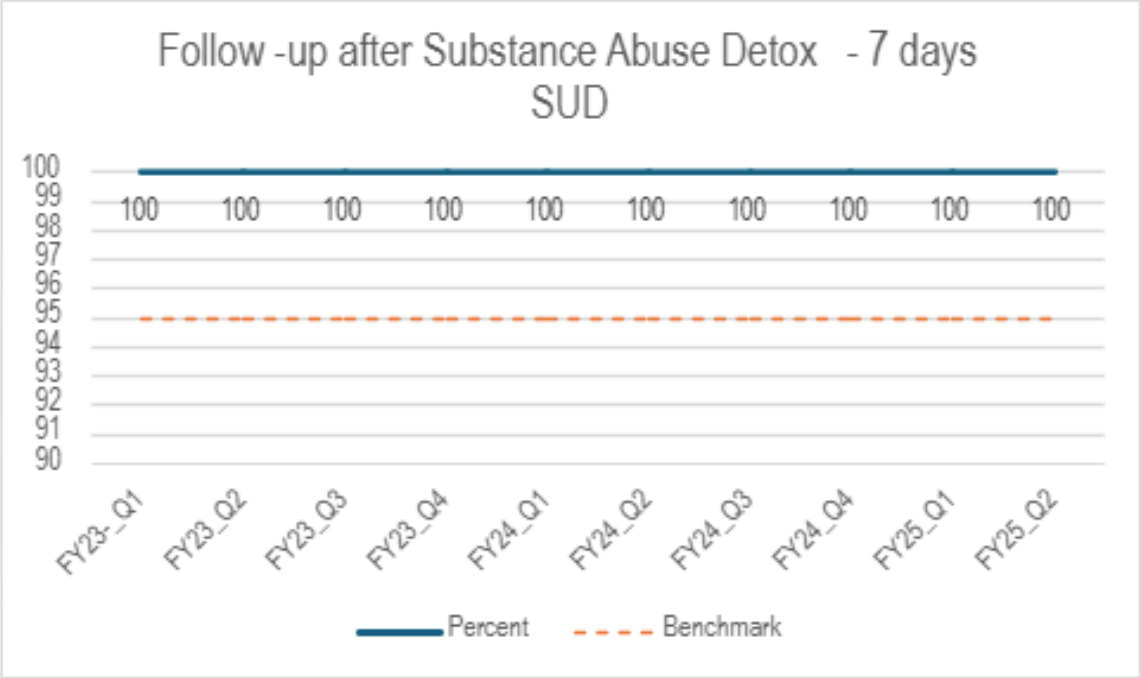


Indicator #4a
95% Standard: Not Met
The percentage of discharges from a psychiatric inpatient unit and seen for follow-up care within seven days. Based on internal tracking, MCCMH steadily improved in ensuring follow-up appointments post-hospitalization for children and adults for Indicator #4a for FY 2025.

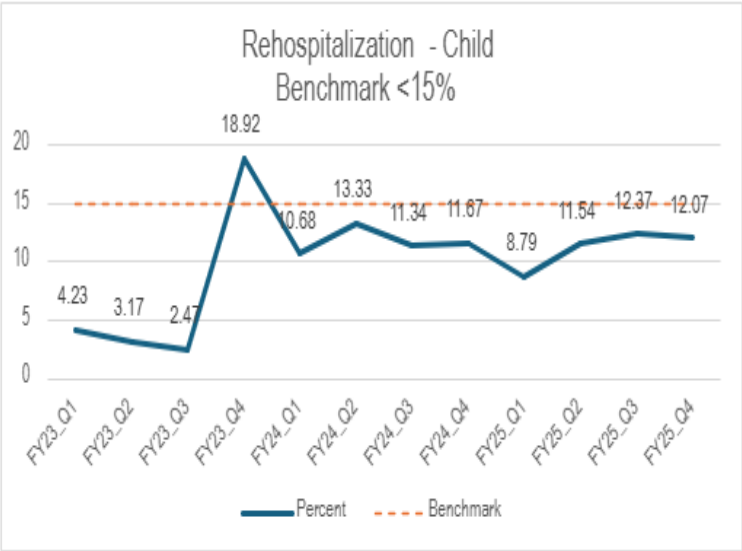

Follow -up after Inpatient Hospitalization - 7 days
Children
100
80
60
40
20
0
70.15
68.84
78.13
91.3
89.58
81.54
89.09
70.79
77.59
FY23_Q4 FY24_Q1 FY24_Q2 FY24_Q3 FY24_Q4 FY25_Q1 FY25_Q2 FY25_Q3 FY25_Q4
Percent
Benchmark

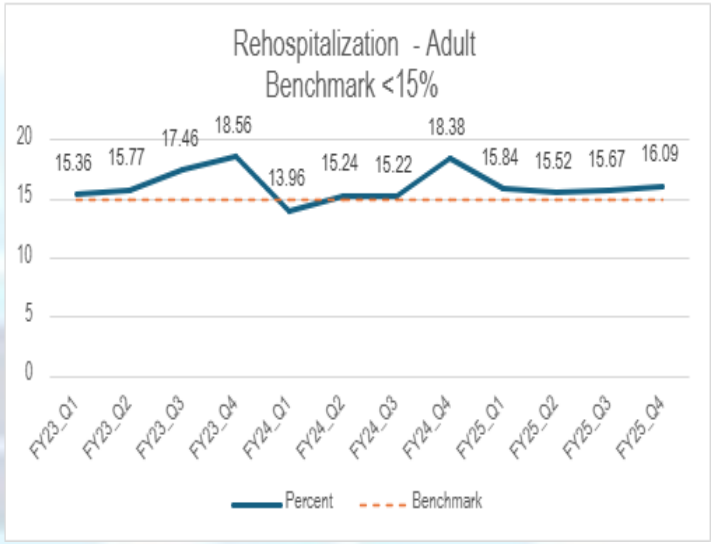

Follow -up after Inpatient Hospitalization - 7 days
Adult
100
80
60
40
20
0
51.46
56.53
75.93
85.55
88.41
79.53
79.46
69.83
79.75
FY23_Q4 FY24_Q1 FY24_Q2 FY24_Q3 FY24_Q4 FY25_Q1 FY25_Q2 FY25_Q3 FY25_Q4
Percent
Benchmark

Indicator #4b
95% Standard: Met
The percentage of discharges from a substance abuse detox and seen for follow-up care within seven days. Based on internal tracking, MCCMH has remained consistent at 100% for FY 2025.



Indicator #10
15% or Less Standard: Partially Met
The percentage of readmissions of children and adults during the quarter to an inpatient psychiatric unit within 30 days of discharge. Based on internal tracking, MCCMH saw an overall increase in recidivism for children but kept it below 15%. On the other hand, adults saw a decrease, but slightly above the 15% benchmark for FY 2025.





FY 2025 Performance Measure Improvement Strategies Overview

MCCMH internal performance goals were partially met throughout FY 2025. Below is a chart that depicts MCCMH's target improvement areas throughout FY 2025 and status based on completion and implementation.

Target Improvement Area	**Status**
Collect, analyze and monitor PI data on a quarterly basis	Met
Implement monthly Provider Meetings	Met
Improve validation efforts based on PMV findings	Ongoing
Develop process improvement plans for negative trends and patterns	Ongoing
Enhance EMR reports to improve provider specific data reports	Ongoing
Meet MDHHS Standards	Ongoing

FY 2025 Performance Measure Improvement Strategies

MCCMH continues to work towards meeting or exceeding MDHHS benchmarks for each of the MMBPIS performance measures. For areas that perform below the standard, MCCMH developed a work plan to address areas of deficiency to improve outcomes.

Areas to address included but are not limited to data quality improvements, performing primary source verification quarterly, and all ongoing improvement areas suggested during external audits. An important area of focus for MCCMH is to increase data awareness and visibility with its Provider Network by providing access to performance indicator (PI) reports/dashboards. This will support the Provider Network to implement provider-level strategies to target their specific areas or deficiencies and overall improve outcomes.

In October 2023, the Bureau of Specialty Behavioral Health Services began a comprehensive review of the existing quality assessment and performance improvement program and implemented a new set of quality programs. This will be in the form of a 3-year rollout. The rollout plan was shared with the PIHPS in September of 2024. Year-1 (2025) measures are as follows:

Year-1 Rollout of New Performance Improvement Initiative

	Measure	**Program**	**Domain**
ADD	Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	BHCS	MH
CDF	Screening for Depression and Follow-up Plan*	BHCS	MH
FUH	Follow-up After Hospitalization for Mental Illness*	BHCS	Access
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	BHCS	MH
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	BHCS	MH
FUA	Follow-up After Emergency Department Visit for Substance Use*	BHCS	Access

FUM	Follow-up After Emergency Department Visit for Mental Illness*	BHCS	Access
IET	Initiation and Engagement into Substance Use Disorder Treatment	BHCS	SUD
MSC	Medical Assistance with Smoking and Tobacco Use Cessation	BHCS	SUD
AMM	Antidepressant Medication Management	BHCS	MH

Throughout FY 2025, the Quality Department at MCCMH implemented Quick Reference Tools that were developed internally based on the Medicaid Adult and Child Core Sets. This allows for quick review by staff to understand what is required of them and how to document properly in the EMR. MCCMH successfully provided Quick Reference Tools on the following metrics that had been previously highlighted for improvement:

- ADD-CH: Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase
- APP-CH: Use of First-Line Psychosocial Care for Children/Adolescents on Antipsychotics

Another Quality Improvement Initiative that was implemented in FY 2025 was based around lower performance in the following metric: FUH-AD: Follow-Up After Hospitalization for Mental Illness – Adult.

Consumer psychiatric inpatient admission recidivism has been a long-standing issue that many health systems work to improve. As a part of both the monitoring of MMBPIS indicator #10 as well as the FUH-AD metric, MCCMH worked to understand what characteristics this population has in common and what potential resources this population lacks that could hopefully lead to increased engagement with mental health services.

MCCMH developed a dashboard that allows medical directors to understand prescribers' utilization of long-acting medications among those who may frequent the emergency room. Once the dashboard is complete and fully tested, providers will be granted access so they can review their data in real time and make necessary improvements.

Through analysis of this population, the Clinical Department was able to establish what MCCMH calls the Transition Team. This team works with individuals who have had three or more inpatient psychiatric admissions in the last 12 months with poor/no engagement with mental health services. This amazing group works with consumers while they are still in the hospital, as well as meets them where they are in the community (at their homes, shelters, on the streets, etc.) to provide support with connecting to mental health services, as well as financial, educational, and transportation resources.

Although this program is still in its infancy, preliminary data indicate vast improvement in the average time between inpatient stays, with some having a three-times increase in the amount of time spent out of the hospital after working with the Transition Team at MCCMH. Continued monitoring and interdepartmental collaboration will occur in FY 2026.

Performance Measure Activities

MCCMH conducts at least two Performance Improvement Projects (PIP) every year. This past year, MCCMH worked on two PIPs aimed at addressing clinical and non-clinical aspects of care as approved by the state. Current Performance Improvement Projects include:

1. Increase the percentage of adults receiving follow-up appointments and a reduction in racial disparity between Caucasian and African American persons served post inpatient psychiatric hospitalization.

2. Increase the number of MCCMH persons served enrolled in the MDHHS Habilitation Supports Waiver Program.

Clinical Performance Improvement Project

MCCMH began a Clinical PIP in calendar year (CY) 2021 focused on increasing the percentage of adults receiving follow-up appointments and reducing racial disparity between Caucasian and African American persons served post inpatient psychiatric hospitalization. MCCMH has completed several barrier analyses and implemented intervention strategies over the past four years to help bridge the identified disparity, as well as the lack of follow-up care across all populations. Some of the interventions include but are not limited to increasing the number of available appointments, pursuing system updates to accurately reflect appointment availability, enhancing provider network communication and understanding of requirements, improving data visibility, prioritizing transportation resources, identifying zip codes associated with greater percentages of the disparate population, and enhancing education on available supportive programs. Additional detail on MCCMH's identified barriers and associated intervention strategies can be seen in Figure 1 below:

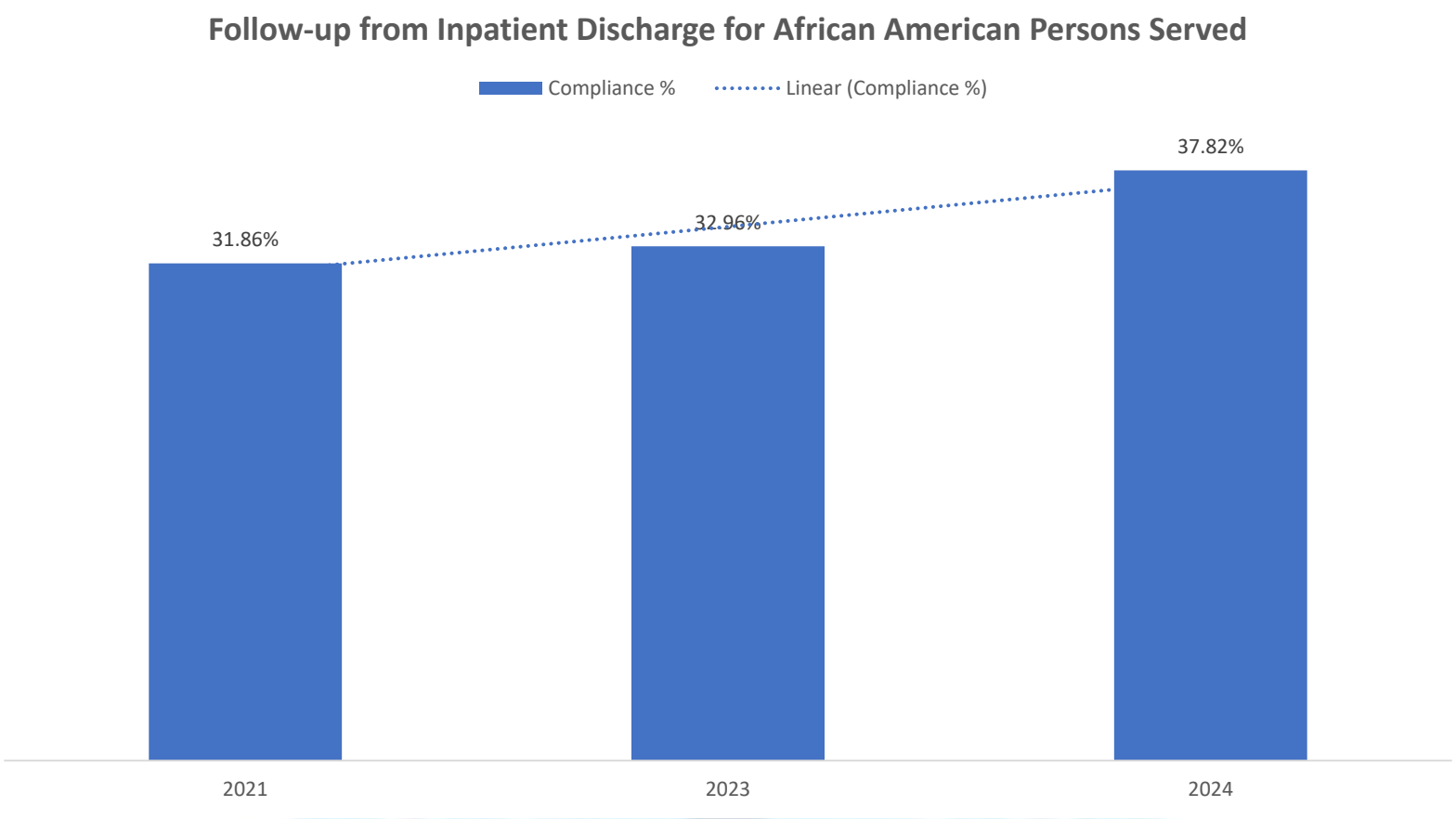
Barrier Priority Ranking	Barrier Description	Intervention Initiation Date (MM/YY)	Intervention Description	Select Current Intervention Status	Select if Member, Provider, or System Intervention
1.	Limited appointment availability with directly operated and contract service providers.	2/23 and ongoing	1. Increase number of available appointments at MCCMH North and East locations for individuals discharged from inpatient psychiatric units. 2. Leadership is meeting one on one with providers to understand their challenges and identify ways to mitigate them.	Continued	Provider Intervention
		4/23	3. Update the EMR calendar to accurately represent available appointments within the network.	Due to the challenges in MCCMH's current EMR system, this is no longer being pursued.	System Intervention
2.	Outdated formalized processes for hospital discharges.	3/23	1. The MCCMH Hospital Liaison Team will update formal processes to improve communication with members after discharge to provide support attending their follow-up appointment.	This initiative is complete, and the transition team has now been implemented.	Provider Intervention
		3/23	2. Managed Care Operations staff will improve coordination with the	Continued	Provider Intervention

			MCCMH Hospital Liaison Team for discharging members.		
3.	Lack of communication with network on performance measure standards.	5/23	1. Issued a memo to Provider Network to remind providers of the required standard and detail MDHHS/PIHP standards.	Completed	System Intervention
		6/23	2. Meet with providers to reiterate the importance of follow-up after an inpatient stay and provide space to further discuss challenges providers may be facing.	Continued	Provider Intervention
4.	Unidentified trends and barriers related to follow-up care.	4/23	1. Conducted a provider survey to identify network-wide barriers related to care coordination.	Completed	System Intervention
			2. Utilize dashboards to trend out-of-compliance cases and identify trends and patterns specific to race and ethnicity.	Continued	System Intervention
5.	Limited data visibility with network regarding	4/23	1. Develop dashboards for providers on compliance rates with MDHHS performance measures.	Continued	Provider Intervention

	MDHHS performance measures.				
		6/23	2. Develop formalized processes with providers to review their current compliance rates.	Continued	Provider Intervention
6.	Transportation resources	11/24	1. Once MDHHS required health plans to provide transportation for those on the plan, MCCMH created a service guide with the Medicaid Health Plans information and how to access transportation services	New	Provider and member Intervention
7.	Targeted outreach for the desperate population.	12/24	1. Developed an outreach program targeting individuals with 3 or more episodes of rehospitalization and not linked to a provider. 2. Implemented an intensive community-based case management by implementing the MCCMH transition team	New	Provider Intervention
8.	Lack of providers in specific zip codes	09/24	1. Targeted intervention by looking at population, zip codes, and access to outpatient providers.	New	Provider Intervention
9.	Limited knowledge on the Assisted Outpatient Treatment	10/24	1. Provided education to providers and the community on various ways to get members to stay engaged in treatment such as the AOT program.	New	Provider Intervention

	(AOT) program				

Between Remeasurement Year 1 (CY 2023) and Remeasurement Year 2 (CY 2024), MCCMH experienced a statistically significant increase in follow-up after hospitalization for its African American population. This increase is shown in Figure 2 below. MCCMH continues to develop and implement additional improvement initiatives to support all persons served in accessing timely and appropriate services.


Follow-up from Inpatient Discharge for African American Persons Served
Compliance %
Linear (Compliance %)
31.86%
32.96%
37.82%
2021
2023
2024

Non-Clinical PIP

For its Non-Clinical PIP, MCCMH focused on improving its MDHHS Habilitation Supports Waiver (HAB) enrollment across the provider network. MCCMH's average enrollment rate throughout FY 2025 exceeded MDHHS's threshold for "Good Standing" of 97%. MCCMH has conducted internal efforts to develop a structured work plan to guide efforts to increase the number of HAB enrollments. Based on the most recent reports, MCCMH had a total of 477 allotted HAB slots for 2025 and currently has 0 slots available. This places MCCMH above the benchmark.

- 477 Slots Available
- 477 Slots Utilized
- 0 Slots Available
- 100%

Coordinated efforts between the Quality Department and Network Operations began in Q1 of FY 2025 to assess current and ongoing barriers impacting HAB enrollment. Systematic barriers included the waiver's lengthy application process, provider program education and awareness, effective oversight of slot maintenance, disenrollment trends, and identification of eligible individuals.

Based on these identified barriers, MCCMH developed strategies to effectively approach barriers through specific and measurable interventions. MCCMH developed training materials to distribute to the network and has increased meetings with providers to provide education around the HAB waiver program and how to enroll new beneficiaries. This is an ongoing collaboration with providers to provide support to existing and new staff. Disenrollment trend analyses have also helped target specific reasons beneficiaries are no longer enrolled.

To increase ongoing oversight of slot maintenance, MCCMH created reports to share with providers identifying individuals who are currently utilizing HAB waiver services but are currently not enrolled in the program. This report has assisted providers to more easily identify potential beneficiaries to enroll in the program.

In addition, MCCMH has been meeting with individuals at the State level to further understand HAB waiver requirements and advocate for ways to improve the enrollment process for providers.

MCCMH's focus for FY 2025 was to create a structured approach based on identified barriers to ensure the Provider Network received more formal education and training on the benefits of HAB Waiver services.

Barrier Priority Ranking	Barrier Description	Intervention Description	Intervention Status	Intervention Type
1.	Low enrollment in MDHHS' Habilitation Supports Waiver was reported throughout FY 2022	Review previous MDHHS reports to identify patterns and trends.	Ongoing	System Intervention
		Contact Network Operations to discuss current challenges with enrollment numbers and identify any corrective action plans that have been implemented.	Completed	System Intervention
		Get access to MDHHS HAB enrollment platform for Quality representatives.	Complete	System Intervention
		Run claims report and filter by service code to determine persons served who are not HAB recipients but utilize services that are available under the waiver.	Complete	System Intervention
2.	Lack of network initiatives to improve enrollment numbers	Determine any previous or existing initiatives that were developed in this area.	Ongoing	System Intervention
		Gain deeper understanding of current state HAB workgroup and the scope of work it entails.	Complete	System Intervention
3.	Lack of education at provider level regarding eligibility for HAB waiver services	Educate providers on MDHHS' enrollment criteria for HAB.	Complete	Provider Intervention
		Develop training and resources on eligibility criteria and scope of services to share with network providers.	Complete	Provider Intervention
4.	Lack of monitoring processes to review eligibility and provision of appropriate services	Implement ongoing monitoring processes to evaluate the effectiveness of network initiatives.	Complete	System Intervention

5.	Lack of disseminated information to community regarding scope of HAB services	Develop informational pamphlet on services available under HAB waiver and how individuals can determine eligibility.	Complete	Member Intervention
6.	Lack of awareness related to the availability of HAB services in Macomb County	Distribute existing reports on waiver slot availability to MCCMH Leadership for further review and discussion.	Complete	System Intervention
		Work with Children's Department to identify children transitioning from Children's Waiver Program (CWP) to encourage enrollment up until 6 months prior to 21st birthday.	Ongoing	Provider Intervention

Auditing and Monitoring Activities

Health Services Advisory Groups' Validation of Performance Measures

The purpose of the Health Services Advisory Groups' (HSAG) Performance Measure Validation (PMV) is to assess the accuracy of performance indicators reported by PIHPs and to determine the extent to which performance indicators reported by MCCMH, as a PIHP, follow State specifications and reporting requirements.

The reporting cycle and measurement period specified for the review was for the first quarter of FY 2025, which began October 1, 2024, and ended December 31, 2024.

In preparation for the PMV Site Review, MCCMH submitted requested information, including source code, its completed ISCAT, additional supporting documentation, and member-level detail files.

The PMV Virtual Review was conducted on July 15, 2024, and MCCMH received its final report in September 2024. MCCMH received the following validation findings:

- Data Integration: Acceptable
- Data Control: Acceptable
- Performance Indicator Documentation: Not Acceptable

Based on all validation activities, HSAG provided MCCMH's performance indicators with specific findings and recommendations. MCCMH received *Reportable (R)* for all assessed indicators except for one. This means that the indicators were compliant with the State's specifications, and the rates were considered reportable. One was marked as not reportable due to an error that was found during

an internal audit and reported to the state. Remediations have since been implemented to prevent any future errors.

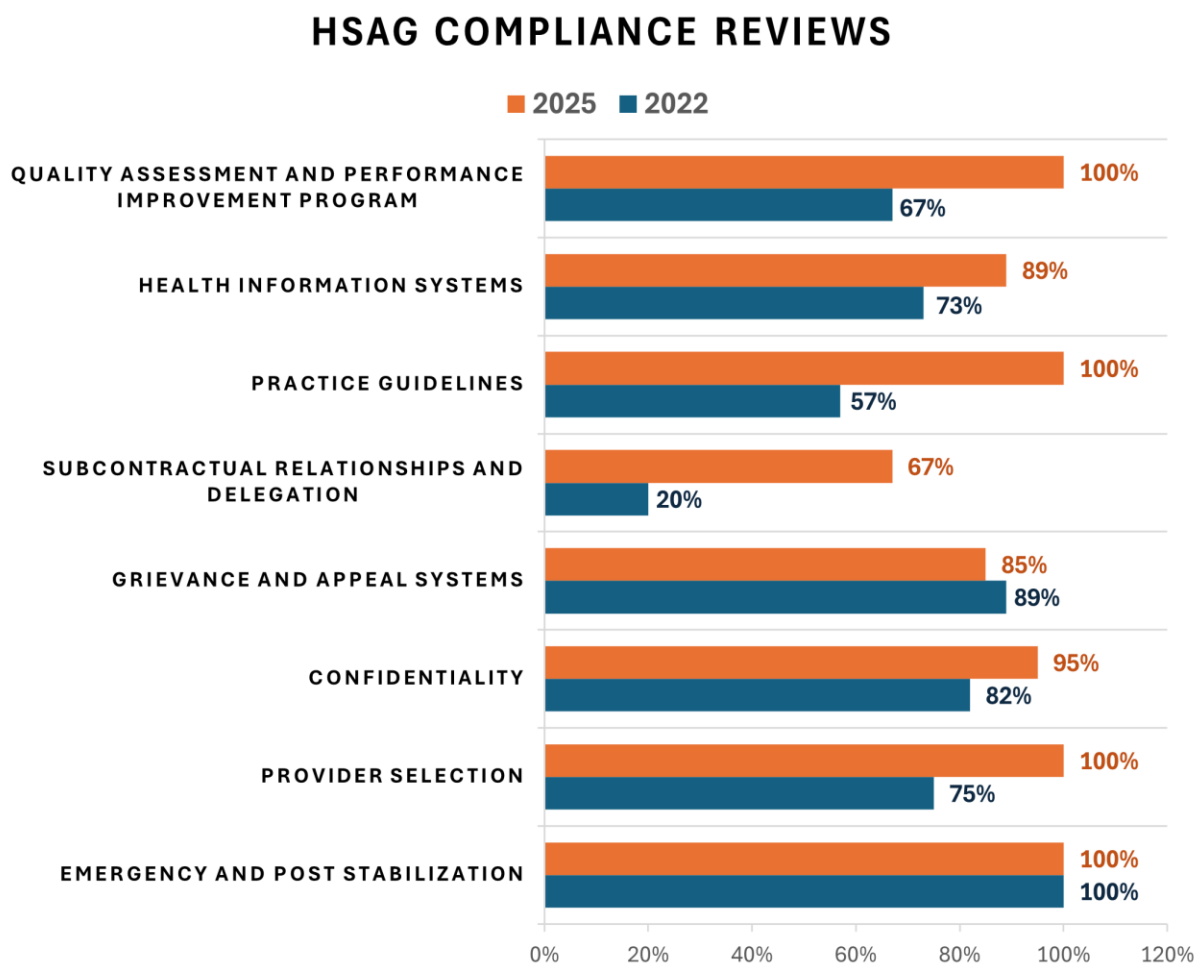
Strengths and weaknesses were identified by HSAG and assessed internally by MCCMH. MCCMH's Quality Department developed an ongoing work plan specific to PMV findings to ensure continuous improvement is targeted related to Performance Indicators. Improvement strategies are more specifically outlined in MCCMH's 2026 QAPIP Work Plan.

HSAG Compliance Review

MCCMH participates in an annual Compliance Review with the HSAG, which assesses MCCMH's compliance with applicable federal and state-specific contract requirements. This review monitors 13 program areas referred to as standards over the span of a three-year cycle. This was the second year in HSAG's cycle of compliance reviews. The eight standards reviewed in 2025 were also reviewed in 2022. These standards included:

- Standard II – Emergency and Post-Stabilization Services
- Standard IX – Grievance and Appeal Systems
- Standard VII – Provider Selection
- Standard VIII – Confidentiality
- Standard X – Subcontractual Relationships and Delegation
- Standard XI – Practice Guidelines
- Standard XII – Health Information Systems
- Standard XIII – Quality Assessment and Performance Improvement Project

MCCMH's overall score for its Compliance Review increased from **75%** in 2022 to **93%** in 2025, demonstrating significant and sustained improvement in its operational functions. The graph below shows the scores MCCMH received in each Standard.



Upon receiving the results, MCCMH developed a Corrective Action Plan (CAP) to remediate all areas identified as "Not Met." Ongoing internal meetings began in November of 2025 to begin the implementation of CAP elements within MCCMH's system of care.

Overall, MCCMH showed significant improvements in all the areas except for the Grievance and appeals section. However, MCCMH is taking the necessary steps to improve this section.

Quality Hospital Audits

MCCMH conducted its Fiscal Year 2025 Quality Hospital Audits for Behavioral Center of Michigan, Henry Ford-Warren, and Harbor Oaks. An audit period from October 1, 2024, to September 30, 2025. Person Served charts and staff files were randomly selected. The Quality team conducted in-person site reviews consisting of clinical records, administrative records, environmental safety, and staff interviews. At the end of each visit, an exit conference was conducted to discuss findings and the next steps. Each hospital received a comprehensive written report once the audit process was complete. If a hospital scored below 95% compliant, a

corrective action plan was implemented, and they had 30 calendar days to submit evidence to close their respective CAP. Once a hospital audit report was finalized, MCCMH's Quality team uploaded the report and supported notices to the MDHHS Inpatient Reciprocity Group for other regions in Michigan to reference. MCCMH aggregated findings from its hospital audits to identify patterns and developed targeted improvement initiatives to better support its provider agencies. Some examples of improvement initiatives include but are not limited to defining MCCMH's role in care coordination, discussing the importance of initiating discharge planning on the day of admission and collaborating with the outpatient provider, and discussing changes in the continuous stay review (CSR) form that will clearly indicate when a member opts to continue care with an out-of-network provider. Improvement initiatives are regularly discussed and monitored through MCCMH's quarterly meeting with hospitals.

Direct Provider Audit

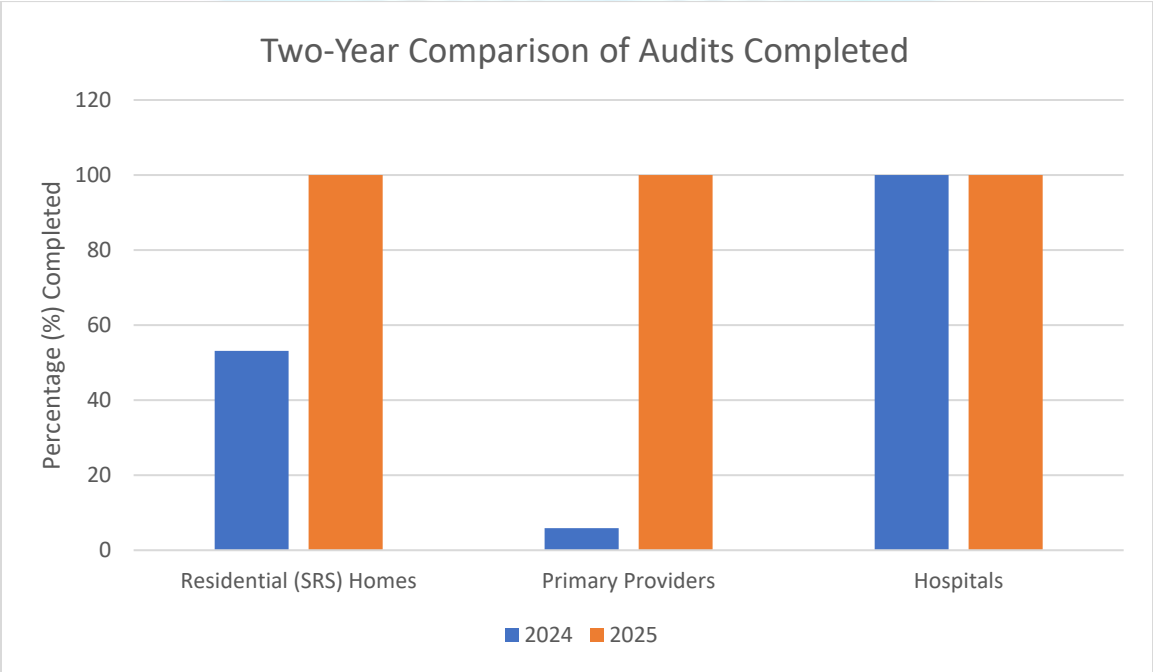
During FY 2025, MCCMH's Quality Department updated its primary audit tools and developed a detailed schedule for the primary provider audit processes. A review of MCCMH's 17 outpatient provider programs was completed in FY 2025. The three common citations were: 1. Evidence that ancillary staff were trained on the IPOS and subsequent reviews as needed was at 61.76% compliance; 2. The IPOS contained SMART goals and objectives that were at 74.31% compliance; and 3. Compliance with the training required for staff ranged from 46.81% to 71.07% compliant (depending on the training). The Quality Department utilized a "White Sheet" process and offered in-person meetings to review cited standards, discuss each area of the review tool, and discuss the next steps with the department head and program supervisors. The Quality Department continues to provide technical support as the departments work through areas of improvement that were requested.

Residential Provider Audit

During FY 2025, MCCMH's Quality Department updated its residential audit tool and set a goal of 100% audit compliance for the residential network audit processes. To maximize the efficiency and effectiveness of these audits, MCCMH developed a detailed schedule for specialized residential homes. These changes led to the completion of 100% of the homes for FY 2025. This was a significant increase from FY 2024, which was 46%. When providers are found to fall below the 95% threshold for full compliance, MCCMH works with the provider to develop a CAP to remediate any areas of concern. The three most common audit citations were as follows: 1. incident report was not appropriately reported to MCCMH within 24 hours of the incident or not reported at all, with 57.49% of homes being compliant; 2. Evidence of Direct Care Staff being trained on the Behavior Treatment Plan with 63.33% of homes being compliant; and 3. Resident Protected Health Information is stored appropriately at 71.03% of homes being compliant. MCCMH continues to partner with providers to highlight areas of strength as well as identify

areas for improvement. MCCMH continues to provide technical assistance to support the providers through one-on-one meetings with providers to address their specific needs and during the quarterly provider meetings.

The Quality Auditing team was fully staffed and implemented an auditing schedule to ensure 100% compliance in completing audits for hospitals, specialized residential services (SRS), and primary providers for FY 2025. As a result, there was a substantial increase in the number of providers audited during FY 2025. The table below illustrates the substantial growth in the percentage of completed audits involving primary and residential home providers from FY 2024 to FY 2025.



Risk Management and Events Data Overview

Incident reports are required to be submitted to MCCMH by the Provider Network for all incidents considered unusual. Incidents are reported via fax or directly submitted using a portal in MCCMH's EMR system. Reports submitted through the fax line are uploaded to the MCCMH incident report module in its FOCUS system (EMR) and reviewed by the Quality Department for tracking, trending, and remediation purposes. Incident reports are coded, and critical/sentinel events are submitted to MDHHS in accordance with MDHHS reporting requirements. All sentinel events are reviewed by MCCMH's Critical Risk Management Committee (CRMC). Recipient Rights concerns are further reviewed by the Office of Recipient Rights. The Clinical Department reviews all medication error incidents that are neither critical nor sentinel events. Suicide ideation incidents are reviewed by the Clinical Department in accordance with the CCBHC guidelines to establish

system-wide risk reduction strategies and direct initiatives to persons served with trending risk concerns, including behavior treatment planning. Due to staffing and incident reporting changes, and after realizing that providers are underreporting, the Quality Department updated the incident reporting process and created an internal procedure for unsubmitted incident reports. The Quality Department also created training to the various provider types around types of incidents to report, when to report, and how to report. The goal is to better maintain the health and safety of the members.

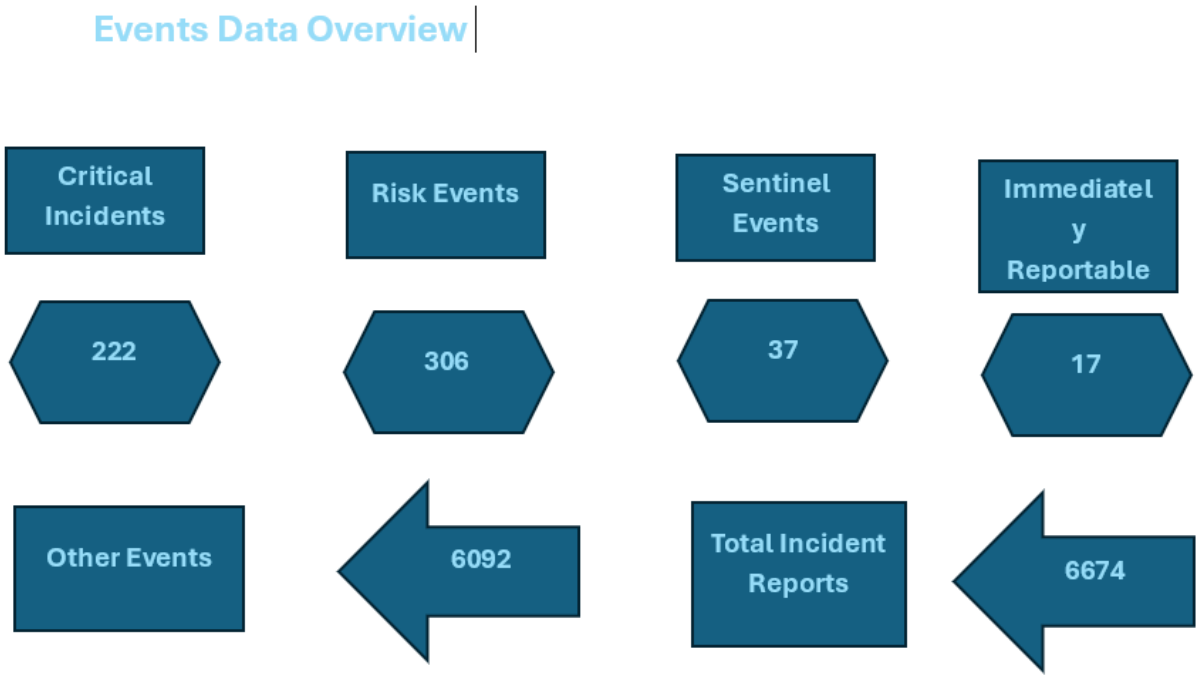
Throughout FY 2025, as the Quality Department enforced the auditing process, lots of cases were identified where incident reports were not reported. To better protect the quality of care and the health and safety of the members, the Quality Department is working on a process to streamline the incident reporting process. This improvement will be fully implemented in FY 2026.

In review of the challenges in FY 2025, the following improvements will be implemented in 2026:

- Better communication and increased staff training to remove any confusion related to staff responsibility for reporting and notification.
- Improve collaboration between the Quality Department and the Office of Recipient Rights to ensure there are no gaps in processes that could impact members or create confusion for staff completing and reporting incident reports.
- Increased enforcing of organizational and contractual standards when provider remediation is necessary to provide process improvement or corrective action.

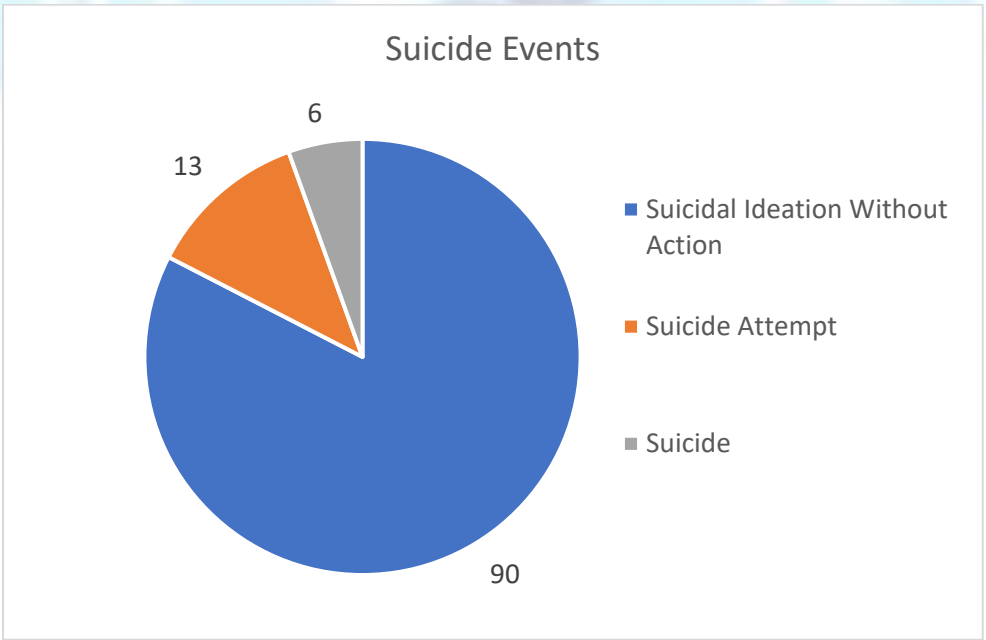
There were 6,674 incidents reported in FY 2025. 222 of these reports were considered Critical, 37 were Sentinel, 306 were Risk Events, and 17 were immediately reportable, while 6,092 of the incidents were classified as “other.” All the incidents were reviewed by the Quality Department. Medication error incidents were reviewed by the Clinical Department and if it was critical or sentinel, it was also reviewed by the CRMC. Recipient Rights concerns were reviewed by the Rights Department. MCCMH’s improved incident tracking mechanisms have improved visibility in trending data and allowed the CRMC to develop appropriate strategies to mitigate risk, even those that fall outside of state reporting requirements. Some examples of such initiatives included the Quality Department’s ability to review recurring non-emergent falls for individuals and follow up with the provider agency to request an RCA and the reviewing of non-critical/sentinel

medication errors and implementing interventions.



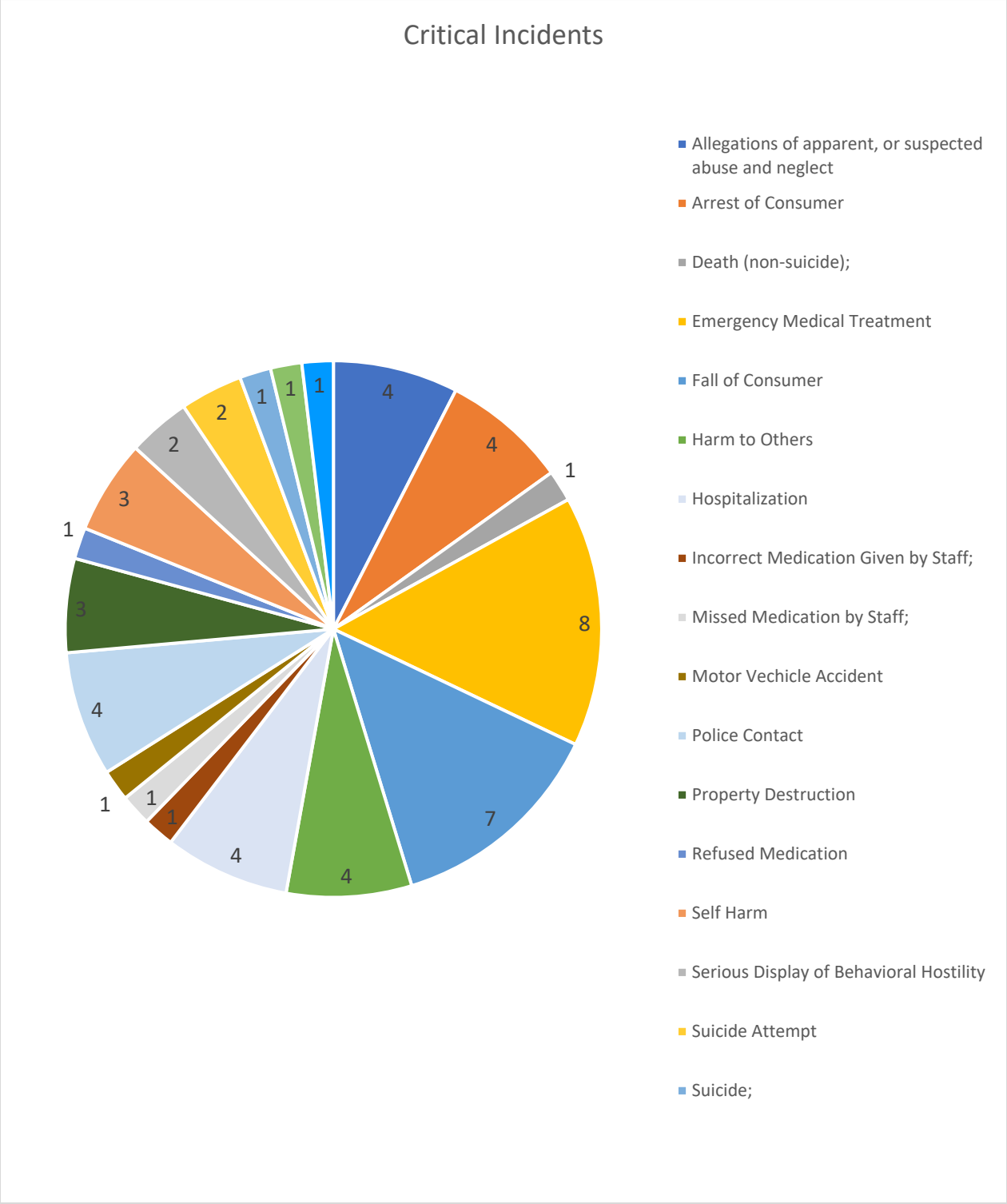
Suicide – Death by, Injury by, Attempts, and Ideation

The graph below shows a breakdown of the number of suicides or attempts in FY 2025. This data is used to support the "Zero Suicide Initiative" and is reviewed by MCCMH's Clinical Department and also at the CRMC.



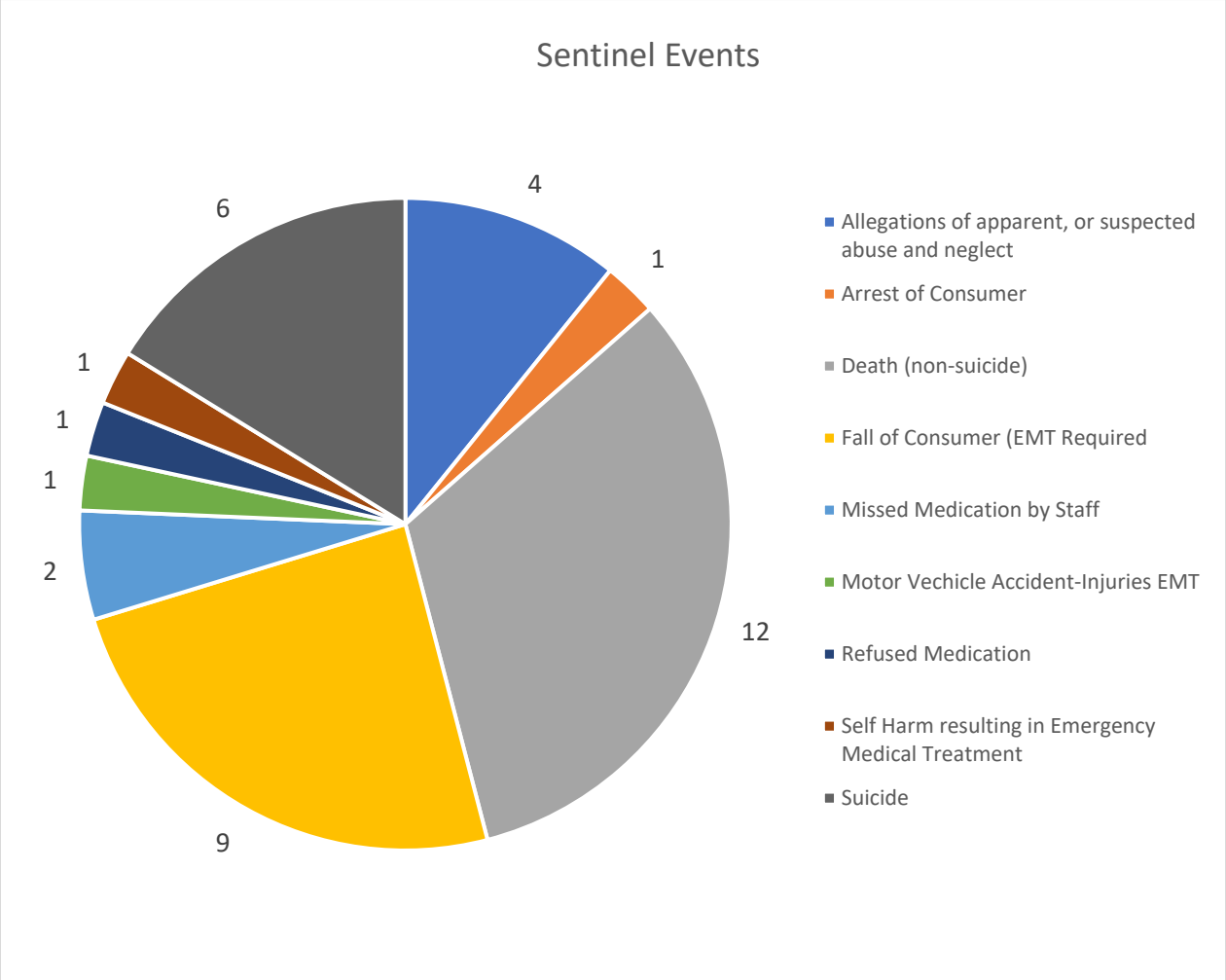
Critical Incidents by Category

The graph below shows the number of Critical Incidents that were submitted for FY 2025. All Critical Events were reported to MDHHS.



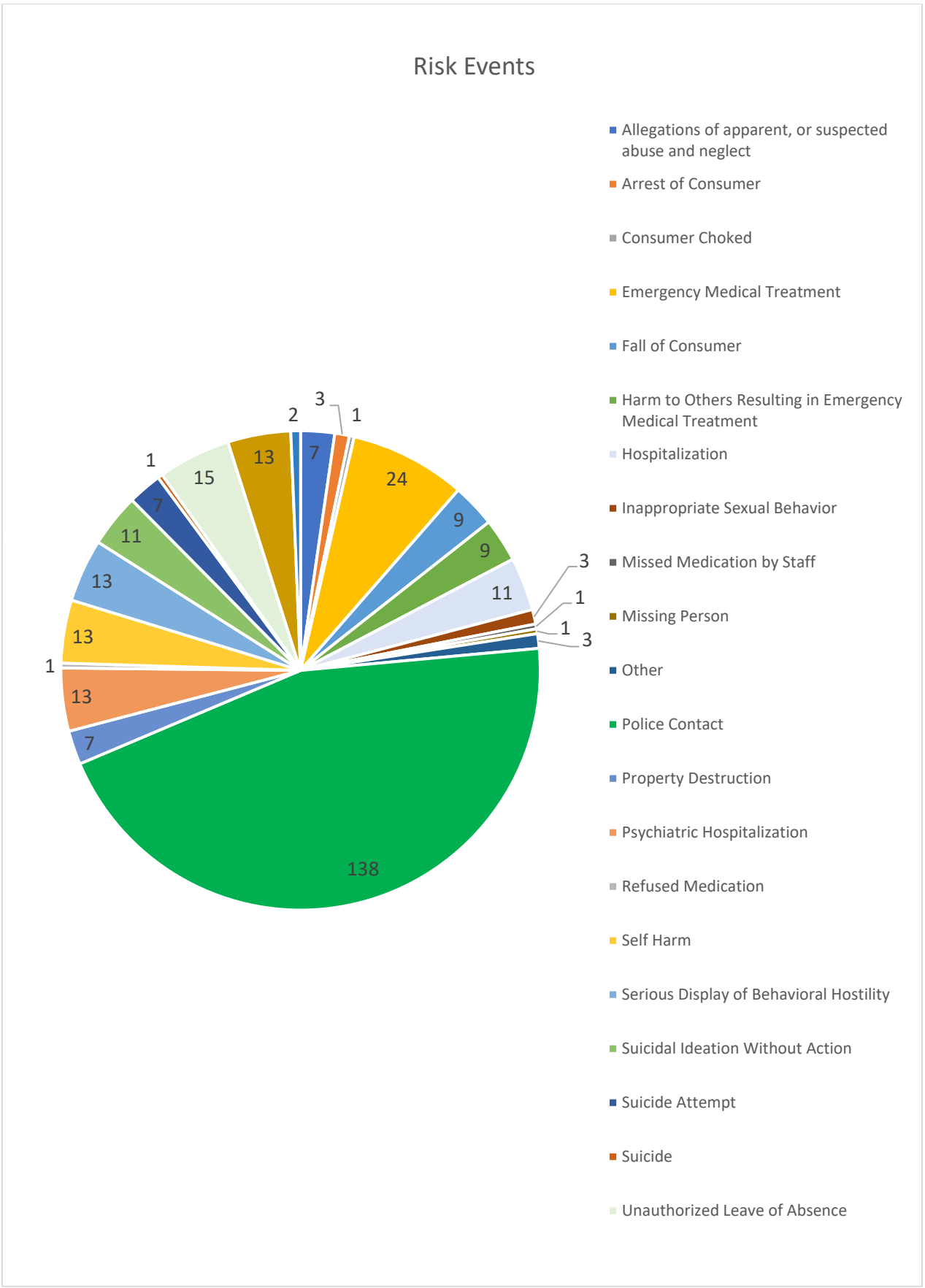
Sentinel Events by Category

The graph below shows the number of Sentinel Events that were identified for FY 2025. All Sentinel Events lead to an RCA request. All sentinel death cases are reviewed by the CRMC.



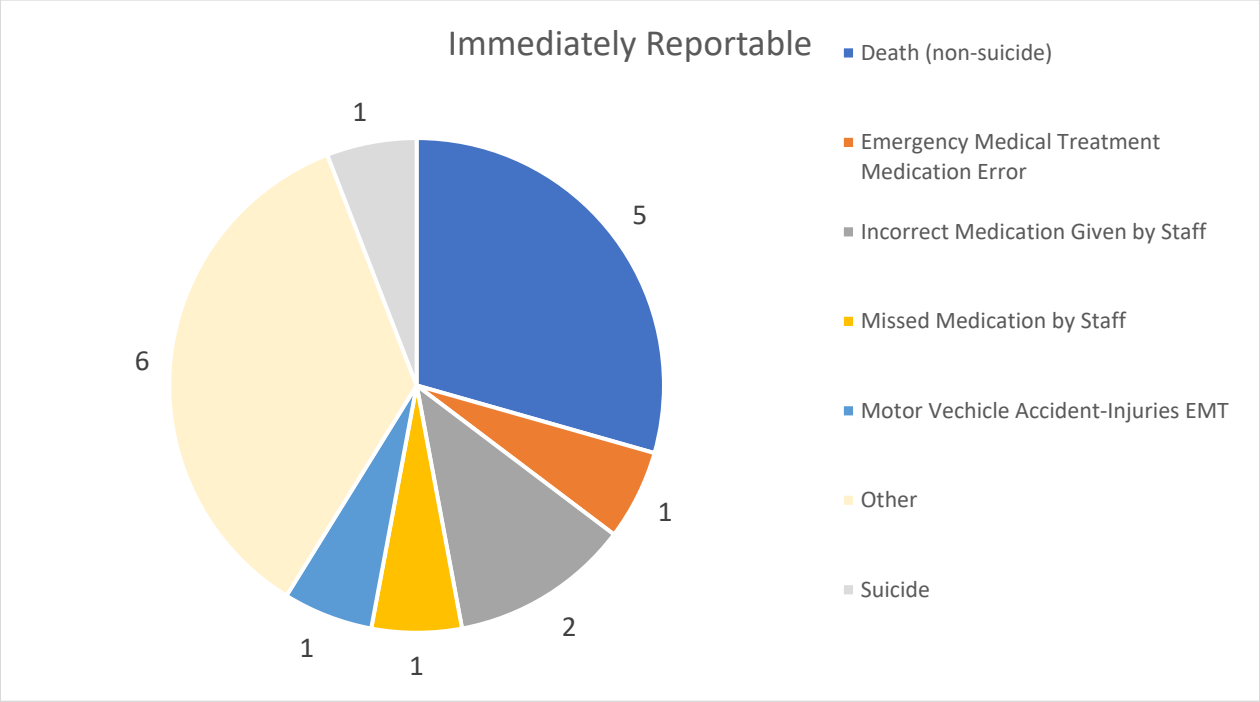
Risk Events by Category

The graph below shows the number of Risk Events that were identified for FY 2025. Risk events are reviewed by the clinical department to support the behavior treatment planning process and assist in mitigating further risk. The Behavior Treatment Plan Review Committee (BTPRC) also reviews the cases more frequently to help provide guidance on adjusting the behavioral treatment plan, staff, and other supports as needed to assure the success and safety of the individual served and the effectiveness of the behavior treatment plan.


Risk Events
Allegations of apparent, or suspected abuse and neglect
Arrest of Consumer
Consumer Choked
Emergency Medical Treatment
Fall of Consumer
Harm to Others Resulting in Emergency Medical Treatment
Hospitalization
Inappropriate Sexual Behavior
Missed Medication by Staff
Missing Person
Other
Police Contact
Property Destruction
Psychiatric Hospitalization
Refused Medication
Self Harm
Serious Display of Behavioral Hostility
Suicidal Ideation Without Action
Suicide Attempt
Suicide
Unauthorized Leave of Absence
7
1
24
9
9
11
3
1
1
3
138
7
13
1
13
13
11
7
1
15
13
2
3

Immediately Reportable Events by Month

The graph below shows the number of Immediately Reportable Events that were identified for FY 2025. The data indicates all deaths that were a result of suspected staff action/inaction. Additional data was marked as immediately reportable; however, it does not meet the criteria as defined by MDHHS. Training and support have been provided to improve the accuracy of reporting. Improvement initiatives have also been put in place to mitigate the future occurrence of reported events. For example, MCCMH's Chief Medical Office (CMO) developed numerous best practice guidelines to support the Provider Network in reducing incidents. In FY 2025, the CMO implemented an initiative to reduce falls of persons served by distributing grip socks to residential homes for residents to wear.



Medication Errors

In 2025 Fiscal Year, 114 incidents reported were on medication error, 96% of those were from AFC homes.

The most common errors for FY25 was the home running out of medication, and the individual missing dose(s).

Two medication errors were deemed critical and were reviewed by the CRMC in 2025

Most common issues identified:

- Delayed medication refills
- Missed morning doses

This data was shared with MCCMH Training Department, resulting in updates to DSP training materials

Death Reports

In 2025 the Critical Risk Management Committee (CRMC) reviewed a total of 21 New Death Root Cause Analysis (RCA) cases, and 1 Mortality Review.

The CRMC found that there were **4** cases reviewed that had a death related to a variety of Chronic Medical Illness.

There were **12** deaths that were from overdose, accidental during recreational using combinations of drugs (majority illicit), 1 Homicide and 4 Suicide deaths.

Some of the trends observed during reviews are as follows:

1. Failure to complete PHQ-9 when clinically indicated

2. Failure to update Crisis Plan based on changes in clinical need

3. Failure to escalate critical trends so proper actions can be taken to provide more supportive clinical interventions to prevent further decline.

4. Provider did not follow the Outreach process as outlined in MCCMH Policy 2-010.

As a result of these reviews, it was evident that the outreach procedure was not followed. In April of 2025 staff received a reminder/education on the outreach procedure. It was also recommended that multidisciplinary teams increase engagement with both the PUPS software and the patient portal, recognizing these platforms as essential tools to enhance outreach and communication with individuals served.

Behavior Treatment Plan Review Committee

During FY 2025, the BTPRC reviewed 853 duplicated behavior treatment plans where restrictive or intrusive interventions had been utilized. This is an increase of 211 reviews since FY 2024 (N=642). BTPRC monitors the least restrictive interventions and makes sure health and safety are taken into consideration in limiting any rights of the individuals served. During FY 2025, emergency physical management was used 43 times (may have been used on the same individual). This is an increase from FY 2024, when the total count was 19. In situations where one or more instances of emergency physical management occurred in a 30-day period, the provider was asked to present in front of the BTPRC more frequently and revise the plan as appropriate or retrain staff if necessary. Other recommendations may have been made as the committee saw fit to ensure quality of care for those we serve. A total of thirty-eight 911 calls were made by staff to seek emergency intervention in cases where all other interventions failed, or staff were not trained or approved for the use of emergency physical management. This is an increase of 14 calls from FY 2024 (N=24). One death was reported during this FY 2025.

Quarterly training occurred on the BTPRC policy, process, and presentation available to all providers.

Utilization Management

Utilization Management (UM) is the process of monitoring and evaluating the services provided to individuals enrolled in the MCCMH system. The purpose of UM is to ensure that all services follow statutory, regulatory, and contractual requirements, while also supporting MCCMH's mission, vision, and guiding principles. MCCMH's UM approach aims to improve health outcomes by ensuring that individuals receive the right service, in the right amount, for the right duration.

The UM process incorporates input from multiple sources, including MCCMH Executive Leadership, the Quality Improvement Committee, the UM Committee, UM staff, providers, and the individuals served. UM activities continually assess the effectiveness of the services delivered through prospective authorization, concurrent review, retrospective review, quality improvement activities, and continuity-of-care planning. MCCMH emphasizes the standardization of UM functions across its service delivery network. Regardless of where UM activities occur, MCCMH maintains responsibility for recommending and implementing improvement strategies, especially when adverse utilization trends are identified. UM staff also support ongoing data integrity efforts, such as detecting overlapping services and coding errors.

MCCMH's organizational structure supports effective administration and evaluation of the UM process. The Chief Executive Officer and Chief Operating Officer provide oversight and direction to the Director of Managed Care Operations (MCO), who is responsible for facilitating the UM Committee. The UM Committee reviews service utilization and the application of medical necessity criteria and approves UM-related policies and procedures. UM initiatives and findings are reported to the Quality Committee at least annually.

MCCMH identifies specific services and supports that require prospective coverage review and approval by UM staff. These reviews consider multiple factors, including clinical documentation, medical necessity, evidence-based criteria, potential outcomes, and available alternatives. The UM process typically begins when providers submit service authorization requests to the MCO division. MCO clinicians evaluate these requests to determine whether they meet medical necessity requirements for the authorization of payment for services. Requests that do not meet medical necessity criteria for authorization are forwarded to a physician or doctorate-level psychologist for a final determination.

Access to Treatment

MCCMH serves as the public provider of mental health, intellectual/developmental disability, and substance use services in Macomb County. Access to services begins with a phone call and the completion of a telephonic screening. The MCO division connects callers with resources that best meet their identified needs, which may include linkage to the MCCMH Provider Network or referrals to external agencies.

MCO monitors several performance metrics to ensure timely responses to callers, as prompt access is essential to maintaining a welcoming and responsive system. In FY 2025, the MCO Access Call Center received 19,083 calls from individuals seeking services through MCCMH. Two key metrics used to evaluate call performance are average speed-to-answer and call abandonment rate. In FY 2025, calls were answered in an average of 43 seconds, surpassing the required standard of 3 minutes. The average call abandonment rate was 1.2%, also better than the required standard of 5%.

Service Authorizations

The MCO division is a high-volume operation in which staffing, processes, and technology must work together to support efficient review, decision-making, and communication. In FY 2025, MCO received 48,403 ongoing service authorization requests, all of which were processed within the required fourteen-day timeframe.

Timely processing is essential, as individuals often need prompt access to clinically necessary services that require authorization. Any delay could result in interruptions or gaps in care. To minimize this risk, the MCO team strives to exceed the standard by targeting a turnaround time that is half of the required limit. As a result, 95% of FY 2025 ongoing service authorization requests were completed within seven calendar days.

Of the ongoing services authorization requests received in FY 2025, 2,402 (4.9%) were denied, and 2,950 (6.1%) were partially denied. These denials led to 115 Local Dispute Resolution (LDR) hearings. Of the LDR outcomes, five determinations were overturned, three were partially overturned, and 107 (93%) upheld the original decision. In FY 2025, there were 21 Medicaid Fair Hearings. Of these, four determinations were overturned, while 17 (80.1%) upheld the initial decision.

In FY 2025, there were 5,439 crisis prescreening requests received by MCCMH and processed by MCO and a delegated provider. 98.2% of these were processed within the required three-hour timeframe. To ensure timely access to treatment, MCO continuously strives to exceed this standard, resulting in 80.1% of the requests being processed within less than one hour.

Next Steps

MCCMH plans to pursue National Committee for Quality Assurance (NCQA) certification in FY 2026. In preparation, UM-related policies and procedures are continuously reviewed and updated to ensure alignment with the highest quality standards. In FY 2026, the UM Committee will prioritize analysis of provider-specific data to identify patterns of over- or under-utilization and develop recommendations for improvement in performance. Also planned for FY 2026, MCCMH will launch a Residential Committee, a multidivisional subcommittee to the UM Committee, to monitor the utilization of resources allocated to individuals authorized for SRS.

The MCCMH MCO division will continue its close collaboration with the Informatics division to design and implement enhanced data-driven processes aimed at improving utilization

management outcomes. Additionally, MCO will continue to expand Inter-Rater Reliability (IRR) activities across the department to promote consistency in the application of criteria used in UM decision-making.

Clinical Practice Guidelines

MCCMH establishes Clinical Practice Guidelines based on the literature of related fields, collaboration with its partners, needs within the system, and best practices as listed by the Substance Abuse and Mental Health Services Administration (SAMHSA).

MCCMH has adopted Clinical Practice Guidelines for Direct and Contract providers. The guidelines were established and guided by authoritative sources such as the American Psychiatric Association but mainly established using Milliman Care Guidelines' (MCG) health criteria and NCQA accreditation standards. MCCMH's current guidelines are:

- Clinical Practice Guidelines - PTSD
- Clinical Practice Guidelines - ADHD and Disruptive Behavior Disorders
- Clinical Practice Guidelines - Bipolar Disorder
- Clinical Practice Guidelines - Major Depressive Disorder
- Clinical Practice Guidelines – Schizophrenia

Additional guidelines are added periodically and as needed to set standards of care.

Clinical Practice Guidelines are reviewed and updated every two years. Throughout FY 2024, MCCMH's updated guidelines were presented to providers during network meetings where feedback was sought. After a period of review and feedback was given, the updated guides were formally adopted. Current Clinical Practice Guidelines are posted on MCCMH's website for ongoing reference and review.

Credentialing and Re-Credentialing Activities

It is the policy of MCCMH that all individuals directly or contractually employed by MCCMH provide a level of care consistent with professionally recognized standards and in accordance with applicable credentialing and certification requirements of MDHHS, the Centers for Medicare and Medicaid Services (CMS), and accrediting bodies. MCCMH is responsible for ensuring that providers meet all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual (MPM) requirements.

In FY 2025, MCCMH updated its credentialing and re-credentialing policy and procedure to align with updates from MDHHS and with NCQA accreditation requirements.

MCCMH has consistently maintained a high standard of notifying practitioners within 10 business days of obtaining all required information. MCCMH has also developed a procedure to provide guidance for MCCMH's credentialing security and monitoring systems. This procedure aligns with the undated NCQA standards.

MCCMH also started completing the credentialing process through the Behavioral Health Customer Relationship Management (BH CRM) system. This new system also allows MCCMH

to comply with the state's three-year reaccreditation requirements. Credentialing and recredentialing breakdowns are as follows:

Practitioner Credentialing

Initial credentialing (new hires): 75

Recredentialed: 129

Organizational Credentialing

Community Living Supports (CLS)/Respite: 3

Specialized Residential: 4

Applied Behavioral Analysis (ABA): 4

Music/Art/Recreational Therapy: 1

Outpatient Mental Health: 1

RFPs Issued

Occupational/Physical/Speech Therapy: 2

Outpatient Mental Health: 2

Improvement Initiatives

MCCMH has continued to ensure procurement of services to support network adequacy and capacity needs for persons served. MCCMH has expanded the provider onboarding process to include a two-day onboarding covering topics such as Recipient Rights, Training, Compliance, Quality and performance requirements, policies and procedures, use of the EMR system, billing, clinical documentation requirements, and best practices. MCCMH has received very positive feedback about the new onboarding process.

MCCMH has also expanded provider education and support by introducing the Focus User Support & Education (FUSE) training. FUSE is designed to train providers and practitioners on how and where to document in the system. MCCH continues to encourage provider participation and feedback around additional areas of interest that are currently not being covered in the training.

Challenges Faced and Possible Solutions

MCCMH Provider Network continues to experience the strain of a staffing crisis, as the entire State of Michigan does. One of the major areas affected by the staffing crisis is SRS and outpatient provider services.

Ways that the challenges have been overcome or plans to overcome:

MCCMH has ensured competitive rates to attract more staff, facilitate onboarding, and staff retention.

MCCMH has issued several RFPs to ensure the network is capable of sustaining the community.

MCCMH has expanded the training department to provide opportunities for contracted providers to receive required training both in person, virtually, and on the learning management system.

MCCMH developed the Placement Review Committee (PRC) platform to support case managers (CM) and SRS providers to link persons to medically necessary services. CMs are provided in an in-person (virtually offered as needed) meeting with SRS provider to facilitate placement in the setting. This platform allows for Q&As between parties. This initiative has shown a higher rate of success when securing an SRS home. MCCMH does track the outcomes of this process and is able to verify with the data that more individuals are being accepted into placement through this collaborative approach.

MCCMH launched the pilot program to support SRS providers to follow a structured process to analyze trend causes leading to SRS immediate discharge decisions. The program also offered opportunities for providers to receive support from MCCMH prior to making a final discharge decision. The findings and lessons learned from this pilot are planned to be adopted in a proposed policy in 2026.

MCCMH has secured SRS contracts with providers who have attained high-quality SRS programs as evidenced by their CARF accreditation in Residential Treatment. These settings have proven to be able to support those with higher needs, sustain staffing, and provide 1:1 care as medically necessary.

MCCMH has also developed a transitional home with an SRS partner in the network. The transitional home has allowed persons served to be provided with the medically necessary services they are authorized for within the required timeframe as well as allowed persons a safe environment while they work with their treatment team to seek a more long-term solution for their needs.

Verification of Billed Services

In accordance with the Balanced Budget Act of 1997, MCCMH contracted Jefferson Wells to conduct the Medicaid Encounter Verification audit. Jefferson Wells used accounting/financial software to stratify data provided by MCCMH by vendor and to select a sample of claims for each vendor. Random samples were selected representing five percent of the number of claims for each vendor, with a minimum of 20 claims per vendor. For those vendors with less than 20 claims, all claims were included in the sample. For those vendors whose claims population exceeded 6,000, Jefferson Wells used a statistical sample with parameters of 95% confidence and a $\pm$5% margin of error, with a maximum sample size of 300.

Audits were conducted in accordance with MDHHS Guidelines for verification of Medicaid services and MCCMH Medicaid Verification Financial Audit Process guidelines. Audits verified the existence of appropriate clinical records for each claim in the sample selection, evaluated the reasonableness of clinical records associated with each claim, verified that services specified in the claim were part of the consumer's Individual Plan of Service, and verified that services provided were included in Chapter III of the Community Mental Health Services Program.

Mental Health Services

Jefferson Wells reviewed clinical records and payment documentation for a random sample of 40,062 claims, representing 1.9% of the population of claims and 2.6% of the dollar value of claims paid. The claims were classified under 179 vendors with the audit period of March 1, 2023, through February 28, 2025.

Results are as follows:

Description	# of Claim Lines	Amounts Paid
Claims Population	2,076,944	$374,258,047.69
Sample Claims	40,062	$9,559,276.08
Percent of Claims Population	1.9%	2.6%

Description	Recoverable	Non-Recoverable	Total Exceptions
$ Amount	$517,624.60	$64,487.32	$582,111.92
# of Claims	1,795	441	2,236
Percent of Total Exceptions $	88.9%	11.1%	100.0%
Percent of Total Audited $	5.4%	0.7%	6.1%

Prior Audit Comparison – a detailed comparison of current year audit results to 2024 results was prepared, with the following summary highlights:

Description	Year	Recoverable	Non-Recoverable	Total Exceptions
$ Amount	2025	$517,624.60	$64,487.32	$582,111.92
	2024	$91,935.31	$536,648.47	$628,583.78
Percent of Total Exceptions $	2025	88.9%	11.1%	100.0%
	2024	14.6%	85.4%	100.0%
Percent of Total Audited $	2025	5.4%	0.7%	6.1%
	2024	2.0%	11.8%	13.9%

This report was shared with the MCCMH Quality Committee. Trends and recommendations were shared with the providers and the MCCMH Board of Directors. After the applicable appeal periods concluded, any provider who scored below 95% was required to complete and submit a corrective action plan to the Quality Department. The Network Operations Department has notified providers

of any recoverable deficiencies, and the Finance Department is responsible for executing any recovery actions warranted.

Substance Use services

Jefferson Wells reviewed clinical records and payment documentation for a random sample of 18,750 claims totaling $1,112,165.63, representing 4.7% of the population of claims and 6.1% of the dollar value of claims paid. The claims were classified under 27 vendors from the audit period of March 1, 2024, through February 28, 2025. The claims were reviewed for compliance with the MDHHS Quality Assessment and Performance Improvement Program.

Results are as follows:

Description	# of Cases	# of Claim Lines	Amounts Paid
Claims Population	5,013	398,193	$18,239,854.58
Sample Claims	302	18,750	$ $1,112,165.63
Percent of Claims Population	5.3%	4.7%	6.1%

Description	Recoverable	Non-Recoverable	Total Exceptions
$ Amount	$18,889.31	$32,358.59	$51,247.90
# of Claims	250	395	645
Percent of Total Exceptions $	36.9%	63.1%	100.0%
Percent of Total Audited $	1.7%	2.9%	4.6%

After the applicable appeal periods concluded, any provider who scored below 95% was required to complete and submit a corrective action plan to the Substance Use Services Department. Providers were notified of any recoverable deficiencies and the Finance department is responsible for executing and recoverable actions warranted.

Provider Network Monitoring Activities

MCCMH developed a Network Adequacy Plan in Q2 of FY 2025 to address the needs and requirements of its system of care in accordance with MDHHS guidelines. MCCMH has monitoring processes in place to attend to its network's needs and adjust as necessary. The Network Adequacy Plan outlines specific steps MCCMH has taken to review its network, identifies various departments and stakeholders involved, and outlines provider contracting processes that support and ensure an appropriate provider network. MCCMH is supported by its directly operated programs as well as by expansive behavioral health and SUD networks. MCCMH contracts with providers over a two-year period to ensure covered services are available for the persons served. Organizational Credentialing policies and processes that comply with pertinent standards from MDHHS, NCQA, and other external entities were also updated and implemented throughout the network during FY 2025.

Network Adequacy

MCCMH provides a comprehensive provider network of specialized services, which are geographically accessible to all individuals served in its community. In addition, MCCMH ensures supports are in place with the capacity to provide services sufficient in amount, scope, and duration to meet the needs of all eligible persons who may require specialty mental health benefits and/or SUD services.

Mental Health

MCCMH contracts with close to 200 vendors and 500 providers to provide a wide variety of mental health services needed to adequately serve persons in Macomb County. Some of these services include, but are not limited to:

- Applied Behavioral Analysis
- Assertive Community Treatment
- Behavioral Services
- Campership
- Children's Residential
- Case Management Services
- Community Living Supports
- Crisis Residential (Adult)
- Crisis Residential (Children)
- Equine Therapy
- Home Based Services
- Intensive Crisis Stabilization Services
- Interpreter Services
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Music Therapy
- Art Therapy
- Recreation Therapy
- Massage Therapy
- Peer Support Services
- Private Duty Nursing
- Psychiatric Hospital (Adult or Child)
- Psycho-Social Rehabilitation Programs
- Respite Services
- Skill Building Services
- Specialized Residential Services
- Wrap Around Services

SUD

MCCMH contracts with a variety of providers who offer a comprehensive array of SUD prevention, treatment, and recovery programs to meet the SUD needs of people in Macomb County. Some of these services include, but are not limited to:

- Withdrawal Management
- Residential Treatment Services
- Medication for Opioid Use Disorders (MOUD)
- Intensive Outpatient Treatment
- Outpatient Treatment
- SUD Health Home Services
- Women's Specialty Services
- Peer Recovery Coaching
- Recovery Housing
- Prevention

MCCMH strives to provide all services needed to its community members and those served. This is not an all-inclusive list of behavioral health care or SUD services, which are offered within MCCMH's system of care. Throughout the changes in our State and the staffing crisis our Provider Network continues to experience, MCCMH has supported its Provider Network to ensure the maintenance and ability for individuals to receive medically necessary services in a timely manner.

MCCMH has an interactive map that is made available to the public on MCCMH's website. This map offers a comprehensive list of Provider Agencies throughout Macomb County as well as outside of the County, as services are available to meet the needs of all those we serve. This functionality also includes search features by both provider type and geographic area. Additionally, the map includes pop-up features for each provider that offer additional public information such as phone numbers, addresses, and services provided.

New Vendors in FY 2025

CLS/Respite: 3

Specialized Residential: 4

ABA: 4

Music/Art/Recreational Therapy: 1

Outpatient Mental Health

RFPs Issued in FY 2025 and Vendors to be Onboarded in FY 2026

Occupational/Physical/Speech: 2

Outpatient Mental Health: 2

Member Satisfaction

The MCCMH Quality Department annually assesses the satisfaction of its members by conducting member satisfaction surveys. MCCMH surveys members actively receiving services from Board programs and following completion of Board programs. MCCMH makes its survey available to all members receiving services.

The survey results serve as a barometer for gauging member satisfaction and to inform the improvement of program initiatives. The survey results are shared with the Citizens Advisory Council (CAC), the MCCMH Board of Trustees, MCCMH Quality Committee, MCCMH Executive Leadership, Contracted Agency Leadership, persons served and via the annual impact statement, which is made available to the public and published on the website.

Methodology

MCCMH's Quality Department managed the data gathering and aggregation of results. The survey was made available to all members from September 2, 2025, until October 17, 2025. Surveys were distributed to the MCCMH Provider Network. Survey completion is made anonymous, although members may request assistance from staff if desired. The survey was made available through different formats to ensure each member has fair and equitable access to participate. Members were given the option to complete the survey with a paper copy, by scanning flyers with a QR code, or by visiting the MCCMH website and clicking on the secure electronic link. Survey collection was achieved with a combination of in-person survey pickup, mail delivery, secure electronic mail, and online survey. 473 adult surveys and 148 child and family surveys were completed and returned.

MCCMH utilized the Mental Health Statistical Improvement Program (MHSIP) Survey for adults and the Youth Services Survey for Families (YSS-F). Both surveys are nationally recognized, validated, and approved by SAMSHA to obtain members' perception of care in various domains. For children, each question is answered using a Likert Scale ranging from 1= Strongly Disagree to 5= Strongly Agree for children. The MHSIP survey uses a reverse Likert Scale of 1=Strongly Agree to 5= Strongly Disagree. Satisfaction is indicated by a score of at least 3.5 for children and at most 2.5 for adults.

In addition to the Likert Scale questions, MCCMH included three open-ended questions: How would you describe your overall experience with treatment at MCCMH?; What has been the most helpful while receiving services in the last six months from MCCMH?; and What would you like to improve the services that you receive through MCCMH? A sentiment analysis was completed

to analyze the content of each open-ended question. Trends in the qualitative data were compared to the quantitative review of the Likert Scale to further identify any associations between the data.

MCCMH has established network standards of 90% for each domain. If a domain scores below the threshold of 90%, it is identified as an area for improvement. MCCMH reviews domain scores based on network aggregation and at the individual provider agency level. MCCMH may make recommendations to agencies scoring below the 90% threshold in any domain during one-to-one meetings.

Survey Participation

Population	FY 2024	FY 2025
Adult	530	473
Child and Family	133	148

Race

Race	Adult	Child and Family
American Indian or Alaska Native	5	0
Asian	12	7
Black or African American	57	23
Middle Eastern or North African	19	5
More than One Race	12	12
Other	11	6
Prefer not to answer	24	4
White (Caucasian)	333	91

Gender

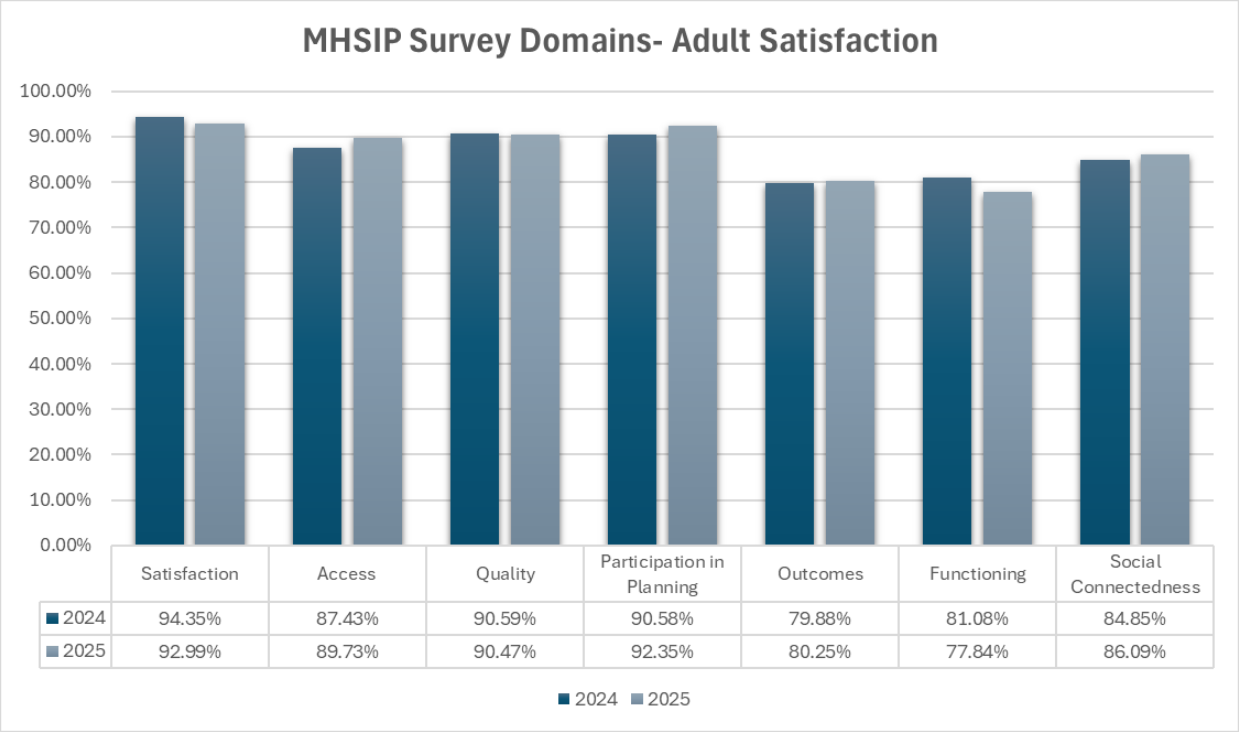
Gender	Adult	Child and Family
Choose to self-describe	0	1
Female	207	54
Male	250	92
Nonbinary or Gender Nonconforming	4	0
Prefer not to answer	12	1

Age Range

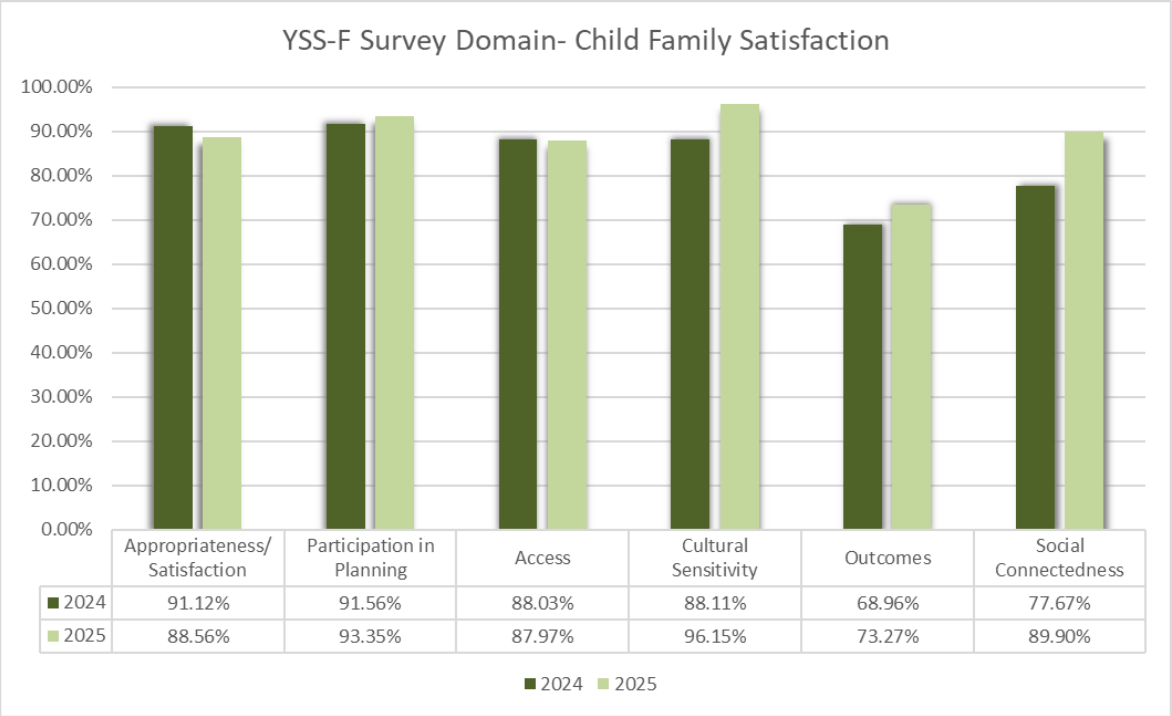
Age Range	Adult	Child and Family
0-4 years old	*	20
5-12 years old	*	81
13-18 years old	5	46

18-29 years old	112	*
30-64 years old	298	*
65+ years old	47	*
Prefer not to answer	10	1

Domain Scores Yearly Comparison



	Satisfaction	Access	Quality	Participation in Planning	Outcomes	Functioning	Social Connectedness
2024	94.35%	87.43%	90.59%	90.58%	79.88%	81.08%	84.85%
2025	92.99%	89.73%	90.47%	92.35%	80.25%	77.84%	86.09%



Domain Growth

Domain growth occurred in four out of seven categories for adults (Access, Participation in Planning, Outcomes, and Social Connectedness. Child and Families similarly saw domain growth in four of six categories, including Participation in Planning, Cultural Sensitivity, Outcomes, and Social Connectedness.

Domain Decline

General satisfaction reduced in score for both adult and child/family populations. Adults reported a decline in the Quality domain (.12%). Adults reported a decline in satisfaction with the Outcome domain (.37%). The child and family population perceived a decline in Access to care satisfaction (.06%).

Associations and Trends

Adult

Functioning and Outcomes are the lowest-scoring domains.

Improved functioning, such as employment and daily living skills, goes hand in hand with treatment outcomes. Low scores in both domains reinforce the need to find practical improvement strategies for functioning to improve treatment outcomes. A rate increase of dissatisfaction for "Staff told me what side effects to watch out for" was also observed when compared to 2024 data (4.65% vs 3.9%).

Child and Family

Help wanted and help needed statements trend significantly with one another, suggesting that members perceive their treatment needs are met (want vs. need) during the planning process. "It is clear to me in my child's plan how certain interventions will help" and "In my child's plan I can see how my child's strengths will be used" closely correlate. When families understand treatment interventions, they also understand how their child's strengths are used during treatment delivery.

Open-Ended Feedback and Associations

Areas for Improvement

Area of Concern	Feedback	Domains Impacted
Staff/ Wages	High Turnover: "Don't just switch or not tell when case manager or therapist is going to change." Recruitment/ retention: "Making obtaining staff easier."	Access Outcomes Quality Functioning
Availability of DCW/ CLS/ Respite	"Availability of staff for CLS and Respite Services." "More staff to take me shopping." "I would improve more CLS and Respite hours." "County does not give enough to staff!"	Access Functioning
Psychiatric Care	Appointments/ Access: "It is extremely hard to get an appointment with my doctor… Their appointments are always booked so far in advance." Medication Issues: "More of a say so in medications." "I feel like I'm being tortured through medication."	Access Quality Outcomes
Communication and Information	"Clearer communication as to understand better." "When a person comes for the [first] time help them understand the information given." "If a COORDINATOR has left his/ her position please notify the consumers family."	Participation in Planning Quality

Program/ Service Gaps	Specialty services: "ABA therapy for adults." "More speech therapy." "Increase the availability of services directly dealing with profound autism and behaviors." Life skills: "Need more help with finding supported employment." "Help to find independent living options."	Access Quality

Strengths

Strengths	Feedback	Domains Impacted
Quality of Staff Relationships	"My case manger is the best!!! She helps us all the time." "Linda Lezzotte is my son's case worker and she always goes above and beyond."	Quality Social Connectedness
Therapy and Skills Building	"I like the therapy sessions." "I've also learned some new coping skills!" "DBT skills group." "Skill building services have given me friends."	Social Connectedness Outcomes Functioning
Day Programs and Community Integration	"Enrollment in day program, advice about other supports." "Attending Crossroads Clubhouse and socializing with peers." "I get out of the house and making friends. Everybody is nice here."	Social Connectedness Functioning
Effective Crisis/ Coordination	"I could easily get in touch with support coordinator to get certain issues sorted out." "Dr. Lapo and Latisha Quickly resolved this matter with just a phone call and medication update."	Access Quality

Improvement Strategies

Ongoing

During FY 2025 MCCMH completed one-to-one meetings with its agency providers to review membership satisfaction survey results in detail. MCCMH analyzed agency rates ahead of one-to-one meetings in preparation for each meeting and reducing wasting resources and time. Each meeting reviewed perceived strengths and weaknesses, according to agency members. Agency scores were compared against network averages. When an agency fell below network averages, those scores were highlighted in reporting as areas for improvement. Similarly, strengths were addressed as areas to leverage when improving perceived areas of weakness. MCCMH will adopt a similar approach for agency meetings.

Recommendations

Focal Points: Functioning, Outcomes, and Staffing

Quantitative scores and qualitative feedback support functioning as the primary concern.

Functioning represents members' practical, day-to-day independence and ability to navigate the community, relationships, and ability to work. This domain is MCCMH's lowest-scoring domain amongst the adult population.

Outcomes domain represents members' improvement in areas such as ability to cope when things go wrong. Outcomes is the lowest-scoring domain for the child and family population and the second lowest-scoring domain for the adult population.

Access to services and Participation in Planning saw improvements despite consistent feedback on system staffing issues causing delays or interruptions in treatment.

Vulnerable Individuals

MCCMH considers its entire population vulnerable individuals due to most individuals treated being severe mental illness (SMI) or serious emotional disturbance (SED). MCCMH created updates in the electronic medical record in FY 2023 to include the addition of physical health goals and SUD goal prompts, which in turn compile an integrated care plan. The creation of a dashboard to measure the number of integrated care plans was started, and steps were taken to validate the report.

LTSS Activities

MCCMH ensures individuals receiving long-term support or services (e.g., individuals receiving case management or supports coordination) are incorporated in the review and analysis of information obtained from quantitative and qualitative methods. MCCMH continuously reviews care between care settings and compares services and support received based on the individual's plan of service. Specific findings from MCCMH's Member Satisfaction Survey that was completed in FY 2025 are described further in the Member Satisfaction Section of this report.

MCCMH continues to review, analyze, and monitor person-centered planning practices, IPOS reviews/amendments, and standardized assessment scores that support level of care, such as the Level of Care Utilization System (LOCUS). This includes an assessment of care between care

settings and a comparison of services and supports. LTSS members remain included as survey participants and members of the CAC.

Over the past year, MCCMH prioritized monitoring and improving continuity and coordination of care that persons served receive across the behavioral health network and has taken action to improve and measure the effectiveness of such improvement strategies. MCCMH has engaged in internal improvement workgroups surrounding network improvement and training of staff on person-centered planning practices, periodic reviews of service, LOCUS and SIS assessments, specialized nursing assessments, behavioral assessments, and psychiatric evaluations. MCCMH has prioritized updates to Clinical Practice Policies that depict standards related to these areas to ensure compliance with current federal, state, and other external requirements to which MCCMH is held.

Person Served Rights

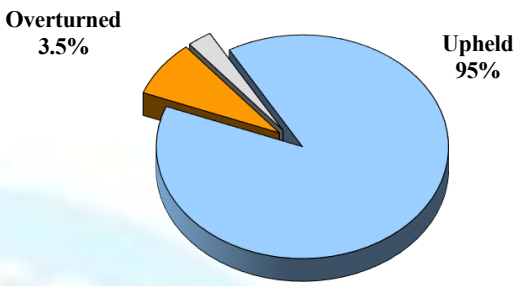
Throughout FY 2025, MCCMH's goal to ensure the completion of all Office of Recipient Right's investigations within the mandated timeframes has been met. The Office of Recipient Rights has consistently exceeded contract requirements and expectations. Due to the importance of this goal and to ensure members' rights within MCCMH, this goal will continue.

Grievances & Appeals

A grievance is a formal expression of dissatisfaction with something MCCMH has done. A Local Appeal is a formal request for a review of an action made by MCCMH. The following report highlights the total number of grievances and appeals in the first quarter of the Fiscal Year of 2024 for MCCMH. It breaks down both categories and frequency. Possible trends, improvements, and actions will also be identified. The data reflects the information required by and submitted to MDHHS.

Grand Total of Appeals

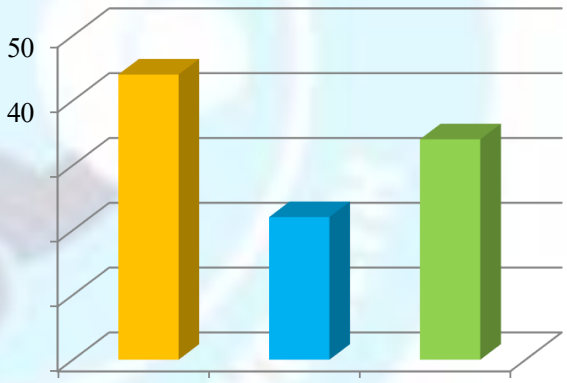
	Q1	Q2	Q3	Q4
Appeals Upheld	19	14	33	43
Appeals Overturned	2	1	1	0
Appeals Partially Upheld/Overturned	0	1	0	1
Total Appeals	**21**	**16**	**34**	**44**



Services Appealed

Alcoho/Drug Halfway	0	0	0	1	1%
All Services	0	1	0	0	1%
Children's Waiver	0	0	0	1	1%
CLS	6	2	14	10	28%
CLS/Respite	4	3	2	3	10%
Goods & Services	0	1	0	0	1%
Local Inpatient	0	0	2	0	2%
Methadone Tx	0	0	0	1	1%
OT/PT	1	0	0	0	1%
Overnight Health & Safety	0	1	0	1	2%
Personal Care	6	7	8	13	30%
Residential Sub. Abuse	0	0	0	1	1%
SED Waiver	0	0	1	1	2%
Skill Building	0	0	0	0	0%
State Hospitalization	0	0	0	1	1%
Respite	3	1	7	11	21%
Substance Abuse	1	0	0	0	1%

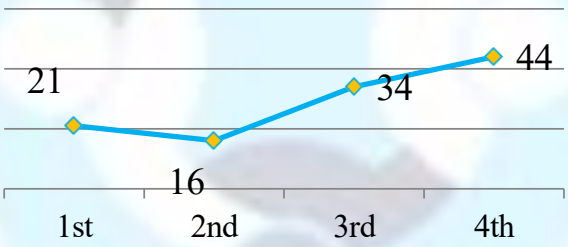
Top Four Appealed Services



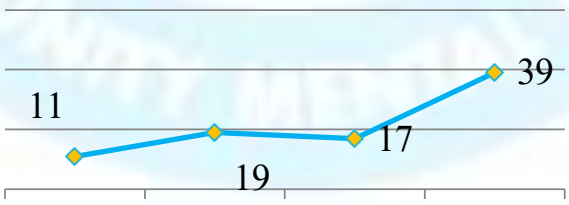
	Q1	Q2	Q3	Q4
Appeals Resolved Timely	21	16	34	44
Untimely Appeals	0	0	0	0
Denied Expedited Requests	1	0	1	3
Expedited Appeals	0	0	2	0
Extended Appeals	0	1	0	1
Average Days for Resolution	21	25	19	22

	Q1	Q2	Q3	Q4
Medicaid Fair Hearings Upheld	2	2	2	3
Medicaid Fair Hearings Overturned	1	1	1	0
Medicaid Fair Hearings Dismissed	3	1	1	2
Total Medicaid Fair Hearings	**6**	**4**	**4**	**5**

FY 2025 Appeals Per Quarter

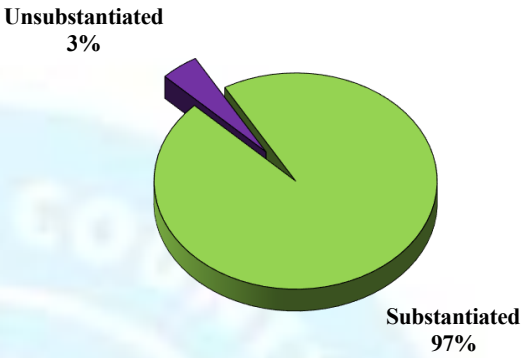


FY 2024 Appeals Per Quarter



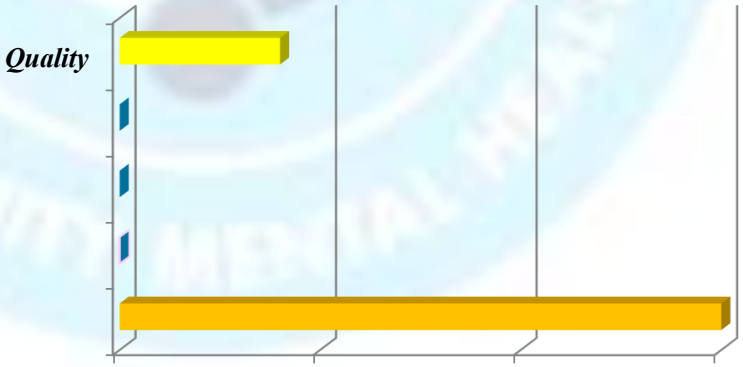
Grand Total of Grievances

	Q1	Q2	Q3	Q4
Grievances Substantiated	10	12	8	7
Grievances Unsubstantiated	1	0	0	0
Total Grievances	**11**	**12**	**8**	**7**



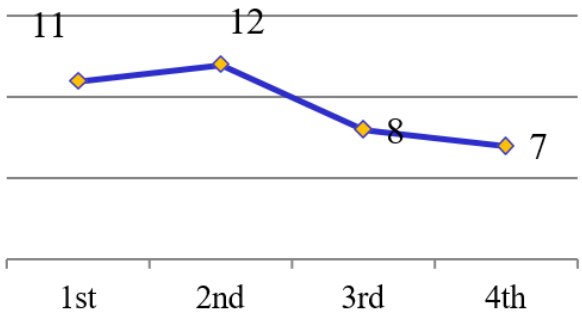
Grievance Categories

Access & Availability	11	10	4	5	79%
Abuse, Neglect or Exploitation	0	0	0	0	0%
Financial	0	0	0	0	0%
Service Environment	0	0	0	0	0%
Quality of Care	0	2	4	2	21%

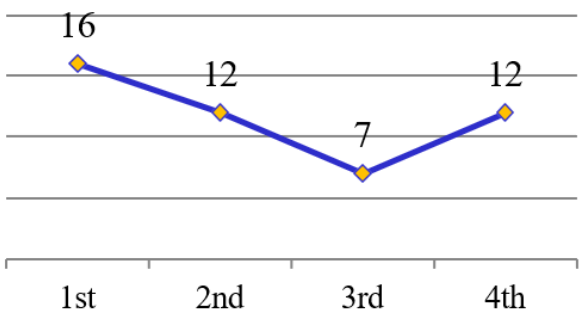


	Q!	Q2	Q3	Q4
Grievances Resolved Timely	11	12	8	7
Untimely Grievances	0	0	0	0
Average Days for Resolution	20	44	41	26
Grievances Meeting Notification Timeframes	11	12	8	7
Grievances not meeting Notification Timeframes	0	0	0	0

FY 2025 Grievances Per Quarter



FY 2024 Grievances Per Quarter



Trends

During FY 2025, a total of 115 appeals were submitted. Approximately 98% of these appeals resulted in an upheld decision, representing an increase of 87% in FY 2024. Overall, the volume of appeals increased, along with a notable shift in the types of services being appealed. Personal Care services accounted for 30% of all appeals in FY 2025, up from 24% in FY 2024. This 6% increase indicates an emerging trend in appeals related to Personal Care services.

In FY 2025, 38 grievances were reported. Of these, 97% were substantiated, a significant increase compared to the 70% substantiation rate in FY 2024. This elevated substantiation rate remained consistent throughout the fiscal year. Additionally, 71% of grievances were related to Access and Availability, a decrease from 85% in the prior fiscal year. This shift corresponds with an increase in Quality of Care grievances, which accounted for 21% of all grievances.

During the FY, one grievance and three appeals were related to SUD services. Additionally, 19 Medicaid Fair Hearings were completed, consistent with the volume reported in the previous fiscal year. Of these hearings, three resulted in overturned decisions.

Opportunities for Improvement

In reviewing appeal outcomes, the increase in upheld decisions may be associated with the rising number of appeals related to Personal Care services. This trend likely reflects increased scrutiny of group home placements and highlights the importance of ensuring treatment plans accurately reflect each consumer's current medical necessity. Comprehensive and well-supported clinical documentation remains essential to support authorization decisions.

Grievance data continues to identify ongoing concerns related to access and availability of services. Additionally, the increase in Quality of Care grievances may indicate issues related to the appropriateness or consistency of services being delivered. These findings suggest a need for improved coordination with provider networks, as well as enhanced consumer education regarding available services and expectations of care.

During this period, one grievance and three appeals related to SUD services were reported, indicating an opportunity to further evaluate the responsiveness and adequacy of SUD-related care.

Collectively, these trends identify key areas for focused quality improvement, including documentation standards, provider capacity and availability, and consumer outreach and communication.

Actions Taken

The Due Process Coordinator will maintain proactive and ongoing communication with the Managed Care Department, Quality Department, and executive leadership to remain informed of developments related to Personal Care service denials. This includes reviewing the interpretation of treatment plans and ensuring provider documentation is appropriately written to clearly demonstrate medical necessity.

In addition, the Due Process Coordinator will monitor trends in grievance volume and work collaboratively with providers to assess whether communication gaps may be contributing to the increase in grievances.

The Due Process Coordinator will continue to track these trends, identify emerging patterns, and report any significant findings or changes as the new fiscal year progresses.

Customer Service Metrics

The Customer Service line, 1-855-99-MCCMH (1-855-996-2264), operates Monday-Friday from 8 a.m.-8 p.m., closed County holidays. After-hours a phone tree is in place to guide callers through available options, including being connected to the Crisis Center, which operates 24/7/365.

Customer Service staff assist callers that are seeking mental health services and/or SUD treatment. Customer Service staff also assist callers who have general questions regarding the services and supports provided by MCCMH and those requesting to file a grievance, appeal, or rights complaint regarding their services.

During FY 2025, Customer Service handled 66,419 calls. That is a slight increase from the 64,925 calls handled during FY 2024. Currently the Customer Service department has ample staff to support the current call volume. There is one part-time team member, eight full-time team members, including a Customer Service Specialist, who takes calls and provides direct support for the team, and the Customer Service Administrator, who oversees operations of the department.

The MCCMH Customer Service Team has a keen focus on providing excellent experiences to every customer, every time. To achieve this mark, Customer Service Team Members embody the spirit of service to the community and the core values of MCCMH, which are collaborative, accountable, and respectful.

Customer Service KPIs

To support data-driven decision-making, MCCMH focuses on monitoring the following call center metrics: average time to answer, average wait time, abandonment rate, and service level. As questions or service issues arise, the goal of call center staff is to answer questions and address the caller's needs without having to transfer the call whenever possible. If the call must be transferred, it is our goal to connect the caller directly to the subject matter expert that will be able to address their query.

MCCMH Customer Service Call Center KPIs:

1. Service Level: 90% of Customer Service calls shall be answered within 30 seconds.
2. Average Time to Answer: Our goal is to answer all incoming calls within 30 seconds.
3. Average Wait Time: No caller should be left on hold for longer than 2 minutes.
4. Abandonment Rate: The disconnection rate for all incoming calls should be less than 5%.
5. Requeues: A measure of agent availability. If an agent misses a call, it is requested and sent to the next available agent. The benchmark is for each agent to have less than 10 requeues per month.

Phone metrics for the Customer Service call center are reported to the Quality Committee.

Customer Service

Month	Average Wait Time (IN) <2 min.		Call Abandon Rate 5%	Average Speed to Answer 90% in <30 sec.	Total Calls
Oct-24	CSR	00:22	1.81%	87%	5,038
Nov-24	CSR	00:23	2.04%	87%	4,750
Dec-24	CSR	00:15	1.20%	91%	5,105
Jan-25	CSR	00:13	0.60%	95%	5,276
Feb-25	CSR	00:13	0.73%	94%	4,485
Mar-25	CSR	00:16	1.25%	90%	4,887
Apr-25	CSR	00:18	1.00%	91%	5,371
May-25	CSR	00:13	1.37%	92%	5,624
Jun-25	CSR	00:16	1.30%	90%	5,470
Jul-25	CSR	00:17	1.94%	89%	6,983
Aug-25	CSR	00:16	1.60%	91%	6,410
Sep-25	CSR	00:12	0.86%	94%	7,020
Total Calls FY25					66,419
FY25 Average			1.31%	91%	5,535

Customer Service Silent Call Monitoring

While the above metrics are important and tied to team performance, they do not offer insight into the quality of service provided. It is the expectation of MCCMH that all customers are treated with dignity and respect, including on phone calls. To accomplish the task of monitoring call quality, Customer Service calls are routinely monitored by the Customer Service Specialist (Team Lead) and/or the Customer Service Administrator.

Soft skills can sometimes be subjective; therefore, the call monitoring tool was created to identify important elements that MCCMH expects to occur during each call. Rather than giving a subjective rating scale, the tool has been designed with a 'met/not met' scoring format. This data

is monitored and reviewed to look for areas of improvement and to ensure efficient operations of the Customer Service department. All Customer Service data is compiled by the Customer Service Administrator and reported to the Quality Committee and to external governing bodies accordingly. Call monitoring feedback is also shared with Customer Service team members during their individual supervision meetings.

Our goal is to monitor a randomly selected, statistically significant number of calls each month. According to Centerfirst, a contact center advisory service, 1%-6% is a statistically significant sample size. At MCCMH, each Customer Service team member is monitored silently during at least one call per week. While labor intensive, this task is essential for success. We are committed to monitoring at least 1% of the calls during each fiscal year. During FY 2025, we fell just short of this goal, as there was a Certified Community Behavioral Health Clinic (CCBHC) project that required significant effort from the Customer Service team during Q3 of this fiscal year. 1% would have been 664 calls; 632 calls were monitored during this fiscal year.

Protocols from the call monitoring tool are as follows:

- Protocol 1: Followed MCCMH Customer Service Telephone Script: Thanked the caller for calling MCCMH, Identified the line as Customer Service, Stated First Name, asked caller "How may I assist you today?"
- Protocol 2: Assessed call with active listening to quickly identify caller's needs and identify whether a crisis call.
- Protocol 3: Demonstrated empathy and treated caller with dignity and respect.
- Protocol 4: Demonstrated program knowledge, sounded confident and comfortable.
- Protocol 5: Demonstrated a welcoming customer service attitude and willingness to help throughout the call.
- Protocol 6: Used positive language and remained solution focused throughout the call.
- Protocol 7: Spoke clearly throughout the call, did not use jargon, and did not rush the caller.
- Protocol 8: Explained to the caller what steps were being taken to address their needs during the call.
- Protocol 9: Asked caller if all their questions were answered prior to transferring/ending the call.
- Protocol 10: Assessed the caller's satisfaction before transferring/ending the call.
- Protocol 11: Call classification was assessed, and call was transferred to the appropriate department.

Call Monitoring Data for FY 2025

Each Customer Service team member is monitored on at least one call per week. A score of at least 90% must be achieved in all protocol areas indicated on the call monitoring tool. If 90% is not attained, the Customer Service Administrator will assess team-wide patterns and, as appropriate, offer team-wide training and support as outlined in the Customer Service Call Monitoring and Quality Improvement Procedure. The Customer Service KPIs were consistently met, and no corrective action plan was warranted during FY 2025.

Column1	Q1	Q2	Q3	Q4	FY 2025 Cumulative
# Calls Monitored	163	176	126	167	632
Protocol 1	100%	100%	100%	100%	100.0%
Protocol 2	99%	99%	100%	100%	99.5%
Protocol 3	100%	100%	100%	100%	100.0%
Protocol 4	100%	100%	100%	100%	100.0%
Protocol 5	100%	100%	100%	100%	100.0%
Protocol 6	100%	100%	100%	100%	100.0%
Protocol 7	100%	100%	100%	100%	100.0%
Protocol 8	100%	100%	100%	100%	100.0%
Protocol 9	100%	97%	100%	100%	99.3%
Protocol 10	100%	98%	99%	99%	99.5%
Protocol 11	100%	100%	100%	100%	100.0%

CCBHC Quality Measures

The MCCMH CCBHC is expected to monitor nine clinic-reported measures as part of the State Demonstration Project, outlined in the CCBCH Handbook. Several of the measures have benchmarks that depend on the performance of all Macomb County CCBHCs, with benchmarks set at a percentile of all CCBHC demonstration sites' performance. This will be determined by MDHHS, at this writing, it is to be determined. Other measures have a set benchmark, as noted. For Demonstration Year 4, Calendar Year 2025, the following nine measures were tracked and reported:

Clinic-Reported Measure	Description	Performance
ASC: Preventive Care and Screening: Unhealthy Alcohol Use: Screening And Brief Counseling (two sub-measures) *No benchmark	All adults (18 or older) screened for unhealth alcohol use at least once in the past 12 months; percentage of adults (18 or older) who were identified as unhealthy alcohol users who received Brief Counseling	96.7% 86.3%
CDF-AD: Screening for Depression and Follow-Up Plan: Age 18 and Older *No benchmark	Percentage of individuals age 18 and older who were screened for depression, and if positive for depression, received a follow-up plan	84.2%
CDF-CH: Screening for Depression and Follow-Up Plan: Age 12 to 17 *No benchmark	Percentage of individuals age 12 to 17 who were screened for depression, and if positive for depression, received a follow-up plan	82.8%
DEP-REM-6: Depression Remission at Six Months	Percentage of clients (12 year of age or older) with Major Depression or	3.4%

*Benchmark: greater or equal to the 25th percentile of all CCBHC demonstration sites' performance	Dysthymia who reach Remission at Six Months (+/- 60 days) after an Index Event Date	
I-SERV (three sub-measures) *Benchmark: less than the 75th percentile of all CCBHC demonstration sites' performance	Average number of days until Initial Evaluation for new clients; average number of days until Initial Clinical Service for new clients; average number of hours until Provision of Crisis Service following a first Crisis Episode Contact	19.8 days 24.7 days 0 hours
SDOH: Screening for Social Drivers of Health *No benchmark	Percentage of adults (18 or older) screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety	82.8%
TSC: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (two sub-measures) *No benchmark	Percentage of adults (18 or older) screened for Tobacco Use one or more times within the measurement year; percentage of adults (18 or older) identified as tobacco user during the measurement year who received a tobacco cessation intervention during the measurement year or in the six months prior to the measurement year	57.2% 97.2%
SRA-A: Adult Major Depressive Disorder: Suicide Risk Assessment *Benchmark: 73%	Percentage of adults (18 or older) with a diagnosis of major depressive disorder with a suicide risk assessment completed during a visit in which a new diagnosis or recurrent episode was identified	91.6%
SRA-BH-C: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment *Benchmark: 57%	Percentage of youth (6 through 17) with a diagnosis of major depressive disorder, with an assessment for suicide risk	83.6%

Throughout 2025, the CCBHC team has worked with providers to provide support through monitoring, training/re-training, and how-to guides in order to improve both data collection and outcomes.

The CCBHC team created and implemented a CCBHC DCO 101 training for Designated Collaborating Organizations, DCOs and their staff to support understanding and implementation of the CCBHC model as a DCO partner. With each release of an updated CCBHC Handbook by MDHHS, the CCBHC team updated both direct providers and DCO partners on changes in training requirements, performance measures, expectations, and policies and procedures.

One area of focus for the CCBHC team was integrated care, specifically ensuring all individuals served through the CCBHC identified a primary care provider and that care teams coordinated care with primary care, specialty, and substance use service providers. To this end, the CCBHC clinical team monitored care plans, engagement with primary care physicians, and evidence of coordination of care between and among providers. As a result of these efforts, over 92% of individuals served through our CCBHC have a documented connection to a primary care doctor and evidence of coordination of care with that provider in our EMR. In addition, in 2025 MCCMH's CCBHC implemented its first Memorandum of Understanding agreement with a pediatric primary care provider.

MCCMH CCBHC is increasing access to those with SUD treatment needs through expansion of services at one of our DCO partners that specializes in SUD treatment. The team worked on infrastructure, including significant adaptations to our EMR, processes and procedures, and trainings to implement this expansion. Full implementation of the CCBHC SUD services through this DCO agency is expected in early 2026.

Training Opportunities

In addition to the ongoing implementation of MCCMH's Zero Suicide Philosophy, the training department continued to host Assessing and Managing Suicide Risk (AMSR) trainings for clinical staff members and Question, Persuade, Refer (QPR) trainings for supports staff. There was a total of 19 AMSR trainings held for a total of 418 clinical staff members trained. There was a total of 72 QPR trainings held for a total of 1,619 nonclinical staff members trained. Motivational Interviewing (MI) and Integrated Dual-Disorder Treatment (IDDT) are evidence-based programs that were required per the CCBHC handbook beginning in 2024. We offered six sessions of IDDT for a total of 215 clinical staff members trained and offered six MI sessions for a total of 215 individuals trained.

The MCCMH Learning Management System, Brainier, was updated with a new Specialized Residential Curriculum that increased participation and engagement by offering interaction in each module. This update also condensed the curriculum from over 100 separate modules to 22 streamlined learning tracks.

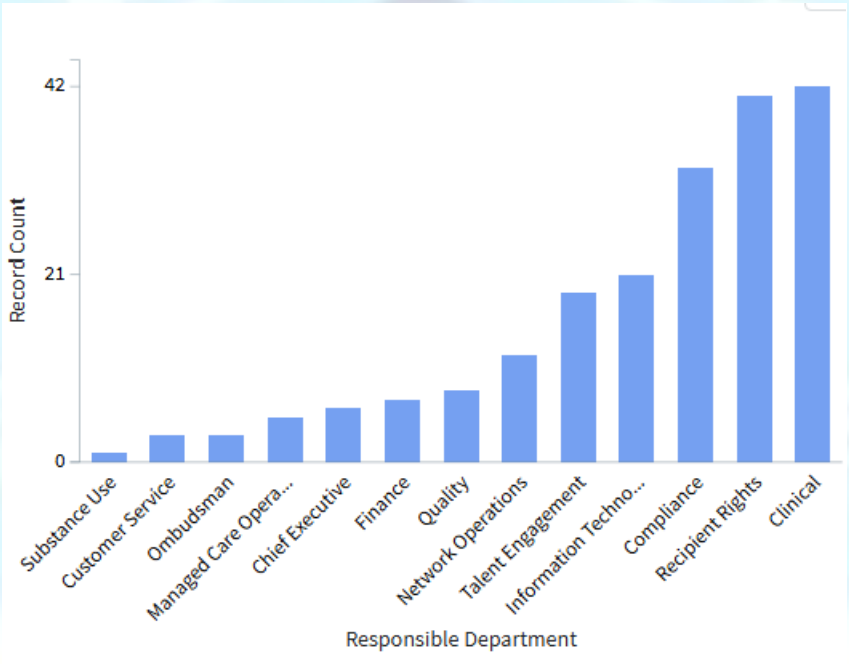
Training Name	# of Sessions Offered	# Attended
AMSR	17	384
QPR	38	1,076
IDDT	7	210
ADV IDDT	2	24
Intro MI	10	254
MI ref	2	14
ACT	3	59
IFS	4	97

Play Therapy	6	207
Eating DO	4	11

Policies and Procedures

During FY 2025, MCCMH continued utilizing the Policy Management Software, LogicGate, to standardize and streamline policy review and approval of lifecycles. LogicGate's governance, risk, and compliance (GRC) software assists MCCMH to ensure that all policies are up to date with current regulations and external requirements.

MCCMH's Policy Manual is divided into twelve unique chapters, and each policy is assigned to a Responsible Department. The Director of the Responsible Department facilitates reviewing their assigned policies and working with MCCMH's Policy Administrator and other departments, as needed, to ensure the necessary revisions are made. Figure 1 below shows MCCMH's policy distribution across Responsible Departments in FY 2025:



Approximately 85 policies were reviewed and approved in FY 2025. This constitutes a more than 50% increase in policy reviews from FY 2024.

FY 2025 Improvement Initiatives

MCCMH maintains short-term "Rock" projects to ensure agency-wide focus on identified strategic planning initiatives. The following areas remain strategic planning focus areas for MCCMH:

Access to Care

MCCMH has an improvement initiative to reduce the average intake time to under two hours. Current objectives for this initiative include developing a patient portal that is available to all

persons served, proposing intake changes to be incorporated into MCCMH's EMR, collecting and reporting average intake times (by intake section), improving workflows for BHTEDS/demographic information collection, and proposing improvements for access to intake for individuals with transportation obstacles.

Putting People First

MCCMH has been engaged in a one-year priority project to center its mission of putting people first. Its efforts include implementing measurement evidence-based practices, establishing standards and metrics for person-centered planning and staff supervision, and implementing a system for intervention. Current objectives for the project include measuring evidence-based treatment outcomes, implementing specific updates to the EMR, and focusing on quantifiable measurement systems to ensure documented supervision between clinician and supervisor considers HIPPA and other legal considerations.

Diversity, Equity, and Inclusion

MCCMH's 2025 Diversity, Equity, and Inclusion (DEI) work, including training delivery, trauma-informed care support, communication efforts, and organizational improvements aligned with:

- 2024 DEI Assessment Findings
- 2024 DEI Annual Report
- MiFAST Trauma-Informed Care Review requirements
- CCBHC and MDHHS cultural competency expectations

The focus is on measurable actions, compliance considerations, and system-level improvements that support equitable and trauma-responsive care.

Key 2024 Assessment Findings Informing 2025 Work

The 2024 DEI Assessment identified several priority areas that shaped 2025 planning:

1. Improve disaggregated demographic data
2. Strengthen confidence in reporting discrimination
3. Address declining survey participation
4. Increase transparency in career growth pathways
5. Expand disability inclusion
6. Reinforce DEI training effectiveness
7. Address persistent disparities in follow-up care for Black/African American clients
8. Strengthen equitable recruitment practices
9. Formalize culturally affirming spaces implementation

Recommended Organizational Actions

- Expand DEI training capacity
- Strengthen adherence to CCBHC cultural competency standards
- Improve multilingual and accessibility supports
- Integrate equity competencies into roles
- Maintain stable DEI infrastructure (newsletters, committees, monitoring)
- Trauma-Informed Care Review Support (January 2025)
- In preparation for the MiFAST Trauma-Informed Care Review, MCCMH provided evidence demonstrating DEI integration across organizational systems. Documents included:
    - DEI references in the MCCMH Strategic Plan
    - MCO Policy 10-002 (Human Resources/Diversity)
    - P.E.O.P.L.E. Newsletter
    - DEI Steering Committee materials
    - Cultural Competency Training curriculum
- Consultation supported Standard 1b by connecting DEI practices to trauma-informed principles such as safety, empowerment, and identity affirmation.

2025 DEI Accomplishments

- Workforce Education & Training
    - Quarterly Implicit Bias Training
        - Delivered consistently throughout 2025, reinforcing trauma-informed communication and meeting MDHHS requirements.
        - Delivered: 12/5/24, 3/18/25, 6/2/25, 9/8/25
        - Next scheduled: 12/15/25
        - Evaluations reflected strong engagement and understanding.
    - Cultural Competency Training (Required Onboarding Course)
        - Self-paced online module completed by all new MCCMH team members.
        - Curriculum updated and uploaded February 2025.
        - Supports CCBHC cultural competency expectations.
        - Provides foundational DEI and trauma-responsive guidance for new hires.
    - Leadership/Supervisory DEI Training
        - Delivered February 24, 2025, focusing on:
            - Unconscious bias
            - Inclusive supervisory practices
            - Preventing microaggressions
            - Supporting allyship and belonging
            - Responding to concerns and resolving conflict

        - This strengthened supervisory capacity and trauma-informed leadership.
    - Training Developed in 2025 (Placed on Hold)
        - The following DEI training modules were developed in 2025 and remain in draft form pending final review and scheduling:
            - The Power of Inclusive and Trauma Responsive Language
            - Microaggression Training
            - Disability Awareness & Accessibility
            - The 10 Lenses Framework
            - Why Gender Diversity Matters
    - Regulatory & Compliance Notes
        - Microaggression training paused mid-February due to federal policy review.
        - No restart directive issued.
        - Cultural Competency Training finalized and incorporated into onboarding.
        - Implicit Bias Training continued without interruption.
- Communication & Engagement Infrastructure
    - P.E.O.P.L.E. Newsletter
        - Published monthly.
        - Featured "Voices of P.E.O.P.L.E." lived experiences.
        - Recognized during the MiFAST review as evidence of organizational DEI commitment.
    - DEI Steering Committee (DEISC)
        - Provided ongoing consultation and planning oversight.
    - Reviewed needs emerging from 2024 assessment findings
        - Mystery Coffee Initiative
            - Continued as an informal engagement activity
            - Supported cross-department connections and team belonging

<u>Challenges & Compliance Barriers</u>

- Regulatory Training Holds: Federal Title VII guidance required pausing several DEI modules.
- Limited Local LGBTQ+ Resources: While partnerships are strong, Macomb County has limited LGBTQ+ affirming behavioral health providers.
- Data System Limitations: Gaps in demographic data impact equity analysis and monitoring.
- Reduced Staff Engagement: Participation in surveys and optional engagement efforts declined.

<u>2026 DEI Priorities</u>

- Organizational Priorities

- Team Member Readiness Groups (TMRGs): Proposal completed but not implemented; remains inactive unless reauthorized.
- Culturally affirming space enhancements –TBD
- Strengthen demographic data systems
- Continue quarterly implicit bias training
- Deploy paused training modules once approved

- Partnership Priorities
  - Targeted partnership development with LGBTQ+, disability, and culturally specific organizations
  - Evaluate existing partner saturation to identify areas of unmet need

Summary & QAPI Alignment

MCCMH's 2025 DEI efforts strengthened organizational infrastructure despite regulatory pauses and systemic constraints. Required training courses were delivered consistently, leadership development expanded, and multiple DEI modules were completed and prepared for future deployment.

DEI work continued to support trauma-informed practice, multilingual communication, accessibility improvements, and equitable workforce standards. These efforts advance MCCMH's alignment with CCBHC cultural expectations and position the organization for expanded DEI implementation in 2026.

Commission on Accreditation of Rehabilitation Facilities (CARF)

During FY 2025, MCCMH engaged in a series of mock surveys in preparation for the 2026 reaccreditation for its directly operated service programs. MCCMH received full accreditation status valid through June 30, 2026, for the following program(s)/service(s) surveyed:

- Assertive Community Treatment: Integrated: SUD/Mental Health (Adults)
- Assessment and Referral: Integrated: IDD/Mental Health (Adults)
- Assessment and Referral: Integrated: IDD/Mental Health (Children and Adolescents)
- Assessment and Referral: Mental Health (Adults)
- Assessment and Referral: Mental Health (Children and Adolescents)
- Call Centers: Mental Health (Adults)
- Call Centers: Mental Health (Children and Adolescents)
- Case Management/Services Coordination: Integrated: IDD/Mental Health (Adults)
- Case Management/Services Coordination: Integrated: IDD/Mental Health (Children and Adolescents)
- Case Management/Services Coordination: Mental Health (Adults)

- Case Management/Services Coordination: Mental Health (Children and Adolescents)
- Community Integration: Psychosocial Rehabilitation (Adults)
- Court Treatment: Mental Health (Adults)
- Crisis Intervention: Mental Health (Adults)
- Crisis Intervention: Mental Health (Children and Adolescents)
- Integrated Behavioral Health/Primary Care: Comprehensive Care (Adults)
- Intensive Family-Based Services: Mental Health (Children and Adolescents)
- Outpatient Treatment: Mental Health (Adults)
- Outpatient Treatment: Mental Health (Children and Adolescents)
- Governance Standards Applied

In addition to the programs listed above, MCCMH has added CCBHC standards to the 2026 reaccreditation scope. This accreditation status will help MCCMH meet SAMHSA's CCBHC certification criteria through a standardized survey process. This accreditation status will demonstrate MCCMH's ongoing commitment to following a well-defined model of care that is critical to supporting access to high-quality behavioral health services.

CARF surveyors provided feedback that covered MCCMH areas for strength as well as areas for improvement. MCCMH's Quality Department developed a quality improvement plan (QIP) in response to CARF's feedback. The QIP covers the following areas: Performance Measurement and Management, Performance Improvement, Person Centered Planning, Transition and Discharge Planning, and Medication Use.

To improve in these areas, MCCMH developed improved survey mechanisms, data review and analysis techniques, training curriculum, quality oversight processes, and standard operating processes. All improvement initiatives are tracked and monitored using a developed Microsoft Planner, and progress made is discussed at the Quality Committee meeting when necessary.

National Committee for Quality Assurance

MCCMH continued its preparation efforts to apply for NCQA accreditation under the Managed Behavioral Health Organization (MBHO) standards. MCCMH has made significant progress to comply with NCQA's MBHO standards through the enhancement of operational processes and the ongoing review and development of formalized documentation, reports, and files.

MCCMH continues to collaborate with The Mihalik Group (TMG) for consultative advisement on appropriate adherence to NCQA standards and has ongoing meetings to ensure established timelines are being met.

In FY 2025, MCCMH also began preparation efforts to apply for NCQA accreditation under the CCBHC standards. This accreditation status is designed to help organizations meet SAMHSA's CCBHC certification criteria through a standardized survey process. This accreditation status will demonstrate MCCMH's ongoing commitment to following a well-defined model of care that is critical to supporting access to high-quality behavioral health services.

Health Plan Quality Initiatives

In adherence to MDHHS contractual Performance Bonus withholds, Macomb Region 9-PIHP has established partnerships with the eight Medicaid Health Plans (MHP) and developed joint management standards and processes to ensure communication exists to support the success of our mutually shared persons served. The eight MHPs encompassing Macomb Region-9 are Aetna, Blue Cross Complete, HAP Care Source, McLaren, Meridian Health Plan, Molina, United Health Plan, and Priority.

In FY 2025, the following eight Performance Bonus projects for MCCMH:

Contractor-Only Pay for Performance (P4P) Measures

1. Implement data-driven outcomes measurement to address social determinants of health
2. Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD)
3. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
4. Increased Participation in patient-centered Medical Homes

Joint Care Management Metrics with the MHPs

Ensures collaboration and integration between PIHP and MHP) for the integration of behavioral health and physical health services.

1. Implementation of Joint Care Management Processes- Care Coordination
2. Follow-up after Hospitalization (FUH)
3. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-14 and IET-34)
4. Follow-up after Emergency Room Department Visit for Alcohol and Other Drug Dependence (FUA)

In FY 2025, MCCMH Region-9 PIHP performed the following efforts, activities, deliverables, and achievements:

Contractor-Only

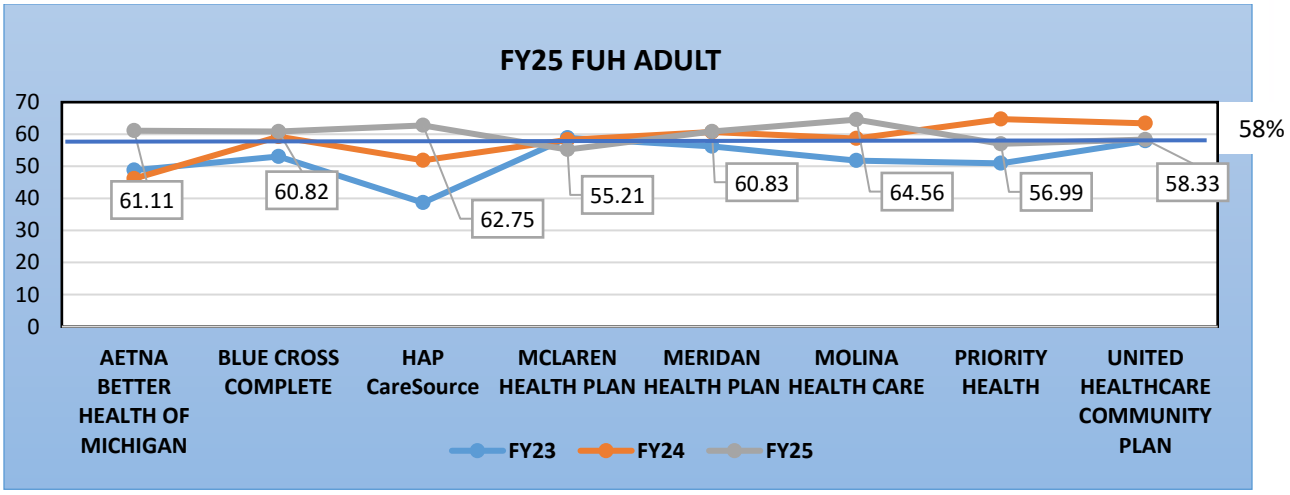
1. Provided an in-depth analysis to MHDDHS regarding the implementation of data-driven outcomes measurement to address social determinants of health of the BHTEDS records to improve housing and employment outcomes for persons served.
2. Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD) performance rate was 65.72%, which is 3.72% above the benchmark. As compared to FY 2024, the rate increased by 5.72%.

3. Initial Engagement - IET 14 performance rate was 40.91%, which met the benchmark by .91%.
   Initial Engagement - IET 34 performance rate was 11.60%, which did not meet the benchmark by 2.40%.
4. Provided a 10 page narrative of Region 9-MCCMH system of care covering the Increased Participation in Patient-centered Medical Homes in the areas of Increased Participation in Patient-centered Medical Homes, including comprehensive care, patient care, coordinated care, accessible services, and quality and safety.

Joint Care Management

1. Care Coordination: Conducted 96 care coordination meetings and developed joint care coordination plans with the MHPs and increased care coordination to 25% of the high-risk population.
    1. In FY 2025, a total of 215 persons served were provided with care coordination. As compared to FY 2024, there was an increase of 112 persons served.
    2. Participated in all state-wide collaborative workgroup meetings as scheduled with the 10 PIHP and 11 MHP partners across the state of Michigan to develop, discuss, and establish the CC360 platform and protocols to meet the MDHHS initiatives.
    3. For FY 2025, Foster Care Coordination was conducted and will continue to be conducted on a monthly basis with the MHPs.
2. Follow-Up After Hospitalization: Developed weekly individualized FUH reports and sent them to MDHHS to distribute to the MHPs.
    1. Outcome Results
        1. Follow-up after Hospitalization for the Adult population – Trend FY 2023-2025
            1. As shown below in Chart 1, for the FY 2025 the FUH outcome resulted in McLaren and Priority are below the 58% benchmark. As compared to FY 2024, both HAP and Aetna were below the benchmark and this was the first year for both of the MHPs that they were meeting the benchmark for the past two years.

Chart 1

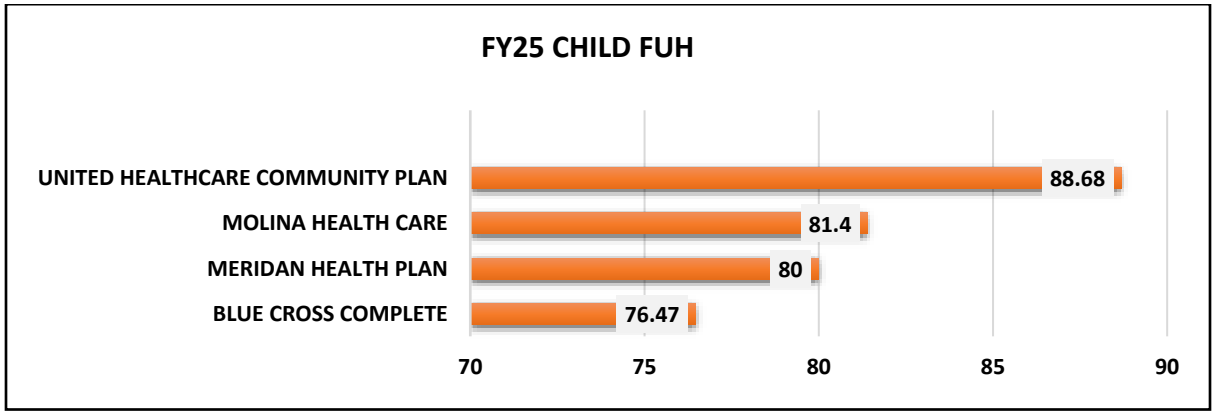


2. Follow-up after Hospitalization for the Child Population
    1. As shown below in Chart 2, the FUH outcomes resulted in Meridian, Molina and United meeting the 79% benchmark rate. Blue Cross Complete had 76.47% and did not meet the measure. HAP Caresource, McLaren Health plan, Priority Health, and Aetna Better

Health of Michigan did not have the number of members required to qualify for the measure to count.

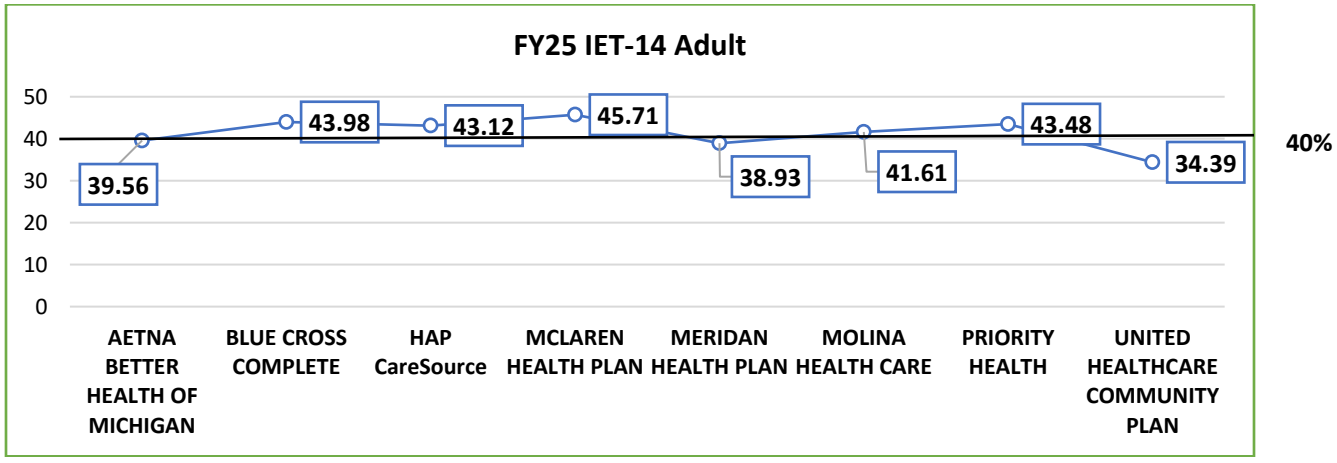
2. FUH measure is also measured by racial disparity and the results will be formulated in the state financial report.

Chart 2



3. Initial Engagement: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
    1. IET-14
        1. As shown below in Chart 3, the performance rate resulted in Blue Cross Complete, HAP, McLaren, Molina, and Priority meeting the 40% benchmark. Aetna, Meridian, and United did not meet the benchmark.

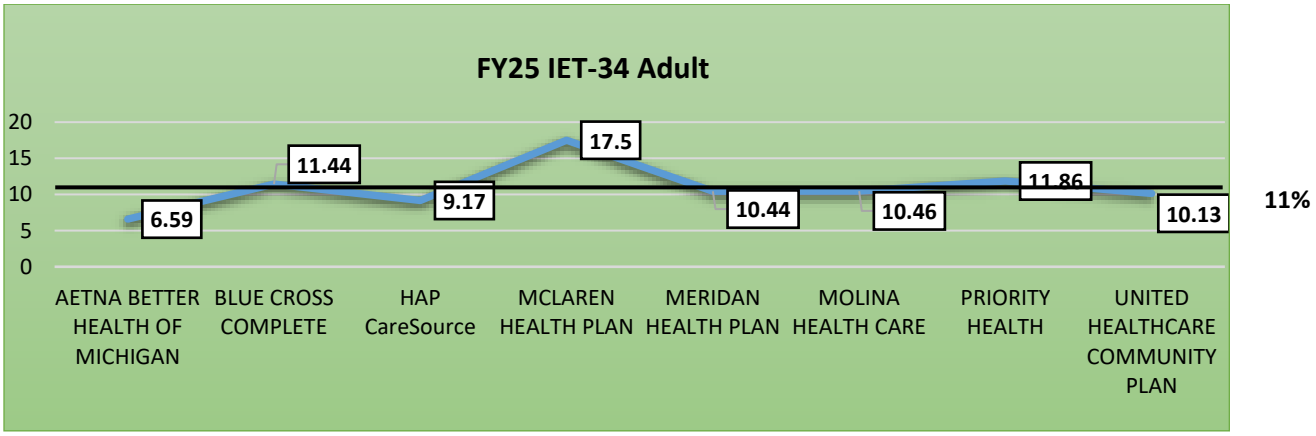
Chart 3



    2. IET-34
        1. As shown below in Chart 4, the performance rate resulted in Blue Cross Complete, McLaren, and Priority meeting the 11% benchmark. Aetna, HAP, Meridian, Molina, and United did not meet the benchmark.

2. IET measure is also measured by racial disparity and the results will be formulated in the state financial report.

Chart 4



4. Follow-up after Emergency Room Department Visit for Alcohol and Other Drug Dependence: FUA is measured by racial disparity, and the results will be formulated in the state financial report.
    - Worked co-jointly with AFIA to develop internal quality reports to track/monitor the social determinants of health for employment and housing

Challenges

The main challenge in meeting the FUH, IET, and FUA measures has been the engagement of follow-up care. For FY 2026, as the standard of percentage performance is increasing for the FUH to 62% and IET-34 to 15%, additional efforts will be conducted to work towards follow-up engagements. Additional areas of challenge involve racial disparity metrics being met consistently for the IET and FUA.

Continued meetings will be held with the MHPs to work on improved outcomes with the FUH, FUA reports, and IET HEDIS metrics.

MI Health Link Initiatives

As of December 31, 2024, Macomb successfully de-delegated from the two MI Health Link (MHL) ICO partners: HAP CareSource and Molina.

With these transitions, throughout 2025, Macomb has continued to serve MHL-enrolled beneficiaries and will continue to do so, as a paneled provider to the Medicare Advantage Plans, as well as through its CCBHC and SUD and Behavioral Health Home programs.

MIC Program Initiatives

Effective January 1, 2026, the MHL program at the MDHHS level will transition to a new program called MI Coordinated Health (MICH) Program. Macomb has entered into Coordinating Agreements with all eight of the Highly Integrated Dual Eligible-Special Needs Population (HIDE-SNP) plans awarded in the Region 10 – Detroit Metro Prosperity Region – Macomb, including: Aetna, AmeriHealth, HAP CareSource, Humana, Meridian, Molina, Priority Health Choice, and UnitedHealthcare Community Plan.

Beneficiaries who are Medicare-Medicaid Dual Eligible, enrolled in MHL will have their benefit enrollment transition from the ICO, to a HIDE-SNP plan with their respective health plan provider. Any beneficiaries engaged in behavioral health services with Macomb, during the program transition, will continue to be served at Macomb without interruption or change in their care.

Macomb will also be able to provide services to any newly enrolled MICH members who wish to engage in and prefer to receive behavioral health services with a Macomb Provider.

- Monthly exchange of enrollment and eligibility files
- Ongoing Care Coordination efforts with the CMSHP Case Holders and HIDE-SNP Care Coordinators
- Participation in Integrated Care Team (ICT) Meetings