Quality Assurance and Performance Improvement Program (QAPIP) Fiscal Year 2025 Evaluation Report

All SWMBH Medicaid Business Lines

Evaluation Period: October 1, 2024 - September 30, 2025

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SWMBH Quality Assurance and Performance Improvement Program (QAPIP)

I. Introduction

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) has a documented Quality Assurance and Performance Improvement Program (QAPIP) that meets the required federal regulations: the Medicaid Managed Care rules, 42 CFR § 438, and requirements outlined in the PIHP/MDHHS contract.

Southwest Michigan Behavioral Health (SWMBH) uses the QAPIP Plan and Evaluation to assure all contractual and regulatory standards required of the Regional Entity, including its PIHP responsibilities and oversight of the eight Community Mental Health Service Partners (CMHSPs) in the region, are met. The QAPIP Plan describes the organizational structure for the SWMBH's administration and evaluation of the QAPIP, the elements, components, and activities of the QAPIP, the role of recipients of service in the QAPIP, the mechanisms used for adopting and communicating process and outcome improvement, and to implement improvement strategies to meet and exceed best practice performance levels.

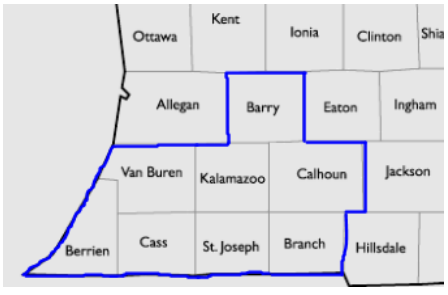
For SWMBH purposes, "beneficiary" includes all Medicaid eligible individuals (or their families) located in the defined service area who are receiving, or may potentially receive, covered services and supports. The following terms may be used interchangeably within this definition: member, customer, recipient, enrollee, individual, and person served.

This annual evaluation is comprised of initiatives undertaken by SWMBH and the Region from October 1st, 2024, through September 30th, 2025, for Medicaid Services and includes the status of FY25 QAPIP Plan goals. The formulation of the QAPIP goals includes incorporating numerous federal and state requirements and guidelines, and best practice standards. Additionally, more information related to the QAPIP standards can be found in SWMBH policies and procedures and other departmental plans. SWMBH's QAPIP is designed to promote high quality customer service and outcomes by systematically monitoring key performance indicators integrated with system-wide approaches to continuous quality improvement efforts.

The authority of the SWMBH Quality Management and Clinical Outcomes Department and the Quality Management Committee (QMC) is granted by SWMBH's Executive Officer (EO). SWMBH's Board of Directors retains the ultimate responsibility for the quality of the business lines and services assigned to the regional entity, and they review SWMBH's QAPIP Evaluation and approve the QAPIP Plan on an annual basis.

Service Population and Eligible Beneficiaries Served

SWMBH (Region 4) served 35,198 unique beneficiaries from October 1, 2024, to September 30, 2025, with 299,322 Medicaid Eligible in the Region.



Beneficiaries served include:
Adults with Severe and Persistent Mental Illness (SPMI)
Adults with Intellectual or Developmental Disabilities (I/DD)
Adults with Substance Use Disorders (SUD)
Children with Severe Emotional Disturbance (SED)
Children with Intellectual or Developmental Disabilities (I/DD)

How to Read This Report

SWMBH has adopted a rating system to evaluate the key performance indicators and QAPIP Plan objectives. Throughout the evaluation, a five-point scoring rubric is used to rate each evaluated component as follows:

1. A score of 1 or "Poor" indicates a critically unmet need that requires immediate follow-up.
2. A score of 2 or "Subpar" is given to an area that markedly needs improvement but does not necessarily require urgent, immediate attention.
3. A score of 3 or "Acceptable" is indicative of an area that minimally meets that area's requirements.
4. A score of 4 or "Good" reflects an area that exceeds the acceptable requirements but may still contain room for minor improvements.
5. A score of 5 or "Excellent" is reserved for those areas that far exceed the acceptable requirements and need only very minor, if any, improvements.

A. Performance Measures

Description

Each Community Mental Health Service Program (CMHSP) was responsible for reviewing and submitting valid and reliable performance indicator data to SWMBH for analysis each month in FY25. SWMBH promoted data integrity by using electronic controls within the spreadsheets used for reporting Michigan's Mission-Based Performance Indicator System (MMBPIS) data. SWMBH had a Clinical Quality Specialist dedicated to the oversight and monitoring of the data to ensure completion and accuracy per the MMBPIS Codebook prior to submission to MDHHS. SWMBH submitted quarterly outcomes to MDHHS per the FY25 contract schedule. SWMBH used the QAPIP to assure minimum benchmarks were achieved on performance indicators as established by MDHHS and analyzed causes of statistical outliers when they occurred. Status updates and regional trends were regularly reviewed and discussed at the Quality Management Committee (QMC) and other committees to support planning and coordination. Additional oversight and monitoring occurred in the annual CMHSP Site Reviews where the SWMBH Quality Management (QM) Department analyzed progress with MMBPIS data and primary source verification documentation. Results were communicated to CMHSPS and Corrective Action Plans (CAPs) were requested, as appropriate. When State benchmarks were unmet or other issues arose, SWMBH required CMHSPs or SUD providers to submit CAPs and verified implementation. Appreciation letters were issued to CMHSPs meeting all State benchmarks each quarter. These actions supported ongoing improvements in service quality, delivery, and health outcomes.

FY25 Identified Barriers and Analysis

While SWMBH intermittently missed the quarterly state benchmarks for indicators 4a and 10 involving follow-up after inpatient discharge and inpatient recidivism, Region 4 met overall benchmarks for all MMBPIS indicators except for indicator 3 landing just under the 72.9% benchmark at 70.34% for FY25. Beneficiary no shows, cancellations, and requests outside the 14-day requirement for appointments were widespread barriers in meeting this access measure. SWMBH continued to focus on improving Indicator 3 outcomes as part of the FY25 Non-Clinical Performance Improvement Project (PIP) to further identify causal barriers, provide recommendations to improve access and timeliness, and monitor progress. Additional details of this project can be found in the corresponding PIP section.

In FY24, MDHHS announced a three-year rollout of the Behavioral Health Quality Transformation beginning in FY25, after which the MMBPIS will sunset. While the shifts to national core indicators will create a more comprehensive, standardized system aligned with state and national requirements, the gradual release of implementation details and standards from MDHHS has hindered preparation for the transition. It was ultimately decided to continue only MMBPIS Indicator 2a in FY26 in the absence of identifying another access measure.

Improvement Efforts Made in FY25

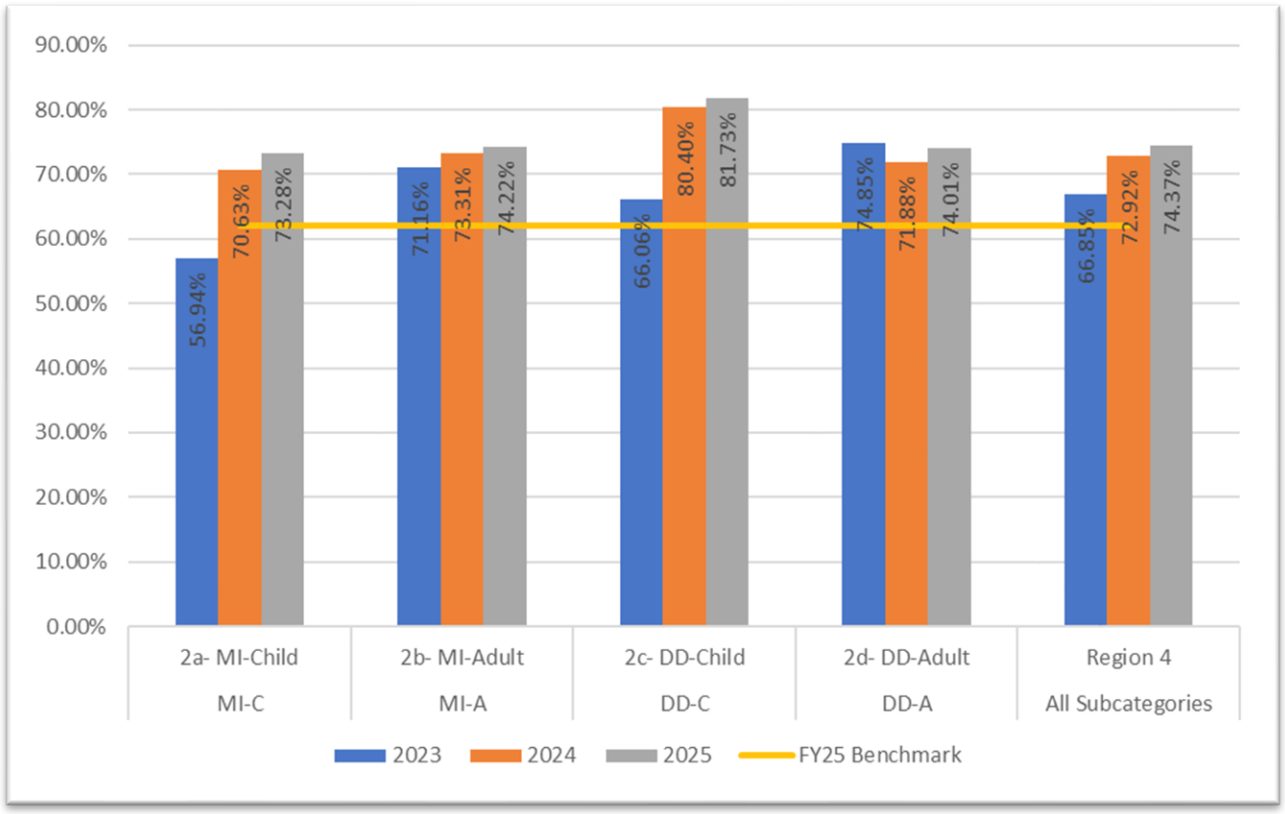
Ongoing issues with the timeliness and accuracy of Behavioral Health Treatment Episode Data Set (BH-TEDS) admissions in SmartCare by CMHSPs and SUD providers were further confirmed during the FY24 Health Services Advisory Group (HSAG) Performance Measure Validation (PMV) audit; however, SWMBH's increased monitoring may have contributed to improved outcomes with indicator 2e in FY25. SWMBH analyzed non-compliance for indicators 2a and 3 using final quarterly MMBPIS data from each CMHSP, while some CMHSPs prioritized real-time analyses to identify trends and improvement areas in consumer engagement and access to services. Region 4 led the state in Indicator 2 outcomes for three of four quarters, demonstrating strong access to services. With the focus shifting to the Behavioral Health Quality Transformation metrics, SWMBH established a comprehensive Tableau report using CareConnect360 data to monitor regional outcomes of all new indicators included in Year 1 (2025) and Year 2 (2026) measure set. This report was reviewed during QMC meetings and available to CMHSPs to assess data detail and monitor CMH performance as they transition to the national core indicators.

FY25 Results

Indicator	Where Progress was Monitored	Frequency of Monitoring	FY24	FY25	Eval Score	FY26 Recommendations
1 - Percentage of Children who receive a Prescreen within 3 hours of request (>= 95%).	QMC	Quarterly	99.67%	99.40%	5	The goal was met and will not continue in FY26 due to the termination of MMBPIS.
1 - Percentage of Adults who receive a Prescreen within 3 hours of request (>= 95%).	QMC	Quarterly	99.72%	99.27%	5	The goal was met and will not continue in FY26 due to the termination of MMBPIS.
2a - Percentage of new persons during the quarter receiving a completed bio psychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adult, MI-child, IDD-adult, IDD-child (>=62%).	QMC	Quarterly	72.92%	74.37%	5	This goal was met, will stay the same and be monitored through FY26.
2e - Percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with substance use disorders (>=68.2%).	QMC, SUD Directors Workgroup	Quarterly	65.97%	69.71%	5	The goal was met and will not continue in FY26 due to the termination of MMBPIS.
3 - percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations: MI-adult, MI-child, IDD-adult, and IDD-child) (>=72.9%).	QMC	Quarterly	59.21%	70.34%	3	This goal was not met and will not continue in FY26 due to the termination of MMBPIS.
4a(a) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit-Children (>= 95%).	QMC	Quarterly	97.35%	96.50%	5	The goal was met and will not continue in FY26 due to the termination of MMBPIS.
4a(b) - Follow-Up within 7 Days of Discharge from a Psychiatric Unit- Adults (>= 95%).	QMC	Quarterly	97.17%	95.66%	5	The goal was met and will not continue in FY26 due to the termination of MMBPIS.
4b - Follow-Up within 7 Days of Discharge from a Detox Unit (>=95%).	QMC, SUD Directors Workgroup	Quarterly	98.11%	100%	5	The goal was met and will not continue in FY26 due to the termination of MMBPIS.
10a - Re-admission to Psychiatric Unit within 30 Days-Children (<=15%).	QMC	Quarterly	9.01%	11.74%	5	The goal was met and will not continue in FY26 due to the termination of MMBPIS.
10b - Re-admission to Psychiatric Unit within 30 Days-Adults (<=15%).	QMC	Quarterly	13.06%	14.16%	5	The goal was met, will stay the same and be monitored through FY25.

MMBPIS Indicator#	MMBPIS Performance Indicator	State Standard	Q1 2025	Q2 2025	Q3 2025	Q4 2025	2025 Overall
1a	Pre-Admission Screening Children	95%	99.52%	100.0%	99.12%	98.92%	99.40%
1b	Pre-Admission Screening Adults	95%	99.63%	98.85%	99.74%	98.90%	99.27%
2a(a) MI-C	Request to Intake MI Children	62%	72.90%	73.29%	70.00%	76.75%	73.28%
2a(b) MI-A	Request to Intake MI Adults	62%	74.41%	73.14%	75.36%	74.04%	74.22%
2(c) DD-C	Request to Intake IDD Children	62%	76.24%	79.58%	82.27%	87.07%	81.73%
2a(d) DD-A	Request to Intake IDD Adults	62%	77.78%	68.89%	71.15%	80.00%	74.01%
2a Overall	**RFS to Intake within 14 days - All subcategories**	**62%**	74.14%	73.48%	74.19%	75.61%	74.37%
2e	Request to Service SA	68.2%	70.96%	68.20%	70.49%	69.29%	69.71%
3a(a) MI-C	First Service MI Children	72.9%	69.72%	70.30%	72.48%	71.40%	70.98%
3a(b) MI-A	First Service MI Adults	72.9%	65.33%	73.47%	72.36%	68.59%	69.95%
3(c) DD-C	First Service IDD Children	72.9%	61.05%	73.28%	65.65%	66.43%	67.00%
3a(d) DD-A	First Service IDD Adults	72.9%	70.21%	87.50%	91.67%	90.00%	84.24%
3 Overall	**BPS Assessment to First Service within 14 days - All subcategories**	**72.9%**	66.47%	72.87%	72.42%	69.50%	70.34%
4a(a)	IP Follow Up Children	95%	95.45%	94.52%	100.0%	94.6%	96.50%
4a(b)	IP Follow Up Adults	95%	94.48%	96.41%	96.60%	95.16%	95.66%
4b	Detox Follow Up	95%	100.0%	100.0%	100.0%	100.0%	100.00%
10a	IP Recidivism Children	<15%	6.06%	11.88%	12.00%	17.86%	11.74%
10b	IP Recidivism Adults	<15%	12.70%	15.82%	12.50%	15.78%	14.16%

SWMBH Quarterly Performance MMBPIS Indicator 2a
Biopsychosocial Assessment Completed within 14 days of Request for Service
Longitudinal Analysis



B. Performance Improvement Projects (PIPs)

Description

MDHHS requires that the PIHP conduct and submit PIPs annually to meet the requirements of the Medicaid Managed Care rules, 42 CFR Part 438. According to the managed care rules, the quality of health care delivered to Medicaid beneficiaries in PIHPs must be tracked, analyzed, and reported annually. PIPs provide a structured method of assessing and improving the processes, and thereby the outcomes, of care for the population that the PIHP serves. The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that the PIHP executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the quality improvement strategies and activities conducted by the PIHP through the PIP.

The following are steps used to identify, implement, and evaluate the progress of a PIP.

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

In FY25 there were two Performance Improvement Projects that SWMBH targeted for progress. Those PIPs include:

1. Clinical: Reduce racial disparities in follow-up after Emergency Department (ED) visits for alcohol and drug use (AOD).
2. Non-Clinical: Improve access and timeliness of new persons starting a service by four sub-populations: MI-adults, MI-children, IDD-adults, and IDD-children (MMBPIS Indicator 3).

Performance Improvement Project #1 (Clinical)– Reduce racial disparities in follow-up after ED visits for alcohol and other drug use (AOD).

Topic Selection and Historical Results

MDHHS requires that each PIHP select a performance improvement project topic to address healthcare disparities. The topic was selected through an evaluation of SWMBH performance and utilization data, assessing for the presence of racial and ethnic disparities. The evaluation included racial and ethnic stratifications of utilization rates of behavioral health services, access to medication-assisted opioid treatment, timely access to behavioral health services (measured by MMBPIS), and the Centers for Medicare and Medicaid Services (CMS) Core Set/Healthcare Effectiveness Data and Information Set (HEDIS) quality metrics (including Follow-Up After Emergency Department Visit for Alcohol and other Drug Abuse or Dependence (FUA), Follow Up After Psychiatric Hospitalization (FUH), and Initiation and Engagement of Alcohol and other Drug Treatment (IET)). At the end of the analysis, SWMBH found clinically and statistically significant disparities in outcomes in the FUA-30 metric between the White and African American/Black beneficiaries. SWMBH reviewed the results with SUD providers in the region, with clinical, substance use network, and quality leadership at SWMBH. In those discussions SWMBH obtained support for the project's focus, to reduce African American/Black disparities in follow-up after ED visits for alcohol and other drug abuse or dependence.

Historical FUA-30 Rates by Major Racial/Ethnic Groups		Numerator	Denominator	Percent
Calendar Year 2019	ALL RACES AND ETHNICITIES	360	1,685	21.36
	AFRICAN AMERICAN / BLACK	32	333	9.61
	HISPANIC	5	47	10.64
	WHITE	281	1,122	25.04
Calendar Year 2020	ALL RACES AND ETHNICITIES	305	1,638	18.62
	AFRICAN AMERICAN / BLACK	38	328	11.59
	HISPANIC	10	61	16.39
	WHITE	238	1,139	20.90

Measurement of Performance Using Objective Quality Indicators

The goal of the project is to decrease the disparity between African American/Black and White beneficiary rates of follow up after ED visits for alcohol and other drug use, from baseline to remeasurement, without a corresponding decrease in White beneficiary follow up rates. Data will be stratified by race/ethnicity by MDHHS and delivered to PIHPs. The specific aim is to eliminate any statistically significant disparity between the African American/Black and White populations.

PIP Performance Measures

1. The percentage of African American/Black beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence (AOD).
2. The percentage of White beneficiaries with a 30-day follow-up after an ED visit for AOD.

For each measurement period, Pearson's chi-square test will be used to determine if a statistically significant difference remains between the proportions of White beneficiaries and African American/Black beneficiaries who receive a follow up service within 30 days of an ED visit for AOD. If there is no longer a statistically significant difference between the two populations, then SWMBH will have achieved the project's aim.

Baseline Results

SWMBH FUA-30 Rates by Major Racial/Ethnic Groups		Numerator	Denominator	Percent
Calendar Year 2021 (Project Baseline)	ALL RACES AND ETHNICITIES	369	1,760	20.97
	AFRICAN AMERICAN / BLACK	52	358	14.53
	HISPANIC	12	81	14.81
	WHITE	286	1223	23.39

The 2021 baseline rate of 30-day follow up after ED visits for alcohol and other drug abuse or dependence was 14.53% for African American/Black beneficiaries, compared to a rate of 23.39% for White beneficiaries. Using a chi-square test of independence, White beneficiaries were found to be significantly more likely than African American/Black beneficiaries to receive a follow up service for an ED visit for AOD in 2021, with a p value of .0003 ($X2$ (1, N = 1581) = 12.9). This difference is significant at $p < .05$. The disparity in rates of follow up for the White and Hispanic populations was not statistically significant.

Remeasurement 2 Results

SWMBH FUA-30 Rates by Major Racial/Ethnic Groups		Numerator	Denominator	Percent
Calendar Year 2024 (Remeasurement 2)	ALL RACES AND ETHNICITIES	512	1,309	39.11
	AFRICAN AMERICAN/BLACK	76	306	24.84
	HISPANIC	22	71	30.99
	WHITE	389	849	45.82

For FY25 PIP Activities, SWMBH evaluated 2024 performance metric results and activities.

There were increases in the rates of ED follow up in 2024 (remeasurement 2) compared to 2021 (the project's baseline), with an overall follow up rate of 39.11% in 2024 compared to 20.97% in 2021. However, the statistically significant disparity between the African American/Black and White populations remained, with an African American/Black population rate of 24.84% compared to 45.82% for the White population. A chi-square test of independence resulted in a p value < 0.0001 (X^2 (1, N = 2071) = 113.54). This difference is significant at p < .05. The increases in follow up rates can be attributed to increased attention to the metric and new interventions put in place by both behavioral health providers and hospitals. Unfortunately, this did not correspond with a decrease in disparities.

Implementation of Interventions to Achieve Improvement in Access and Quality of Care

During FY24, SWMBH continued encounter reporting for services delivered by peers embedded in EDs in Kalamazoo County. This ensured that SWMBH received credit for these follow-up services and allowed for easier monitoring and identification of issues (like access or network capacity difficulties).

SWMBH has had a grant-funded Health Equity Grant Coordinator on staff since 2023. In FY24, this individual facilitated six focus groups with regional CMH staff to understand local drivers of inequity in behavioral health services and to address gaps in service access. These discussions were on-going through FY25 and will result in county-specific action plans to address the identified gaps. SWMBH also coordinated an anti-stigma campaign with radio and internet ads and billboards, to de-stigmatize mental health and substance use treatment in non-white populations. The campaign received an Honorable Mention by the MarCom Awards. The MarCom Awards is a prestigious international competition that honors excellence in marketing and communication. In FY24, streaming audio from SWMBH's anti-stigma campaign reached at least 20,000 unique users and videos reached at least 40,000 unique users each quarter. In FY25, SWMBH hosted an online Heath Equity Series that consisted of 6 sessions, and one in-person symposium to increase awareness of healthcare disparities, biases, and stigma.

Barriers to successful interventions have included difficulty hiring for the peer ED outreach position in Van Buren County, and challenges with encounter reporting for peer ED follow up in counties outside of Kalamazoo. An ongoing challenge with the PIP has been that the region depends on local EDs to inform the provider network when a beneficiary in the ED requires substance-use-related follow up and EDs are not incentivized to assist PIHPs with this project. Past meetings with local EDs have not resulted in increased referrals, so SWMBH has been holding regular meetings with the Medicaid Health Plans (MHPs) in the region, to identify ways to coordinate and increase ED referral rates in partnership with the plans. SWMBH is conducting an analysis of FUA rates with the largest MHP in the region to identify which EDs have lower follow up rates and higher disparities. This analysis will drive future interventions.

Evaluation of the Effectiveness of the Interventions Based on the Performance of Measures

SWMBH evaluates the effectiveness of the interventions using Plan-Do-Study-Act (PDSA) cycles. For the first major intervention, peer follow up services, SWMBH monitors the racial/ethnic distribution of peer contacts, and the proportion of peer services reported as encounters. In FY24, SWMBH did not meet the goal of the racial/ethnic distribution of peer ED follow up contacts matching the racial/ethnic distribution of the FUA population. SWMBH also did not meet the goal of increasing the proportion of Project ASSERT (Alcohol and Substance Abuse Services, Education and Referral to Treatment) contacts reported as encounters over Remeasurement 1. Project ASSERT will continue to be implemented, but for remeasurement 3, we will focus on alternative improvement strategies since these have not resulted in significant improvement other than ISK now submitting encounters.

For provider training, SWMBH uses evaluations and attendance to assess impact. In FY24, SWMBH met the goals of: 1) at least 75% of training participants agreeing that the trainings provided knowledge and tools to reduce healthcare disparities, 2) that each online training would have at least 25 participants, and 3) the symposium would have at least 75 participants.

For the marketing campaign, SWMBH monitors audio completion rate for streaming audio, and clickthrough rates for social media. In FY24, SWMBH met the goals of 1) streaming audio reaching at least 20,000 unique users quarterly with an audio completion rate of 95% or more, and 2) social media ads will reach at least 40,000 unique users quarterly with a clickthrough rate of at least 0.9%.

The training and marketing interventions have consistently reached their goals in reaching intended audiences and effectiveness of training but have not had a measurable impact on the project goal. The peer support interventions have faced challenges in staffing, receiving referrals (especially for the Black/African American population), and encounter reporting.

Planning and Initiation of Activities for Increasing or Sustaining Improvement

SWMBH has not yet achieved the improvements that were hoped to be achieved with this project. Through the course of the project, SWMBH will continue to assess the success of the interventions, and modify, add, or eliminate interventions as needed to ensure improvement can be achieved and sustained. In FY26, SWMBH will focus on collaboration with Medicaid Health Plans to increase ED follow up, since most of the individuals in the denominator have contact with the plans but not the PIHP or CMH system. SWMBH will also work with Michigan Public Health Institute to develop and implement interventions in at least two counties to reduce access disparities.

Performance Improvement Project #2 (Non-Clinical) – Improve access and timeliness of new persons starting a service by four sub-populations: MI-adults, MI-children, I/DD-adults, and I/DD-children (MMBPIS Indicator 3).

Topic Selection and Implementation of Interventions

A new non-clinical PIP was chosen in FY24, to improve access and timeliness of new beneficiaries starting a service by four sub-populations: MI-adults, MI-children, I/DD-adults, and I/DD-children, which is MMBPIS indicator 3. In October 2023, MDHHS published benchmarks for MMBPIS indicator 3 in the revised MMBPIS Codebook version 6. This topic was chosen because of the great impact on the quality of services for those new to services. As described in Section A, SWMBH tracked and monitored data for all MMBPIS indicators with established benchmarks. Since the benchmarks were defined for MMBPIS indicator 3, SWMBH has monitored and analyzed regional performance with this metric. In doing so, SWMBH established the cumulative baseline

results for FY23 of 56.78%. The established MMBPIS CAP process for indicators falling below the benchmarks each quarter had not improved regional performance as indicator 3 remained below the state benchmark of 72.9%. The goal for improving MMBPIS indicator 3 is to expand access and timeliness of services with new persons starting a service with four subpopulations: MI-adults, MI-children, I/DD-adults, and I/DD-children.

Measurement of Performance Using Objective Quality Indicators and Baseline Results

In FY24, SWMBH and its Provider Network worked to increase the percentage of new beneficiaries starting any on-going service within 14 days of completing a non-emergent biopsychosocial (BPS) assessment, from the FY23 baseline rate of 56.78% to at least 72.9% in the remeasurement period using MDHHS's MMBPIS standards. MMBPIS data was collected from each CMHSP monthly and SWMBH had a Clinical Quality Specialist dedicated to reviewing the MMBPIS data submissions and ensuring complete and accurate data, per MMBPIS PIHP and CMHSP Code Book standards. The SWMBH Quality Management Department also completed primary source verification documentation during the annual CMHSP Site Review.

Implementation of Interventions to Achieve Improvement in Access and Quality of Care

In FY24, SWMBH conducted a survey will all regional CMHSPs to review the processes and flow of access to services and identified causal barriers contributing to the FY23 baseline of 56.78%. The survey indicated that barriers exist due to staffing shortages and the high frequency of beneficiary scheduling issues (beneficiary no shows, request for appointment outside of 14 days, rescheduled appointment, etc.), as these events are not excluded from the indicator. Beneficiaries seeking psychiatric or medication services only were affected by psychiatrist shortages and high no-show rates for psychiatric appointments as well. As suspected, the survey also identified variations between CMHSP intake and first on-going service processes, and what each CMHSP counts as the initial biopsychosocial (BPS) assessment and the first service; this generated thoughtful discussion and clarification. CMHSPs that added pre-planning and peer support as same-day first service, as recommended by SWMBH, have shown improvements with indicator 3.

SWMBH utilized existing QMC meetings to routinely review indicator 3 outcomes and discuss the survey findings and causal barrier analysis with regional CMHSPs. In late FY24, the following recommendations were provided to CMHSPs by SWMBH in efforts to increase Indicator 3 to the MDHHS set benchmark:

- Complete the pre-planning meeting as first service (when appropriate).
- Reduce/simplify clinician workload with the use of technology (i.e., Eleos) or support staff.
- Consider the use of bachelor level staff if last completed assessment resulted in a diagnosis.
- Ensure multiple services occurring on the same day are captured in a reportable way, and ensure staff are appropriately trained on how to document those.
- Involve the use of peer supports to increase beneficiary engagement.
- Consider using nurses to complete health assessment or care coordination for pre-treatment planning for first service after the BPS assessment is completed.
- Consider use of contracted psychiatric services within the region when not available within individual CMHSP or when there are lengthy waits for psychiatric appointments.

FY25 Analysis

While regional outcomes did not reach 72.9% MDHHS benchmark for Indicator 3 in FY25; 70.32% of adults/children received their first service within 14 days of their initial BPS assessment, indicating a significant increase over FY24. In early FY25, SWMBH met with each CMHSP with results below benchmark to review local barriers and processes, as well as strategies used to drive further performance improvement in access and timeliness to services. To simplify clinician workflow and increase job satisfaction, implementation of Eleos Health, technology that automates clinical documentation, occurred region-wide in FY25. Some CMHs reported success with utilizing nursing staff to complete consumer health assessments after the biopsychosocial and

blocking psychiatrist appointment slots for new consumers in the instance a consumer was referred for "medication only" services. These best practices as well as quarterly outcome monitoring were reviewed during regional QMC meetings. Improvement was noted in all four Indicator 3 subcategories (MI/DD, Adult/Children) compared to the previous fiscal year despite variations in denominators (i.e. MI-Adult= 5,124, and DD-Adult=164). Additional analysis was completed to review the quarterly mean days to treatment for both Indicators 2a and 3, measuring mean days to treatment for those requesting services who completed the BPS, and those who completed the first ongoing service after the BPS completion. The benchmark for both indicators defines compliance if the BPS and/or first service were completed within 14 days. The quarterly comparison spanning 2024-2025 indicated a steady decrease (favorable) in the average time to treatment (in days). Because MMBPIS Indicators will discontinue effective FY26 and the new access to care measure has not yet been determined by MDHHS, the Department chose to continue the collection of MMBPIS Indicator 2a outcomes in FY26.

FY23 Indicator 3 Cumulative Outcomes by CMHSP and Subcategory (PIP Baseline)

	MIC	Served	%	MIA	Served	%	DDC	Served	%	DDA	Served	%	FY23 Den		FY23 Overall
SWMBH	**2033**	**1162**	**57.16%**	**4355**	**2480**	**56.95%**	**508**	**248**	**48.82%**	**150**	**111**	**74.00%**	**7046**	**4001**	**56.78%**
Barry	170	129	75.88%	215	146	67.91%	23	14	60.87%	10	10	100.00%	418	299	71.53%
Berrien	384	205	53.39%	884	470	53.17%	167	64	38.32%	32	25	78.13%	1467	764	52.08%
Branch	226	133	58.85%	555	325	58.56%	25	25	100.00%	20	18	90.00%	826	501	60.65%
Calhoun	151	34	22.52%	437	192	43.94%	38	12	31.58%	14	3	21.43%	640	241	37.66%
Cass	124	76	61.29%	116	75	64.66%	43	21	48.84%	13	11	84.62%	296	183	61.82%
Kalamazoo	470	143	30.43%	1367	621	45.43%	141	60	42.55%	33	23	69.70%	2011	847	42.12%
St. Joe	368	349	94.84%	539	495	91.84%	33	31	93.94%	16	16	100.00%	956	891	93.20%
Van Buren	140	93	66.43%	242	156	64.46%	38	21	55.26%	12	5	41.67%	432	275	63.66%
Overall	**7046**	**4001**	**56.78%**												

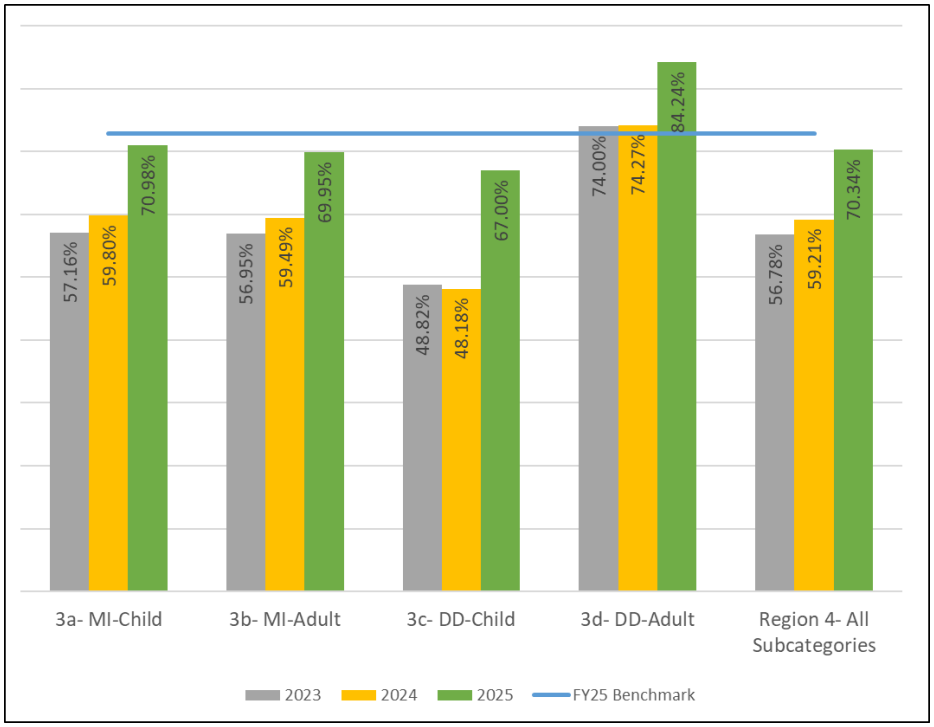
FY24 Indicator 3 Cumulative Outcomes by CMHSP and Subcategory

CMHSP	MIC	Served	%	MIA	Served	%	DDC	Served	%	DDA	Served	%	FY24 Den		FY24 Overall
SWMBH	**2102**	**1257**	**59.80%**	**4772**	**2839**	**59.49%**	**467**	**225**	**48.18%**	**171**	**127**	**74.27%**	**7512**	**4448**	**59.21%**
Barry	164	146	89.02%	263	239	90.87%	24	19	79.17%	10	9	90.00%	461	413	89.59%
Berrien	371	173	46.63%	886	427	48.19%	138	23	16.67%	26	18	69.23%	1421	641	45.11%
Branch	210	104	49.52%	517	338	65.38%	30	22	73.33%	28	26	92.86%	785	490	62.42%
Calhoun	217	61	28.11%	515	213	41.36%	34	11	32.35%	24	5	20.83%	790	290	36.71%
Cass	94	59	62.77%	114	83	72.81%	32	26	81.25%	11	9	81.82%	251	177	70.52%
Kalamazoo	544	270	49.63%	1700	884	52.00%	149	73	48.99%	34	33	97.06%	2427	1260	51.92%
St. Joe	392	367	93.62%	562	501	89.15%	23	21	91.30%	18	17	94.44%	995	906	91.06%
Van Buren	110	77	70.00%	215	154	71.63%	37	30	81.08%	20	10	50.00%	382	271	70.94%
Overall	**7512**	**4448**	**59.21%**												

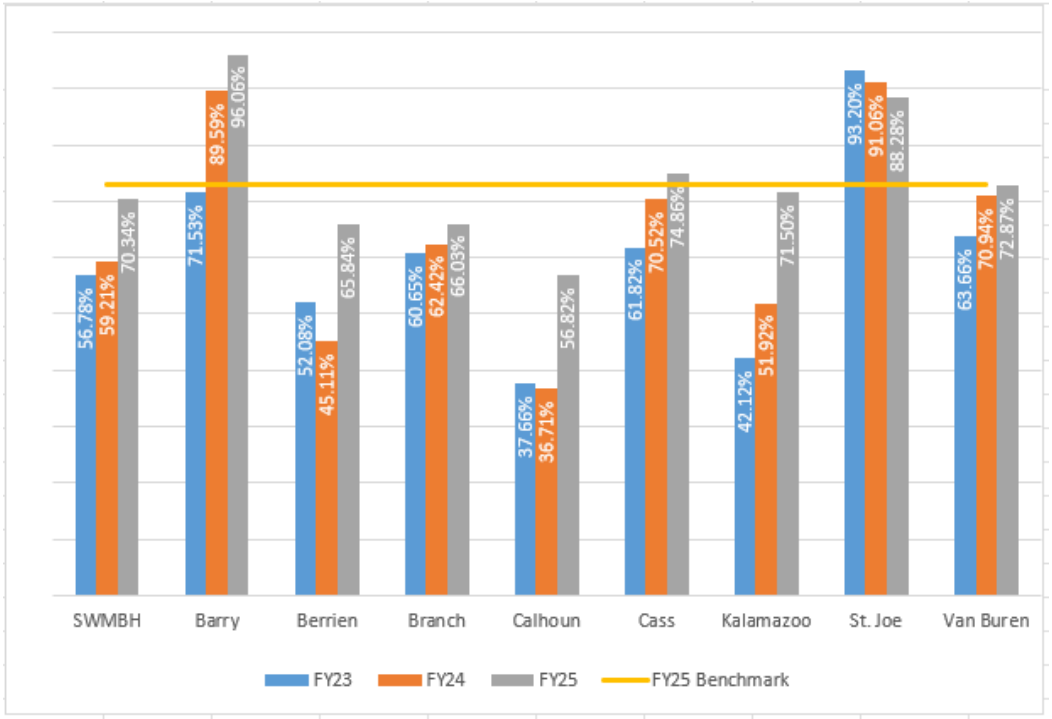
FY25 Indicator 3 Cumulative Outcomes by CMHSP and Subcategory

	MIC	Served	%	MIA	Served	%	DDC	Served	%	DDA	Served	%	Den	Num	FY25 Overall
SWMBH	**2178**	**1546**	**70.98%**	**5124**	**3584**	**69.95%**	**497**	**333**	**67.00%**	**165**	**139**	**84.24%**	**7964**	**5602**	**70.34%**
Barry	217	205	94.47%	273	267	97.80%	33	31	93.94%	10	9	90.00%	533	512	96.06%
Berrien	407	267	65.60%	843	588	69.75%	139	55	39.57%	28	23	82.14%	1417	933	65.84%
Branch	160	86	53.75%	423	296	69.98%	29	19	65.52%	15	13	86.67%	627	414	66.03%
Calhoun	398	262	65.83%	1222	649	53.11%	63	42	66.67%	33	22	66.67%	1716	975	56.82%
Cass	67	43	64.18%	65	52	80.00%	32	24	75.00%	19	18	94.74%	183	137	74.86%
Kalamazoo	511	346	67.71%	1638	1166	71.18%	137	115	83.94%	30	29	96.67%	2316	1656	71.50%
St. Joe	301	259	86.05%	457	412	90.15%	18	14	77.78%	9	8	88.89%	785	693	88.28%
Van Buren	117	78	66.67%	203	154	75.86%	46	33	71.74%	21	17	80.95%	387	282	72.87%
Overall	**7964**	**5602**	**70.34%**												

Indicator 3: BPS to First Service
Subcategory and Overall Outcomes Longitudinal Analysis



Indicator 3: BPS to First Service
Regional and CMHSP Comprehensive Outcomes Longitudinal Analysis



Indicator 2a and Indicator 3: Average Time to Treatment (days)

	2024								2025							
FY24-25 CMHSP Mean	Q1		Q2		Q3		Q4		Q1		Q2		Q3		Q4	
Days Comparison	2a	3	2a	3	2a	3	2a	3	2a	3	2a	3	2a	3	2a	3
Barry	10.15	6.73	12.58	3.60	12.88	3.68	9.28	2.73	12.79	4.97	10.03	2.17	10.8	1.86	8.46	1.73
Berrien	12.73	19.07	14.88	22.10	7.17	24.91	6.60	18.45	10.11	17.78	13.03	12.28	13.16	13.0	10.95	13.05
Branch	1.33	19.25	1.10	9.97	0.44	11.42	0.98	11.71	1.86	12.48	2.03	13.44	1.5	11.63	1.11	7.76
Calhoun	5.38	24.37	7.65	30.64	2.39	19.18	2.26	17.92	2.24	15.17	2.13	9.73	1.45	12.96	1.53	13.88
Cass	8.25	7.74	13.82	10.93	9.06	12.02	12.29	9.34	13.21	10.73	11.33	6.39	12.76	7.64	12.65	5.58
Kalamazoo	5.67	17.50	1.98	13.04	1.74	17.30	1.94	16.53	1.28	11.93	1.68	10.56	1.47	8.59	1.09	10.70
St. Joe	15.48	4.56	16.58	5.21	16.61	5.64	12.5	3.96	13.15	3.2	14.19	5.67	14.54	2.86	13.48	4.96
Van Buren	22.18	13.89	23.00	14.00	19.74	13.86	16.49	12.97	16.1	10.99	16.19	12.45	18.62	11.37	17.23	13.39
Region 4 Overall Average	**10.15**	**14.14**	**11.45**	**13.69**	**8.75**	**13.50**	**7.79**	**11.70**	**8.84**	**10.91**	**8.83**	**9.09**	**9.29**	**8.74**	**8.31**	**8.88**

FY25 Results

Goal	Where Progress was Monitored	Frequency of Monitoring	FY25	Eval Score	FY26 Recommendations
Performance Improvement Project #1 (Clinical) Reducing Racial Disparities in Follow-Up After Emergency Department Visits (ED) for Alcohol and Other Drug Use (AOD). Goal: "To eliminate the statistically significant disparity between African American/Black and White rates of follow up after Emergency Department (ED) visits for alcohol and other drug use, from baseline (2021) to remeasurement 1 (2023) and 2 (2024), without a corresponding decrease in White follow up rates." Monitoring: Remeasurement 2 (2024) results will be available in June 2025. SWMBH will assess performance on the following measures to determine whether the region met the PIP goal for 2024: a. The percentage of African American/Black beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence. b. The percentage of White beneficiaries with a 30-day follow-up after an ED visit for alcohol or other drug abuse or dependence. 2. In FY25, SWMBH will collaborate with the Project ASSERT teams in the three largest counties to increase referrals from EDs and to follow-up on referrals when individuals present to the ED for substance use needs, with specific attention to the Black/African American population.	Regional Clinical Practices (RCP) Committee and Regional Quality Management Committee (QMC)	Bi-Annual	Did not meet the FY25 goal of eliminating the disparity from 2021 to 2024.	**3**	While there was an improvement in ED follow-up overall, up 39.11% in 2024 compared to 20.97% in 2021, the statistically significant disparity between the African American/Black and White populations remained. It is recommended that this goal continue for FY26.

Performance Improvement Project #2 (Non-Clinical) Improve access and timeliness of new persons starting a service by four sub-populations: MI-adults, MI-children, I/DD-adults, and I/DD-children (MMBPIS Indicator 3). Goal: In FY25, SWMBH and its provider network will continue efforts to increase the percentage of new persons starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment. The goal is to reach the MDHHS set benchmark of 72.9%. Monitoring: Quarterly, the PIHP will complete continuous analysis of regional outcomes, reasons for non-compliance and the mean number of days to service per CMHSP-submitted MMBPIS data. By the end of FY25 Q1, SWMBH will complete individual meetings to discuss specific barriers and actions taken to improve access and timeliness with the 3 CMHSPs that had the lowest rates per FY24 Q4 outcomes. Best practices found in these consultations will be shared and discussed with the region during QMC/RCP meetings. ▪ By the end of FY25, the PIHP will review the data and evaluate the effectiveness of the interventions and improvement strategies suggested to determine if the goal was met, and in preparation for revised access measures included in the BH Quality Transformation.	Regional Clinical Practices (RCP) Committee and Regional Quality Management Committee (QMC)	Annually and Quarterly	Partially Met	**3**	Goal was partially met as SWMBH discussed barriers within CMHSPs and shared best practices and monitored progress during QMC meetings. SWMBH's overall Indicator 3 rate measures below 72.9% benchmark, at 70.34%, however, this was a significant improvement from FY24. The PIP will not continue due to MMBPIS sunsetting effective FY26.

C. Critical Incident, Sentinel Event, and Risk Event Management

Description

SWMBH's process for identifying, reporting, and following up on incidents and events that put individuals at risk of harm is outlined in SWMBH Policy 03.05, Incident Event Reporting and Monitoring. The five reportable critical incidents for beneficiaries are defined by MDHHS as suicide, non-suicide death, hospitalization due to injury or medication error, emergency medical treatment (EMT) due to injury or medication error, and arrest. Hospitalization or EMT due to an injury is further classified to include whether the injury resulted from physical management or was due to a fall.

CMHSP Process

Residential treatment providers prepare and file incident reports to the contracted CMHSP when incidents occur. The CMHSPs are responsible for reviewing and classifying the incident reports and submitting the reportable incidents to SWMBH as outlined in policy. SWMBH is then responsible for reporting qualifying incidents to MDHHS in a timely manner, as defined in the contract language, via the MDHHS Behavioral Health Customer Relationship Management System (BH CRM). SWMBH is also responsible for ensuring that MDHHS requests for further information, details related to the remediation of an incident, or any other requests are responded to timely. Risk Event data is made available to MDHHS upon request. SWMBH delegates the responsibility of the process for the identification, review, and follow-up of immediate events, sentinel events (SEs), critical incidents (CIs), and risk events (REs) to its eight contracted CMHSPs.

SWMBH requires that CMHSPs notify SWMBH within 36 hours of an immediate event that is "newsworthy" and/or subject of a recipient right, licensing, and/or police investigation. SWMBH reports those events to MDHHS within 48 hours of PIHP notification via the BH CRM. Following an immediate event notification, SWMBH additionally submits to the MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within 1 year of the individual's discharge from a State-operated service.

The CMHSPs have 3 business days after an incident occurs to determine if it is a sentinel event, and if so, two subsequent business days to commence a Root Cause Analysis (RCA) of the event. The CMHSPs work with the residential treatment provider, when applicable, to complete the RCA. All unexpected deaths (UDs) are classified as SEs and are defined as deaths resulting from suicide, homicide, an undiagnosed condition, accidental, or suspicious for possible abuse or neglect, for beneficiaries who at the time of their deaths were receiving specialty supports and services. SWMBH reviews a random sample of SEs during the annual CMHSP Site Reviews to ensure that all unexpected deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, are reviewed and the review includes:

- Screens of individual deaths with standard information (e.g., coroner's report, death certificate).
- Involvement of medical personnel in the mortality reviews. SWMBH ensures that individuals involved in the review of SEs have the appropriate credentials to review the scope of care (e.g. deaths or serious medical conditions involve a review by a physician or nurse).
- Documentation of the mortality review process, findings, and recommendations.
- Following completion of a RCA, or investigation, the CMHSP or SUD Provider developed and implemented either a plan of correction or an intervention to prevent further occurrence or recurrence of the adverse event or documented the rationale of why corrective actions were not needed.
- Use of mortality information to address quality of care.

SWMBH analyzes CIs, SEs, and REs at least quarterly during the regional Quality Management Committee (QMC)

meetings. The REs reviewed minimally include those that put individuals at risk of harm including actions taken by individuals who receive services that cause harm to themselves, actions taken by individuals who receive services that cause harm to others, and two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period. The quantitative data and the qualitative details of specific incidents or patterns of events are reviewed and discussed to remediate the problem or situation and prevent the occurrence of similar additional incidents or events in the region. Documentation of the review and discussion is maintained the meeting PowerPoint presentation and minutes which are saved on the SWMBH Commons and available to all QMC members. It is the expectation that members that cannot attend the meetings will review the PowerPoint presentation and the minutes, and that all members communicate information from the meetings to the appropriate people within their organizations.

SUD Residential Treatment Provider Process

SWMBH holds contracts with SUD residential treatment providers for the region and delegates the responsibility for identifying, reviewing, and following up on SUD SEs to those providers. If an SUD SE occurs, the provider is required to notify SWMBH of the incident immediately. SWMBH then reports those events to MDHHS within 24 hours via email to mdhhs-bhdda-contracts-mgmt@michigan.gov and additionally reports the SE in the BH CRM.

FY25 Identified Barriers

One barrier first identified in FY23 that continued through FY25 relates the process of requesting and obtaining death certificates to accurately determine the cause of death for reporting and Root Cause Analysis (RCA). Many CMHSPs continue to experience significant delays or are unable to obtain death certificates despite multiple attempts. As a result, they are often required to make “best judgment” determinations regarding cause of death however, this was not possible for 11 incidents in FY25 due to insufficient information. CMHSPs have expressed ongoing concerns about making such determinations given their limited medical expertise, and inconsistencies remain across the state regarding how and when these best judgment calls are made.

Another barrier identified relates to inconsistent definitions of “injury” among CMHSPs and the need for more guidance on what types of emergency medical treatment (EMT) and hospitalizations should be reported as critical incidents versus risk events. Targeted training was provided to two CMHSPs, and the issue was discussed regionally in QMC. Following these efforts, several critical incidents were reclassified as risk events; however, requests to remove these reclassified events from the CRM system have gone unanswered, which has been an additional challenge.

To improve communication and consistency, a Critical Incident PIHP Leads meeting was established at the end of FY24 and has proven valuable, although recently it has been cancelled for several consecutive months. Additionally, a PIHP Critical Incident Manual Workgroup that launched in January 2025 has helped identify and address reporting inconsistencies statewide and while this initiative has been beneficial, progress has been slow, and efforts to obtain a single source document from MDHHS—free from interpretation—has been difficult.

Improvement Efforts Made in FY25

In FY25 SWMBH continued to seek guidance from MDHHS whenever questions or uncertainties arose. Clarification and direction were then provided to CMHSPs to ensure consistent understanding, and support accurate incident and event reporting. Additional training was provided to CMHSPs and SUD providers on proper classification of injuries and the identification of immediately reportable Newsworthy/Community Crisis Critical Incidents; this category was also added to the CRM as a new incident type which was identified as a need by the Critical Incident Workgroup.

The Statewide Critical Incident Workgroup launched at the end of FY24 and the PIHP Critical Incident Manual Workgroup was established in January 2025; both have played key roles in addressing inconsistencies in event reporting. Along with the PIHP Quality Group, these committees have been instrumental in promoting alignment, facilitating discussion, and advancing the development of a comprehensive statewide process manual.

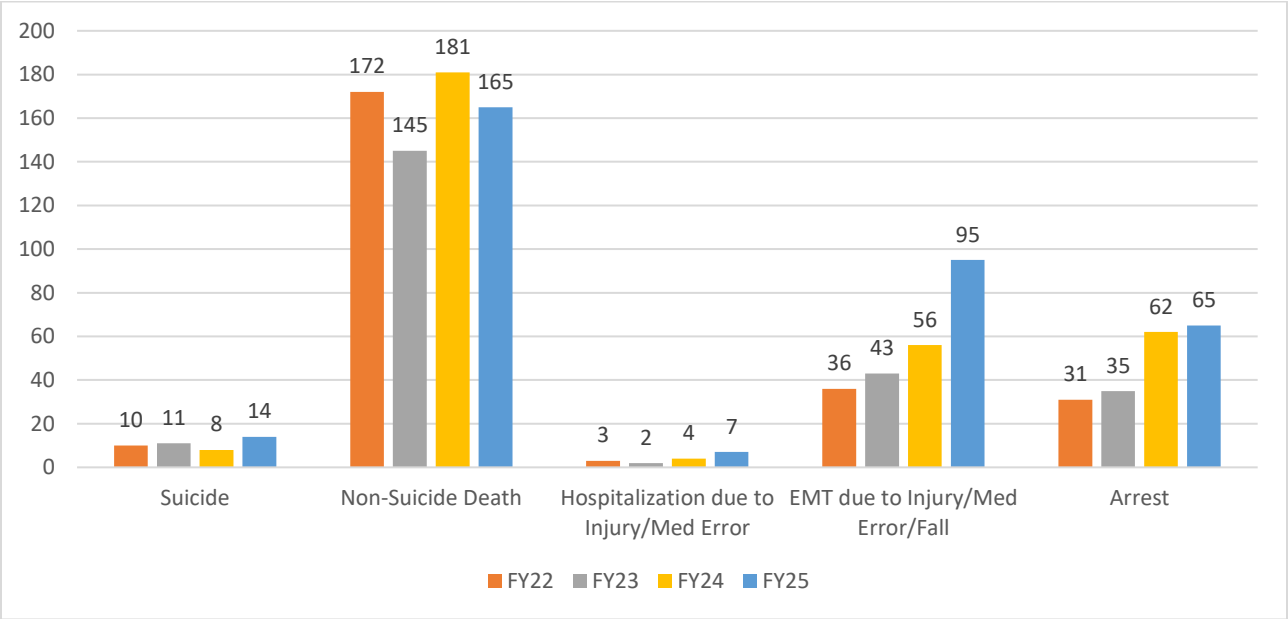
FY25 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	FY25	Eval Score	FY26 Recommendations
SWMBH will report any SUD Sentinel Event that occurs at a contracted residential treatment provider via email to MDHHS and in the BH CRM within 24 hours.	Through submission to MDHHS in the new CRM	As SEs Occur	None to Report	None to Report		No SUD Sentinel Events were reported in FY25. The process for reporting and the goal will remain the same for FY26.
The rate for the region, per 1000 persons served, of suicide deaths will demonstrate a decrease from the previous year.	QMC	Quarterly	0.23	.48	**3**	This goal was partially met as SWMBH discussed barriers and monitored progress quarterly during QMC meetings, however there were 14 suicide deaths in FY25 compared to 8 in FY24. It is recommended that this goal remains for FY26.
The rate for the region, per 1000 persons served, of unexpected deaths due to overdose will demonstrate a decrease from the previous year.	QMC	Quarterly	0.46	.48	**3**	While the number of unexpected deaths via suicide decreased from 16 in FY24 to 14 in FY25, the rate per 1000 persons served increased from .46 to .48. This goal will be updated for FY26.

Quantitative Analysis of SWMBH's CIs, SEs, UDs, and REs

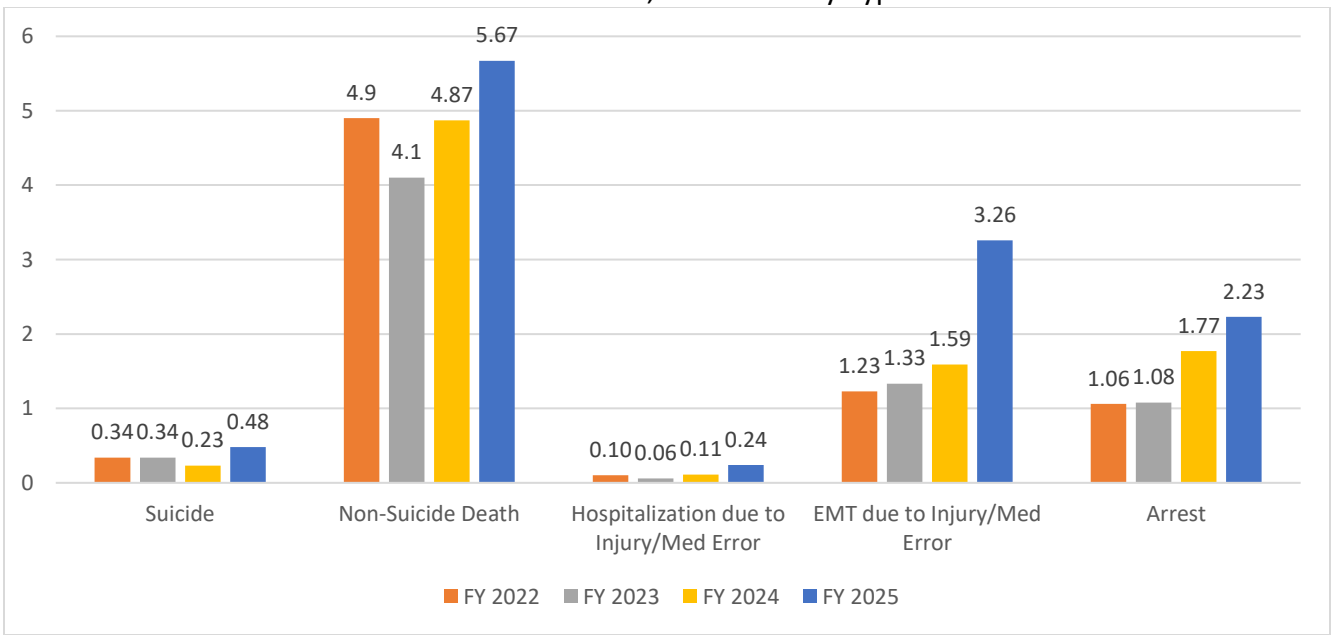
The graphs do not include incidents of Unknown Cause of Death.

Critical Incidents by Category by Fiscal Year



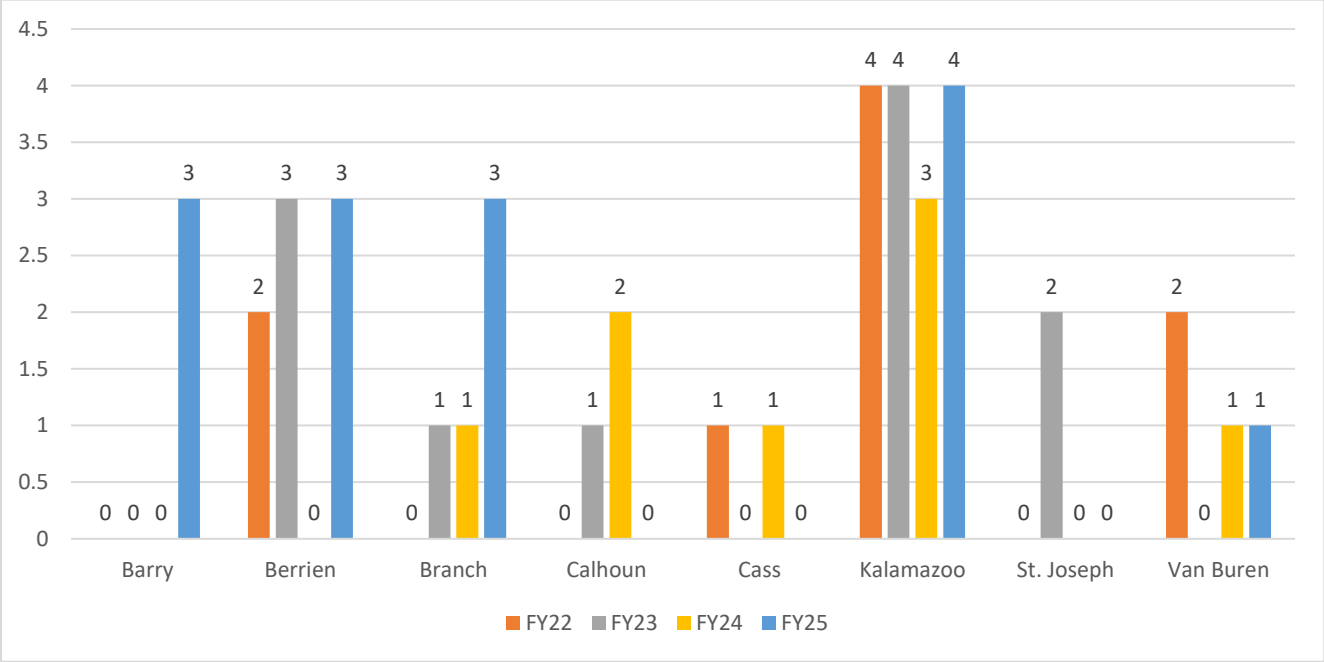
There were no injuries resulting from physical management in FY25.

Critical Incidents Per 1,000 Served by Type FY25

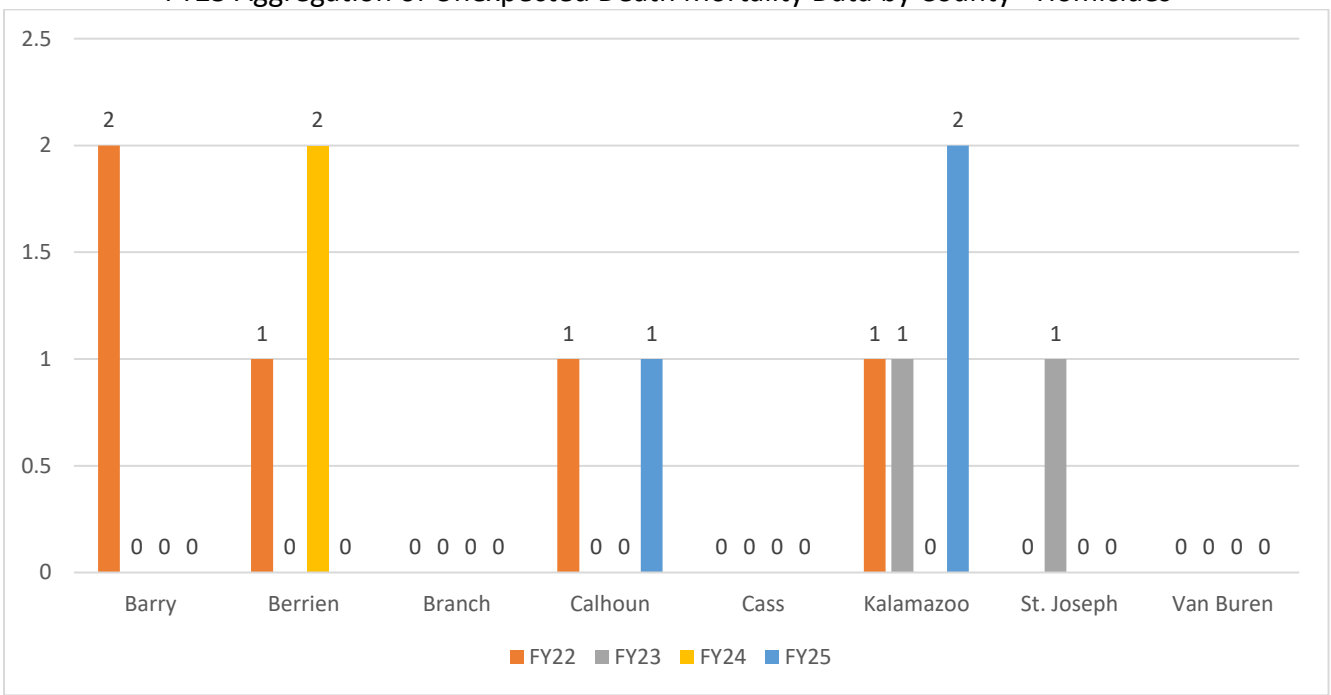


Aggregation of Unexpected Death Mortality Data (Sentinel Events)

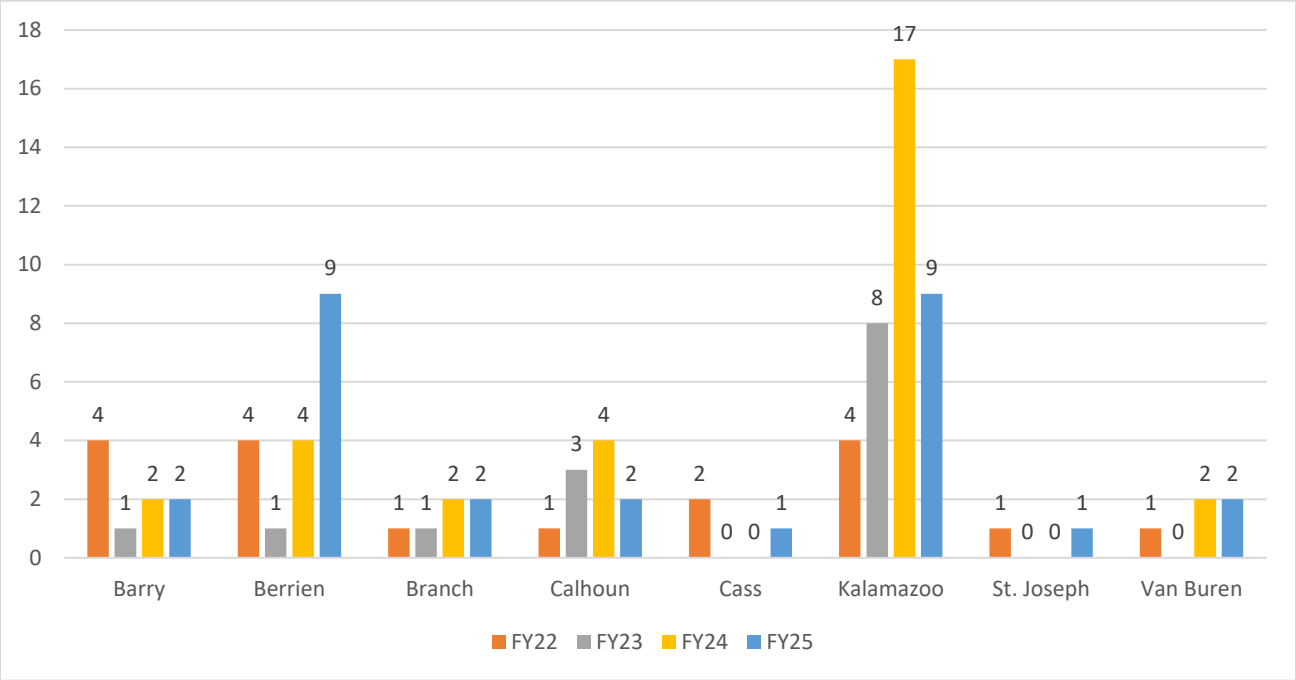
FY25 Aggregation of Unexpected Death Mortality Data by County - Suicides



FY25 Aggregation of Unexpected Death Mortality Data by County - Homicides



FY25 Aggregation of Unexpected Death Mortality Data - Accidental



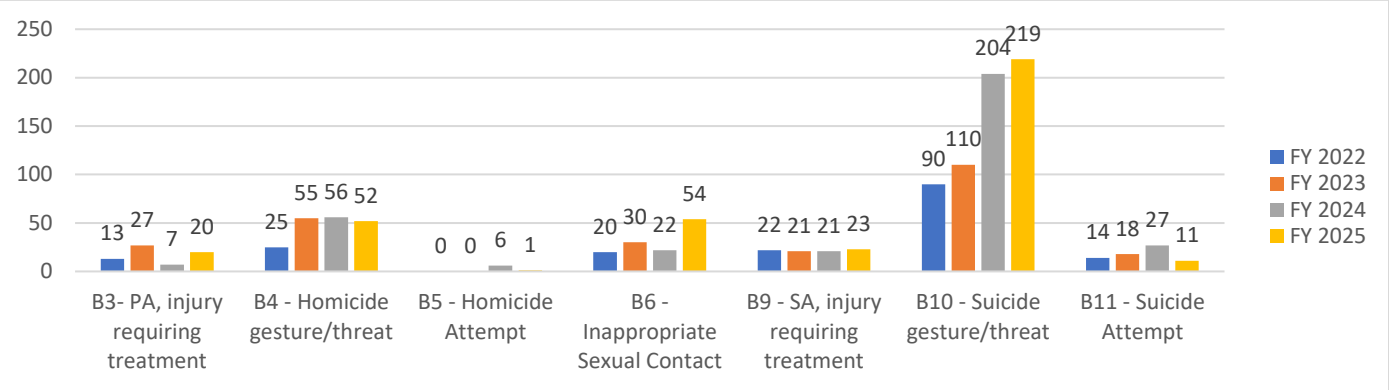
Unexpected Deaths Data by Category

COD	FY21	FY22	FY23	FY24	FY25
Overdose/Drug Related	4	9	8	16	14
Car Accident	2	3	0	1	3
Hit by Car/Train	2	2	1	3	1
Fire	1	0	0	1	0
Medical	0	2	4	6	6
Random Occurrence	0	0	1	0	4
Unknown	2	2	6	3	11

No unexpected deaths were reported in FY25 resulting from an undiagnosed condition or that were suspicious for possible abuse or neglect.

Risk Events (RE)

Risk Events That Caused Harm to Self or Others FY25



Risk Event Hospitalizations (Code H8)

The CMHSPs are delegated the responsibility of tracking and following up on beneficiaries who have two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness) within a 12-month period. While processes vary slightly by CMHSP, hospital discharges are tracked and Case Holders follow up with the beneficiary, residential treatment provider, etc. SWMBH communicated with each CMHSP individually on a quarterly basis related to beneficiaries with multiple hospitalizations to determine why the beneficiaries were hospitalized and to ensure appropriate follow up occurred post discharge. No patterns or improvement areas were identified in FY25.

SUD Residential Treatment Providers – Sentinel Events

No sentinel events occurred in FY25 at the SUD residential treatment providers that SWMBH contracts with.

Qualitative Analysis of SWMBH's CIs, SEs, UDs, and REs

SWMBH presented the analysis of critical incident data to QMC monthly and reviewed unexpected deaths, sentinel events, and risk events at least quarterly. The qualitative discussion of the trends and RCAs leads to improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time in the region. Some examples (not an exhaustive list) of the qualitative discussions from QMC meetings in FY25 included:

- Increase in non-suicide deaths, emergency medical treatments (EMTs), and hospitalizations compared to the previous year (FY24 vs. FY23, discussed early in FY25): QMC reviewed a new brochure on safe substance use developed by one CMH and discussed additional outreach strategies, such as displaying educational content on lobby TVs. QMC members also examined ways to ensure up-to-date emergency contacts are available, noting a pattern of individuals disengaging from services prior to incidents. Plans were developed to increase follow-up with emergency contacts to re-engage these individuals.
- Increase in arrests: CMHSPs continue to note that this trend is likely due to law enforcement's increased willingness to make arrests following the end of COVID-19 restrictions.
- Increase in risk events related to inappropriate sexual contact: Discussion focused on improving consistency in how risk events are coded and implementing enhanced monitoring for affected individuals.
- Highest number of incidents reported in February and March 2025 over the past three years: CMHSPs attributed this rise partly to recent provider training on proper incident reporting and the addition of new 1915(i) SPA reporting requirements.

D. Behavioral Treatment Review

Description

MDHHS requires data to be collected based on the definitions and requirements within the MDHHS Standards for Behavioral Treatment Review and the MDHHS QAPIP Technical Requirement attached to the PIHP/CMHSP contract. Only techniques that are permitted by the Technical Requirement and have been approved during person-centered planning may be used. SWMBH delegates the responsibility for collecting and analyzing data to each local CMHSP Behavior Treatment Review Committee (BTRC). Each CMHSP is also required to submit their BTRC data to SWMBH quarterly, which is made available to MDHHS upon request. SWMBH analyzes data related to intrusive and restrictive techniques, physical management, and/or incidents resulting in 911 calls for emergency behavioral situations to identify and address any trends or opportunities for improvement. The data submitted includes the numbers of interventions and length of time the interventions were used per person. Monitoring this data is important for the oversight and protection of vulnerable individuals, including those receiving long term supports and services (LTSS). Based on the analysis, SWMBH requests the behavior treatment plans (BTPs) on an individual level as needed to review further. The criteria for further review may include, but are not limited to, those with restrictive and/or intrusive interventions, 911 calls, self-injurious behavior, hospitalizations, harm from physical management, etc. During the annual CMHSP Site Reviews SWMBH completes an audit of the data and a sample of BTPs to ensure accurate reporting and adherence to the Behavior Treatment Review Standards by each CMHSP.

FY25 Identified Barriers

SWMBH identified gaps in understanding of the requirements and the impacts of that to the BTRC process in FY25. SWMBH worked collaboratively with the CMHSPs to train staff on the expectations for collection and submission of the data. Changes to the technical requirements and billing codes have been an ongoing challenge for the CMHSPs. MDHHS no longer allows Licensed Master Social Workers and Licensed Professional Counselors to complete a functional behavior assessment which has left gaps in service as the CMHSPs are trying to navigate the shifting of duties within their agencies. Some CMHSPs are needing to find outside providers to assist while others are attempting to hire new staff while also remaining within their budget. A change in MDHHS's guidance regarding HCBS elements needing to be captured in an IPOS has been a system change and challenge for the region as well. New training for case managers on adding these elements to the IPOS has helped in FY25 and SWMBH has been providing technical assistance to CMHSPs on how to meet the HCBS requirements. CMHSPs have been working to revise their processes for reviewing Individual Plans of Service (IPOS) to align with updates to the BTPRC Technical Requirements, which clarify that not all restrictive or intrusive interventions require a behavior treatment plan.

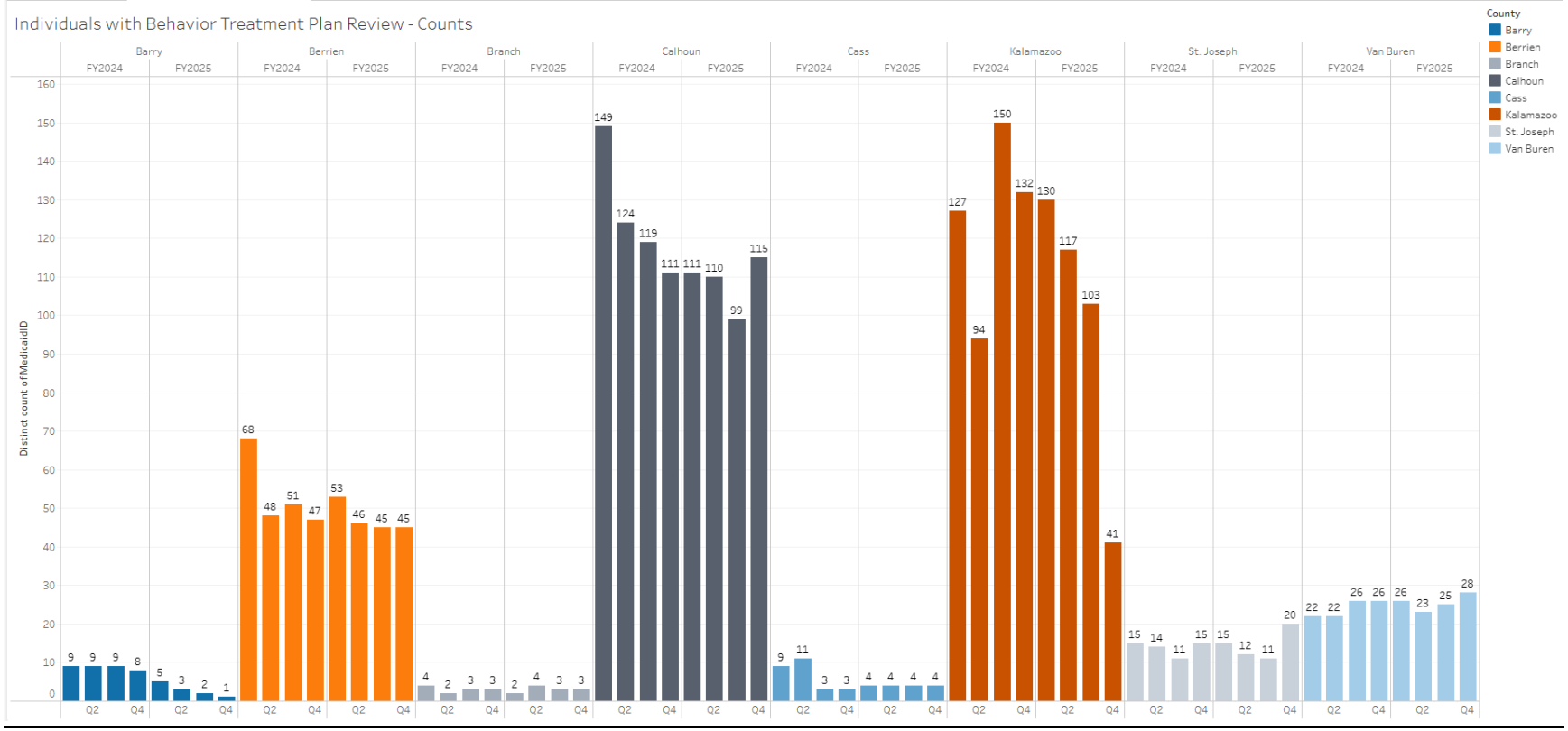
Improvement Efforts Made in FY25

SWMBH provided data driven guidance to each CMHSP throughout FY25. One of SWMBH's Clinical Quality Specialists is charged with ensuring accurate and complete collection and analysis of the data trends for the purpose of quality improvement. A BTRC Workgroup was formed in FY23 to collaboratively update the behavior treatment plan monitoring process within the region. In FY25, the Workgroup discussed best practices on how to implement the HCBS elements into an individual's IPOS and how to implement new processes on how to review these restrictive or intrusive elements in an IPOS. SWMBH began presenting the data during the Quality Management Committee (QMC) meetings to discuss trends and opportunities for improvement in FY24. The quantitative and qualitative discussion of the trends results in improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time in the region. During the FY25 CMHSP Site Reviews SWMBH completed an audit of the data to ensure accurate reporting and adherence to the Behavior Treatment Review Standards by each CMHSP. This is now its own review process, separated from the clinical file review, to better ensure that each standard is being met and allow for more thorough oversight of each behavior treatment plan reviewed.

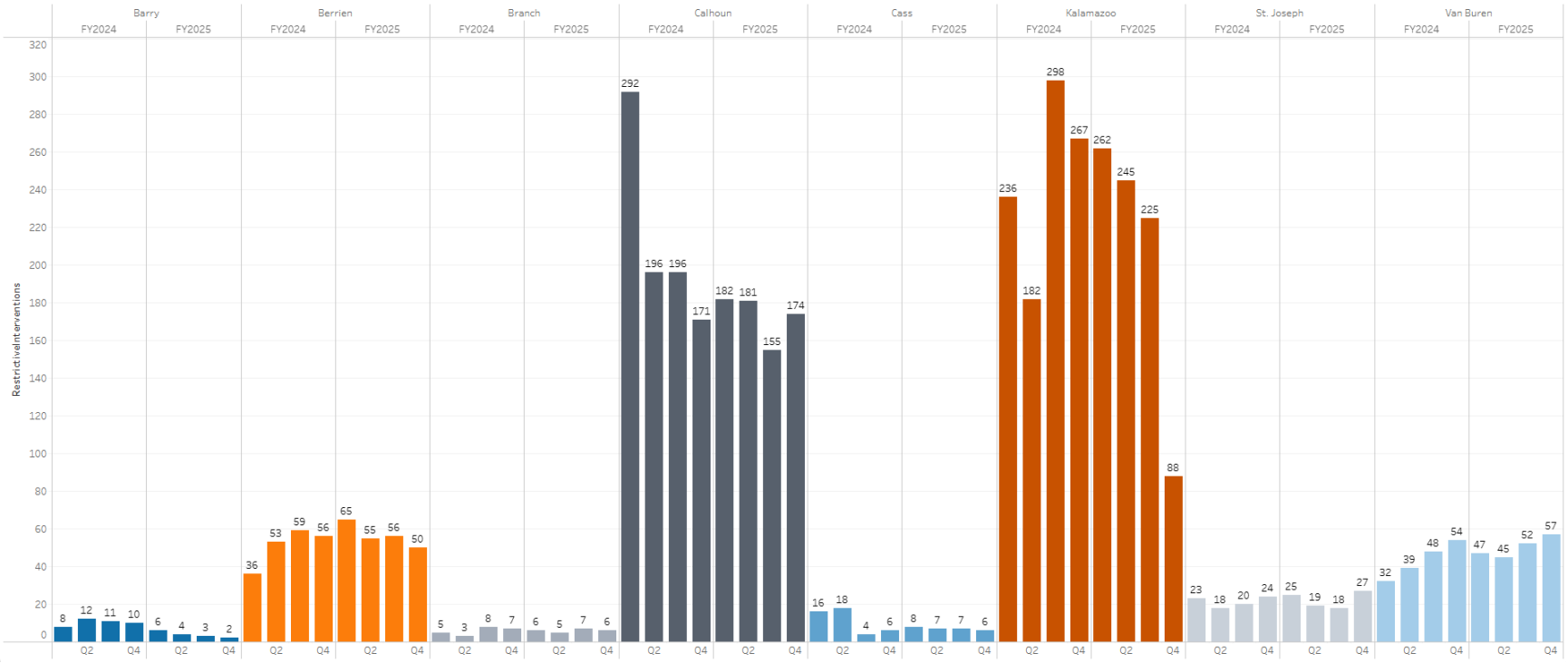
FY25 Results

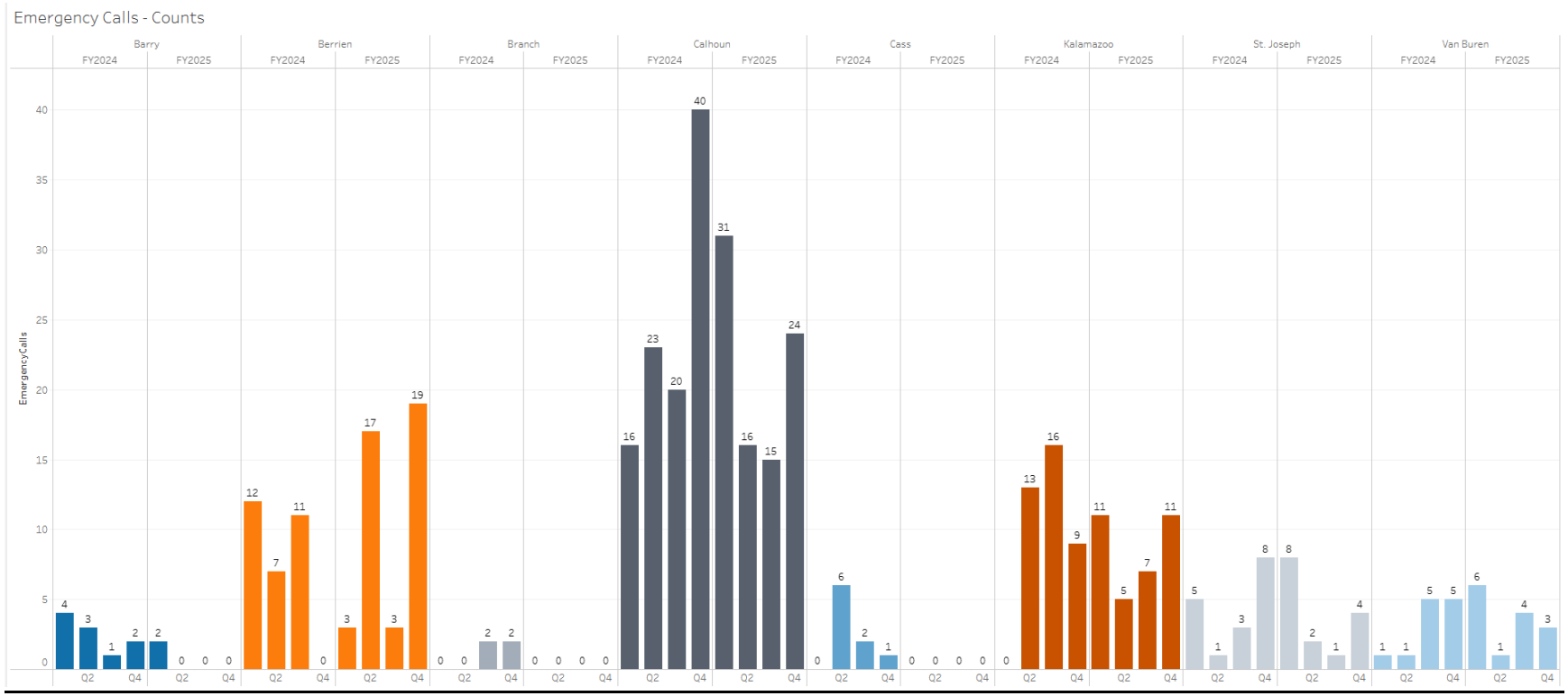
Goal	Where Progress Was Monitored	Frequency of Monitoring	FY25	Eval Score	FY26 Recommendations
SWMBH will complete a quality review of at least 4 behavior treatment plans per CMHSP for FY25	QMC	Quarterly	Partially Met. A total of 28 behavior treatment plans were reviewed across the region, averaging 3.5 per CMHSP.	**3**	The goal will remain the same for FY26. SWMBH will continue to request behavior treatment plans for review based on trends or other identified questions or concerns.
The region will achieve 90% or higher on the Behavior Treatment Plan section of the non-SUD clinical file review tool for the annual CMHSP Site Review.	CMHSP Administrative and Delegated Function Site Review, Clinical File Review Tool	Annually	Met. Regional average score in the Behavior Treatment Planning Section was 95.08%	**5**	The goal will remain the same for FY26. SWMBH will continue to provide technical assistance to the regions who have low scoring areas and request CAPs as needed.

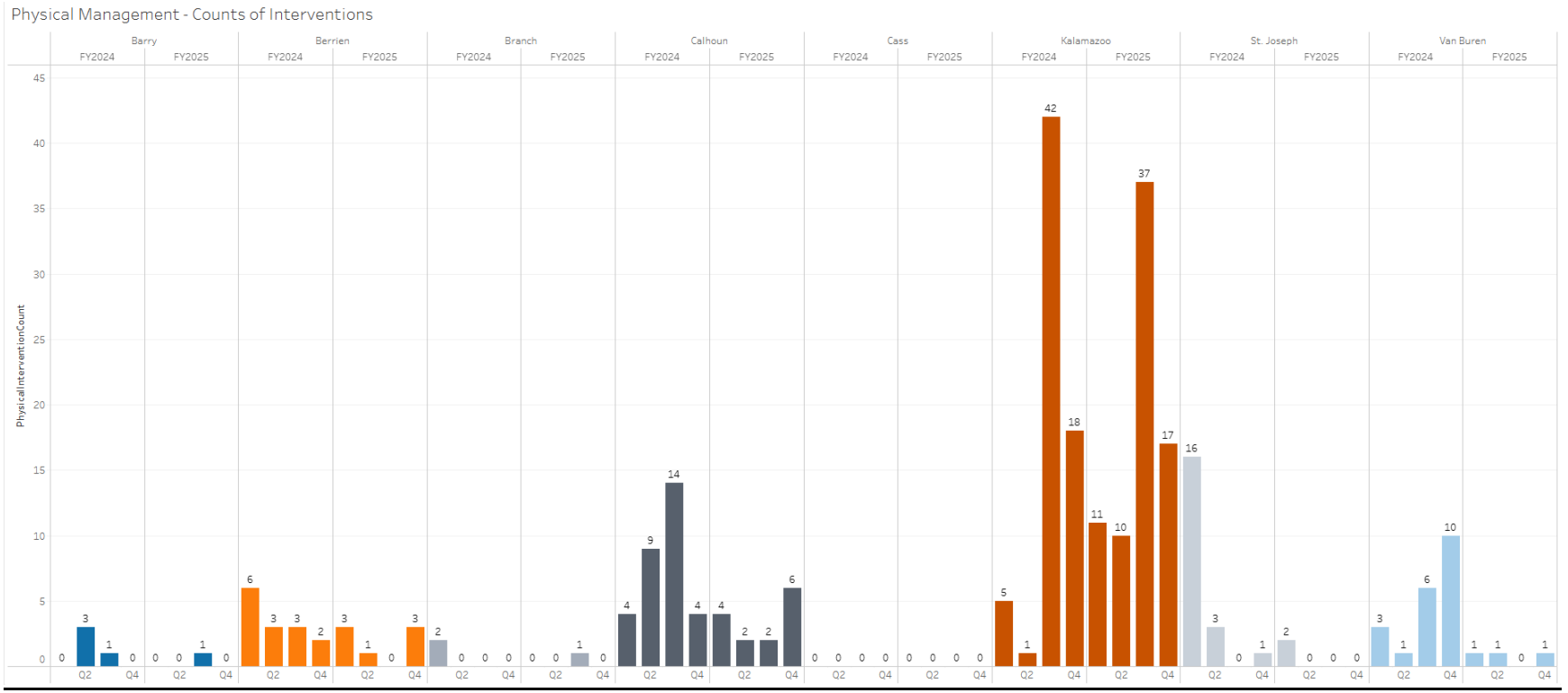
Quantitative Analysis of SWMBH's BTRC Data

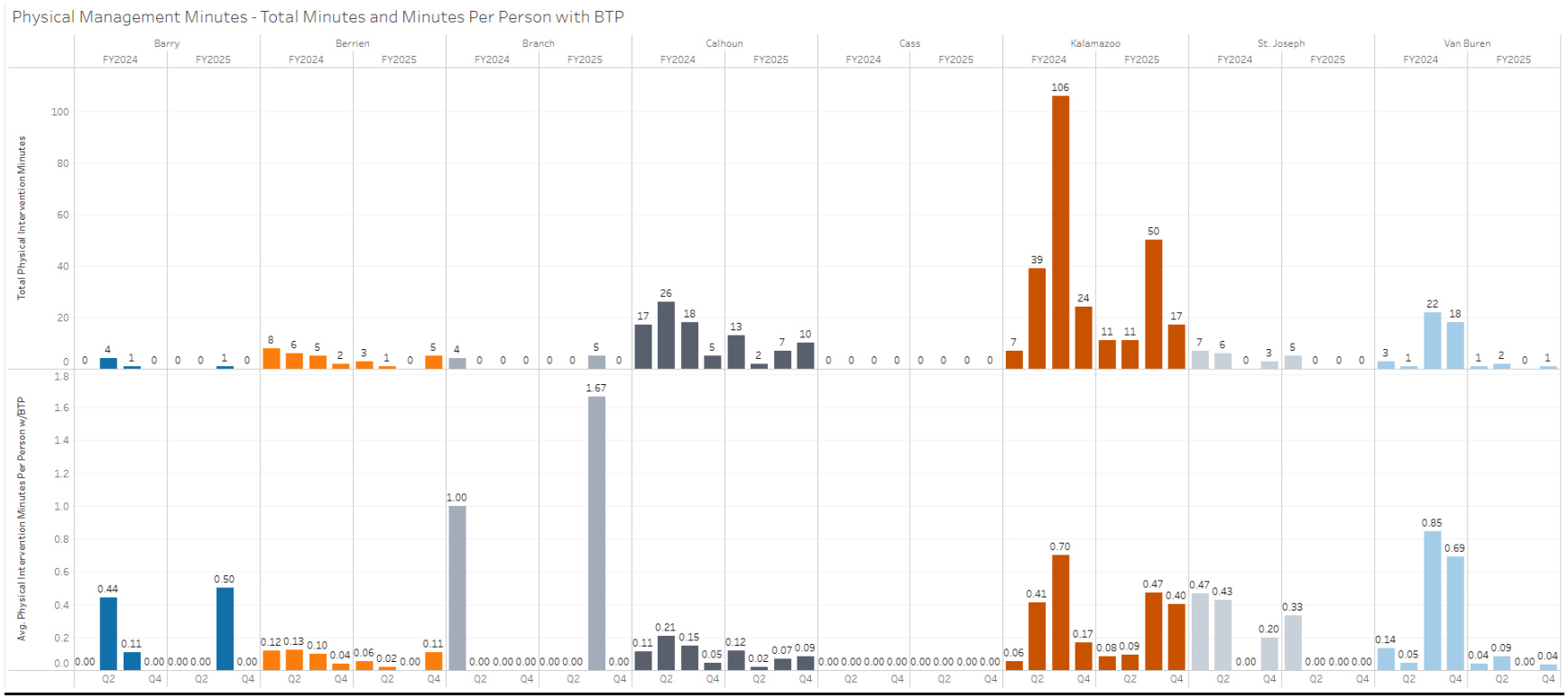


Restrictive or Intrusive Interventions - Counts




Emergency Calls - Counts
Barry
Berrien
Branch
Calhoun
Cass
Kalamazoo
St. Joseph
Van Buren
FY2024
FY2025
EmergencyCalls
0
5
10
15
20
25
30
35
40
Q2
Q4


Physical Management - Counts of Interventions
Barry
Berrien
Branch
Calhoun
Cass
Kalamazoo
St. Joseph
Van Buren
FY2024
FY2025
Q2
Q4
PhysicalInterventionCount
0
5
10
15
20
25
30
35
40
45



Qualitative Analysis of SWMBH's BTRC Data

SWMBH presented the analysis of the data to QMC quarterly, identified regional trends, and asked the CMHSPs to review the data at least quarterly. The qualitative discussion of the trends leads to improvements in the services for beneficiaries, service delivery, and the most appropriate interventions for beneficiaries. Some examples (not an exhaustive list) of the qualitative discussions from QMC meetings in FY25 included:

- Requested feedback on what the group would like to see and/or what additional information is requested.
- Discussion around the BTRC training webinar conducted by MDHHS.
- Trend of Restrictive or Intrusive Interventions (Count) – Restrictive or intrusive interventions in behavior treatment plans have significantly decreased. Six out of eight CMHSPs reported lower counts of these interventions. With increased guidance on titration plans and recent changes to the BTPRC Technical Requirements, we anticipate an even further reduction in FY26.
- Trend of Individuals with a Behavior Treatment Plan (Count) – lower number of beneficiaries who have a behavior treatment plan for 3 out of 8 of our CMHSP's with 2 CMHSP's staying at the same count. With the requirements in the BTPRC Technical Requirements changing and including restrictions just in the IPOS, we may see an even lower count in FY26.

E. Member Experience with Services

a.) Customer Satisfaction Surveys

Description

During FY25 SWMBH contracted with Kiaer Research to administer the customer satisfaction surveys, utilizing revised versions of the Mental Health Statistics Improvement Program (MHSIP) and Youth Services Survey (YSS) as approved by MDHHS. Survey responses were collected starting in June 2025 to meet the goal of receiving 2,100 completed surveys. Surveys were made accessible to beneficiaries via Quick Response (QR) codes and tablets available in CMHSP common areas, through SWMBH and CMHSP websites and social media, and by paper copy. Additionally, each CMHSP provided SWMBH with a beneficiary sample with contact information. Kiaer Research sent the survey to these beneficiaries via email first, followed by Short Message Service (SMS) text. The survey's main objective was to collect beneficiary feedback on services and to identify sources of dissatisfaction. Mechanisms remained in place within the survey to capture responses inclusive of individuals receiving long-term support services (LTSS), case management services, Certified Community Behavioral Health Clinics (CCBHC) services, and other Medicaid services. A full analysis report was produced by Kiaer Research, providing qualitative and quantitative analysis for each of the Adult and Youth survey categories measured. The results and analysis were shared with relevant stakeholders, committees, and the Board of Directors. SWMBH informed providers, beneficiaries, and other stakeholders, by sharing the survey results via the SWMBH website and within the provider and member newsletters. SWMBH provided each CMHSP with their individual quantitative and qualitative (comments) results with which they are required to develop improvement plans, specific to the findings, results, and analysis from their locations for the purpose of systemic improvements. The SWMBH Customer Advisory Committee (CAC) was regularly consulted for feedback on survey process and distribution methods.

FY25 Identified Barriers and Analysis

Overall, 2,252 valid surveys were completed, resulting in the highest cumulative completion rate since 2014. Response rates for both MHSIP (Adult) and YSS (Youth) improved over FY24 rates with 1,603 adult and 649 youth surveys completed. Analysis of MHSIP subcategory outcomes indicate no changes except for Social Connectedness with close-to-statistically significant decrease between 2024 to 2025. MHSIP results indicated that for gender, male and female consumer reported higher scores than non-binary or transgender consumers. Particularly, Outcomes/Functioning and Social Connectedness were notably worse for non-binary or trans consumers. Like FY24 outcomes, statistically significant differences were seen in all constructs for LCBAP (lesbian, gay, bisexual, asexual or pansexual) consumers as their ratings were slightly worse than heterosexual/straight consumers. Oldest respondents (65+) reported highest scores across all constructs. Those aged 45-64 reported some notably lower Outcomes and Social Connectedness scores. Adult LTSS consumers reported worse Access and Outcomes scores compared with non-LTSS adults; however, this result may be attributable to a survey error causing possible misclassification of LTSS consumers. While overall satisfaction rates in the FY25 YSS survey did not differ significantly from FY24, statistically significant differences were found between 2023 and 2025 in the constructs of Satisfaction & Appropriateness, Access, and Outcomes. Youth scores did not differ significantly by gender or sexual orientation, except in treatment participation, which showed a statistically significant difference between male and female youth. Parents of LGBAP youth had weaker ratings of social connectedness. The inability to consistently classify surveys as CCBHC/Non-CCBHC depending on the survey method remained in FY25. Qualitative data was captured via robust respondent comments while quantitative data was captured via a numbered scale on the surveys in 2025.

Improvement Efforts Made in FY25

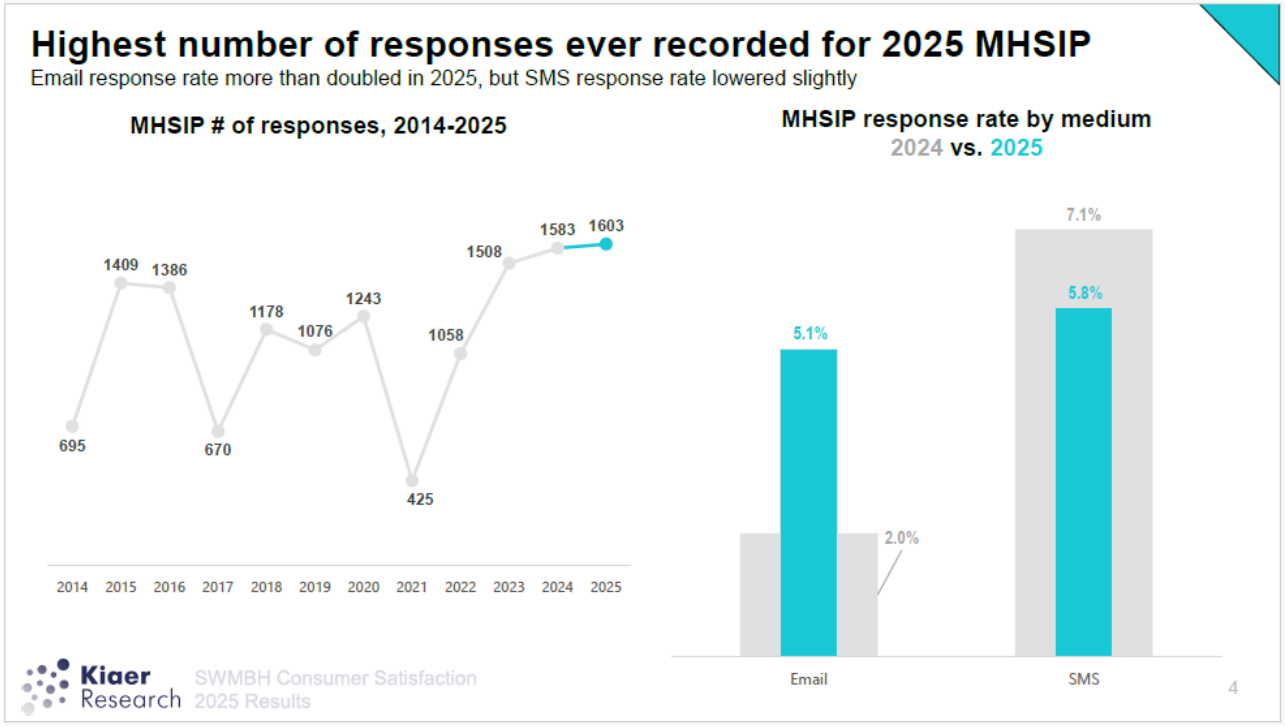
To catch more urgent concerns and filter them to their CMHSPs, consumers were able to request follow-up directly within the survey, like in FY24. This allowed for better resolution of issues and quick referrals for respondents in crisis, and around 14% of youth and adult respondents utilized this survey feature. To further enhance potential longitudinal analysis, questions that assigned anonymous IDs to track respondents' answers over time were continued in FY25. Adult longitudinal satisfaction was largely unchanged from 2024-2025 with just over 240 adult responses connected to their 2024 responses. For youth, about 90 parents/guardians' 2025 responses were connected to their 2024 responses, which indicated satisfaction dropped from 84.2% in-agreement to 78.7%.

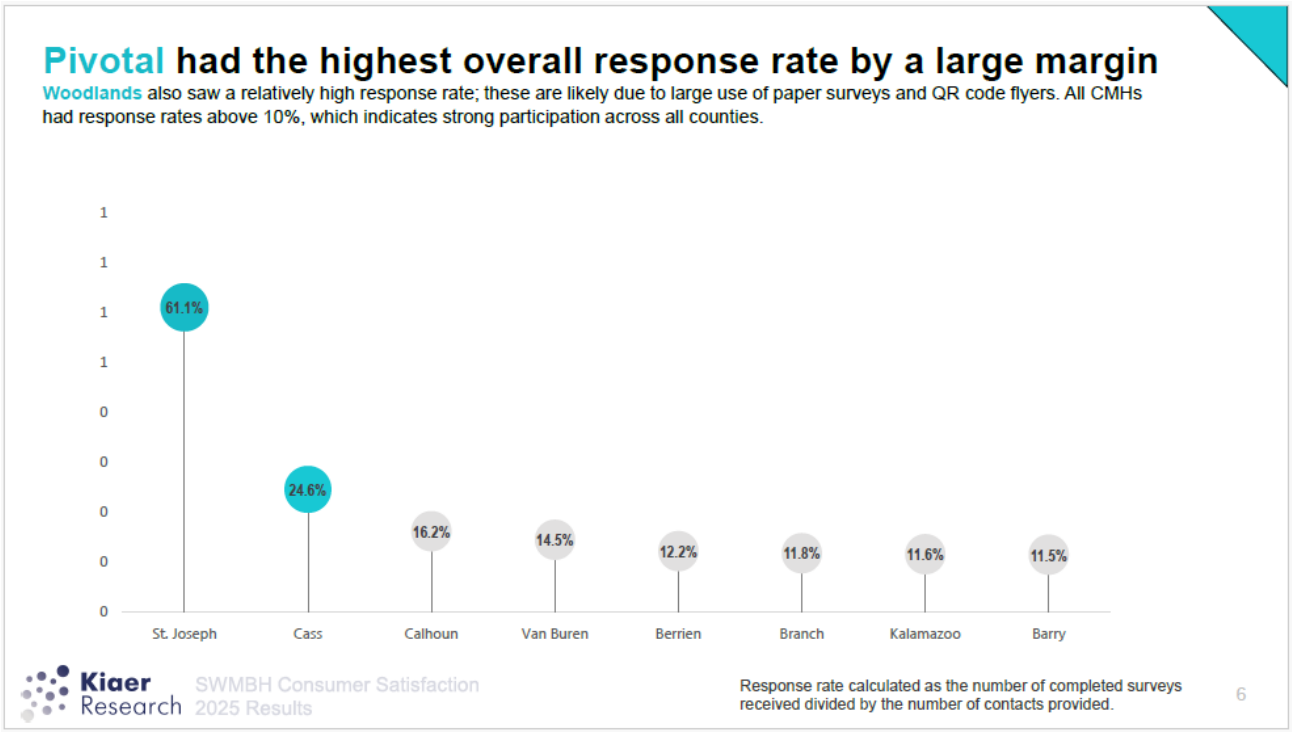
To increase response rates, SWMBH offered a lottery incentive to all survey participants. Following the review of FY24 survey results, several CMHSPs prioritized expanding psychiatric and nursing services and reducing case manager turnover to strengthen workforce development and consumer service access. Efforts to enhance social connectedness and consumer engagement also remained key priorities. Action plans included improving customer engagement and communication through staff training on referral processes, revising text appointment reminders, and offering additional group therapy and peer support services. Further evaluation of the impact of activities implemented in FY25 will occur during early FY26 between SWMBH and each CMHSP, as appropriate. The quantitative and qualitative analysis and development of improvement plans based on the survey results models to improve the quality of health care and services for beneficiaries, service delivery, and health outcomes over time in the region.

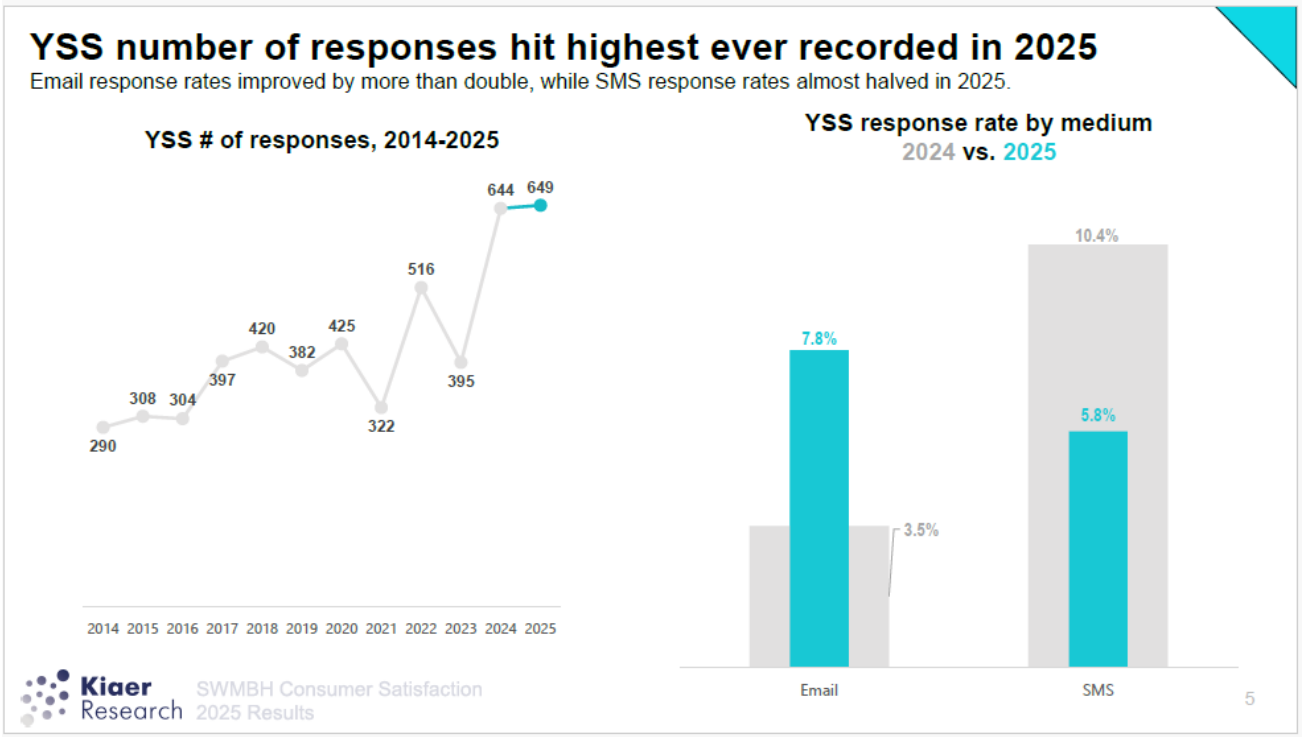
FY25 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	FY25	Eval Score	FY26 Recommendations
Achieve at least 1500 completed MHSIP surveys and 600 completed YSS surveys by making the survey more available/accessible, utilizing email, text, QR code, mobile device, tablet, and paper survey.	QMC	Annually	1583 MHSIP/ 644 YSS Completed Surveys	1603 MHSIP/ 649 YSS Completed Surveys	5	This goal was met and will continue to be monitored in FY26.
The FY25 MHSIP (adult) survey will see an improvement of the region's overall score for the lowest scoring domain in the FY24 survey (Outcomes and Functioning).	QMC, RCP, CAC	Annually	83.49%	84.20%	3	This goal was partially met as the overall score for the Outcomes and Functioning domain increased; however, it was not a statistically significant difference. This goal will continue in FY26.
The FY25 YSS (youth) survey will see an improvement of the region's overall score for the lowest scoring domain in the FY24 survey (Outcomes).	QMC, RCP, CAC	Annually	77.6%	81.70%	4	This goal was met as there was a statistically significant difference between FY23 and FY25 outcomes for the Outcomes domain. This goal will continue in FY26.

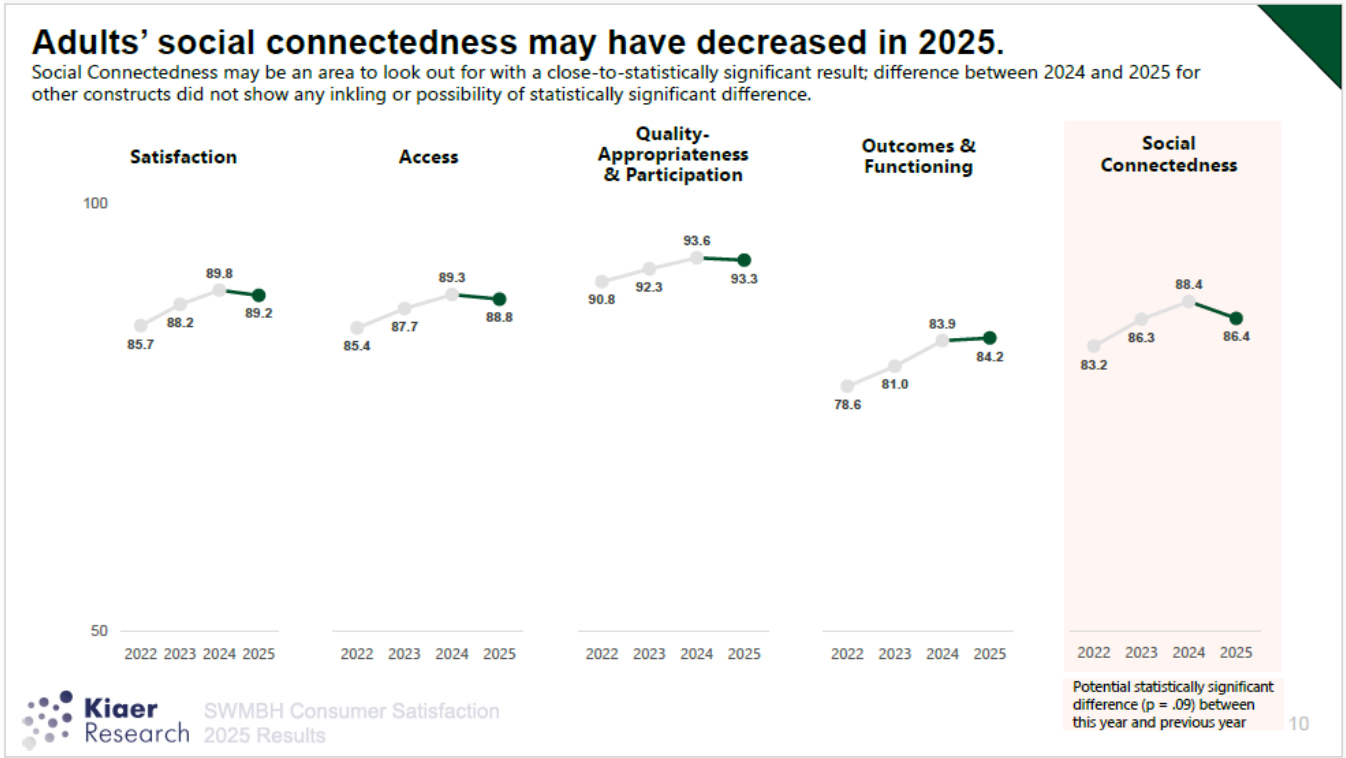
Survey Response Rates





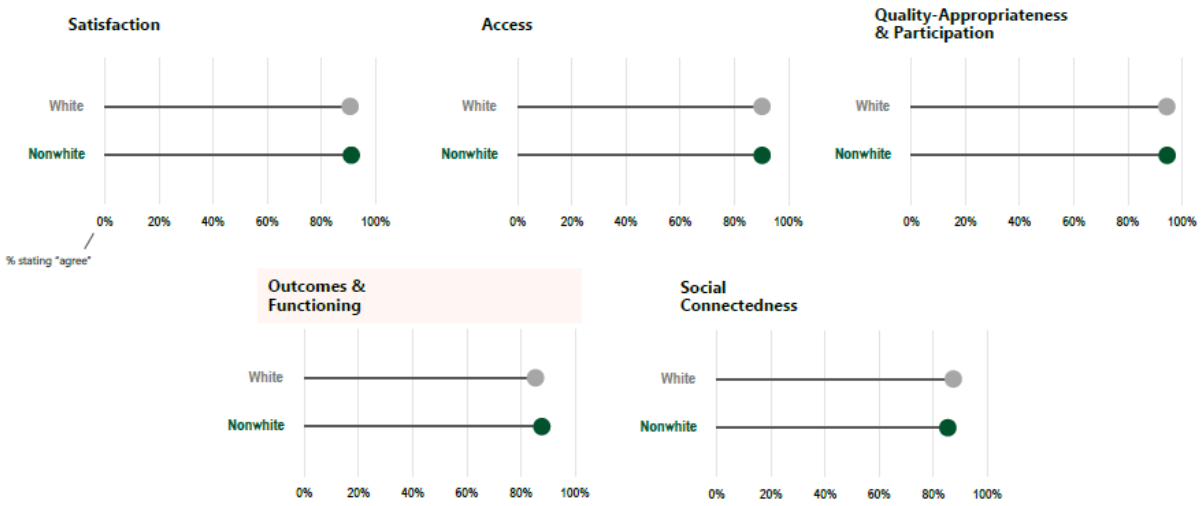


Adult Survey Scores by construct (MHSIP)



Race: Nonwhite consumers reported slightly stronger outcomes

"Nonwhite" category comprises any race other than White, including Black/African American, Asian, Native American, Native Hawaiian/Pacific Islander, or any mix of races. This aggregation was done due to small sample sizes.



Kiaer Research SWMBH Consumer Satisfaction 2025 Results

Statistically significant difference ($p < .05$) between groups (Mann Whitney U)

White n = 1,148
Nonwhite n = 455

21

Adult LTSS consumers reported worse Access & Outcomes scores than non-LTSS adults*

Dark green denotes the percentage of LTSS (long-term social services) consumers in agreement for that construct's items
Gray bars denote the likely range where the true percentage for all LTSS consumers might lie (i.e., margin of error*)

Statistically significant difference ($p < .05$) between LTSS and non-LTSS

*result may be due to survey error leading to potential misclassification of LTSS consumers

margin of error for **LTSS** adults: ±4.2 pts (n = 536)
margin of error for **non-LTSS** adults: ±3.0 pts (n = 1,067)

Kiaer Research SWMBH Consumer Satisfaction 2025 Results

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Opportunities for improvement in access to and diversity of services, staff engagement with consumers,

Of MHSIP respondents who were *dissatisfied* with services, 5 major themes arose from qualitative feedback.

Access, scheduling, and responsiveness
75 comments

Inadequacy of service, program, or support options
51 comments

Medication management issues
41 comments

Staff behavior, perceived disrespect
22 comments

Staff turnover and discoordination
16 comments

Consumers had life-changing accounts of benefit from their CMHSPs

"I am **not homeless** anymore. I'm also getting the mental help I need. **Life is so much easier** becuz of ISK."

"After my husband passed of cancer almost 5 years ago I turned to alcohol to self medicate. I was killing myself with alcohol at 36 yrs old. My peer support specialist and my therapist played a huge role in **saving my life**."

"After I started coming to Riverwood I have been **a lot more stable** and I'm able to **communicate much better.** My family dosent have to see me suffer every day now. Also **we all have a better understanding** of what I'm dealing with so it makes it easier being educated."

"It **saved my life.** I was in a horrible dark place. My family wasn't even speaking with me… My children ignored me as if I didn't exist… Thanks to the help I received and the work I did, **my life is now amazing!!** I am **so close to my children**, my husband and I celebrated 30 years of marriage and I'm so **grateful to be alive** everyday!!"

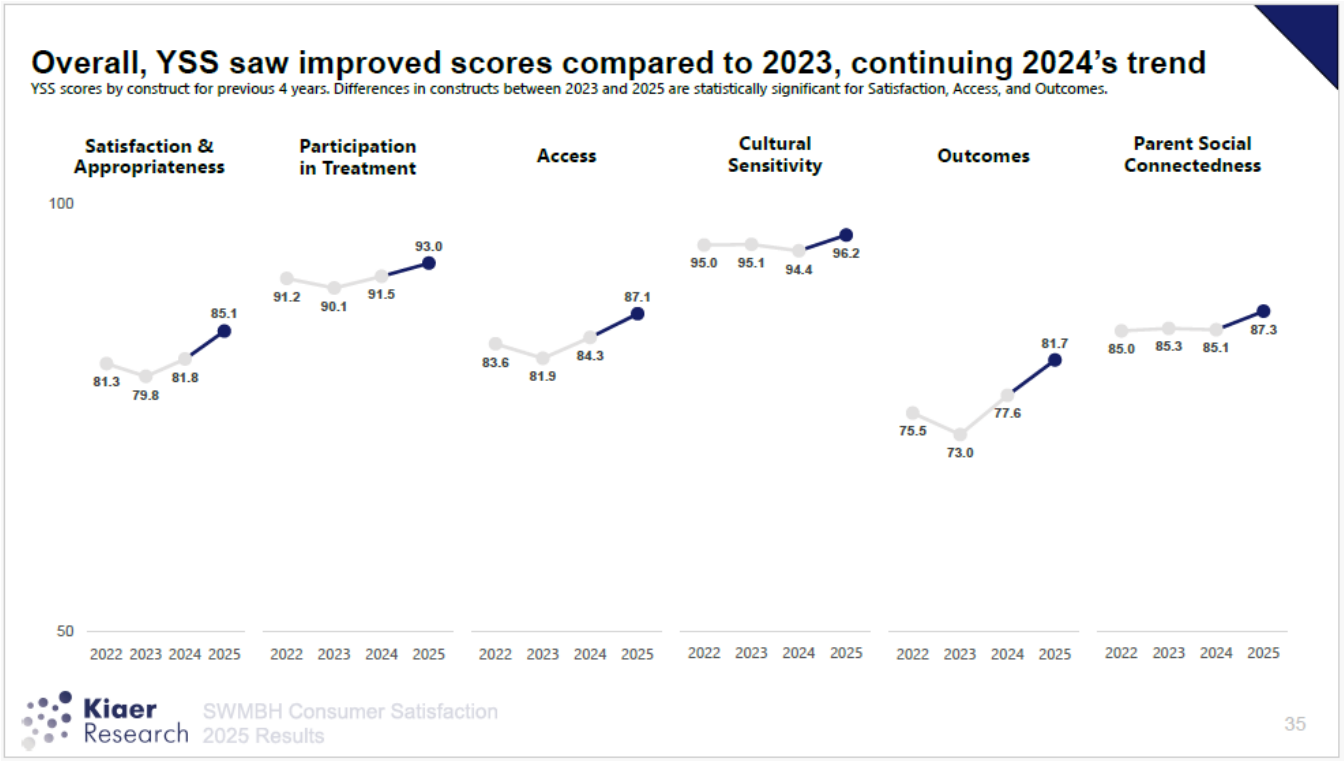
"I am a **better mom** and a better, happier, **more functional** human being, these people **gave me my life back**."

"Because of the therapy and meds and working through my trauma I have now been **a whole year without a hospital stay, I no longer self harm** and have a **better relationship with my kids** and important family."

"I was an alcoholic I no longer drink. I have close to **two years clean** don't ever see myself going back to my old ways. Therefore, I get to spend **more time with my family**. I'm a **better employee**. I'm currently a **business owner** and everyone around me sees a better side of me."

"This agency has **saved my life**. I was off of my meds, suicidal, and absolutely hopeless… My **entire quality of life** has greatly improved thanks to the services I received through ISK. I feel **hopeful and excited** for my future, and I feel **capable of functioning** in day to day life."

Youth Services Surveys by Construct (YSS)



Opportunities for improvement in access to services, staff engagement with consumers,

Of YSS respondents who were *dissatisfied* with services, 3 major themes arose from qualitative feedback.

Limited access/eligibility to services
30 comments

Poor quality or effectiveness of care
30 comments

Setbacks from communication issues
18 comments

Positive highlights from the YSS comments section

"My son **isn't thinking of suicide**, he **isn't self harming**, he's **feeling hope** for his future, and although it's still a struggle for him, he knows he **has a team of people who have his back** and want him to succeed. That's an awesome feeling."

"Just a **complete 180** for our family, all the help with services and rehabilitation centers, our child is **able to do so many new things** she wouldn't do a 1 1/2 year ago. **She's thriving** in school, using AAC devices, verbalizing now, singing, routines, motor skills, etc."

"My child **hasn't self harmed** for a few months now since learning how to cope better with bullying and having anxiety and depression and also has **started engaging in sports again** after school. She seems **much better then when we started.**"

"I was totally lost and alone on helping my child until I was recommended to check out ISK. **From the very first intake** appointment, I was **filled with a sense of hope** for the first time in a long time. I truly believe ISK's support made a **life changing difference** for our family."

"My son was homeschooled for the last 2 and a half years because he was scared to be separated from mom. **He is back in school now.**"

"My child **loves working with his therapist**. He doesn't want to see any other provider and asks when his next visit is. That's **such a switch from other therapy** that he's had. He is **creating more art** at home. He is **naming his emotions** and vocalizing them."

"We are now **better able to communicate as a family**, with his better communication, our family is continuing to **grow stronger**."

"My son is **able to express his emotions** in a way that he never has before."

b.) Recovery Self-Assessment, Person in Recovery version (RSA-r) Survey

Description

The Recovery Self-Assessment-revised (RSA-r) Survey was offered to Medicaid & Block Grant SUD beneficiaries from August 1 through September 15, 2025, to capture satisfaction with the services they receive from their current SUD provider. Participation in the RSA-r survey through SWMBH is encouraged but optional for regional providers and some providers chose not to participate and to measure client satisfaction through alternative methods. The Person in Recovery version of the survey consisted of 32 questions and beneficiaries chose responses based on a 5-point Likert scale, 1 being the lowest scoring option. The questions were grouped into the following six categories: Life Goals, Involvement, Diversity of Treatment, Choice, Individually Tailored Services, and Inviting Spaces. The survey is designed to gauge the degree to which programs implement recovery-oriented practices and is a reflective tool for those in recovery to identify practices in their mental health and SUD services that improve or impede their recovery process. Survey outcomes and analysis were made available to stakeholders via SWMBH's website and are covered in relevant committees and workgroups such as Regional SUD Director's Workgroup, Quality Management Committee and Customer Advisory Committee.

FY25 Identified Barriers and Analysis

The responses from the Recovery Self-Assessments were scored as a comprehensive total, separately as six subcategories, and by individual question. Survey participation slightly decreased compared to the previous fiscal year, from 701 to 639 respondents, and survey participation continues to vary by provider. QR codes were available to increase electronic survey participation again this fiscal year, but the paper form continued to be the preferred method. The regional comprehensive survey score maintained from FY22-FY24 of 4.55 increased in FY25 to 4.59; however, the increase was not statistically significant ($P<0.05$). The mean score for each of the six categories either stayed the same or improved in FY25 compared to FY24. Involvement and Individually Tailored Services were the only subcategories to represent a statistically significant increase. This improvement in the Involvement subcategory is especially meaningful given its historically low performance and the ongoing provider emphasis on promoting community participation and events and development of new groups since the COVID-19 pandemic. The Choice domain remains the highest scoring category at 4.71. One identified barrier is the absence of both national comparative survey data and regional data specific to Michigan.

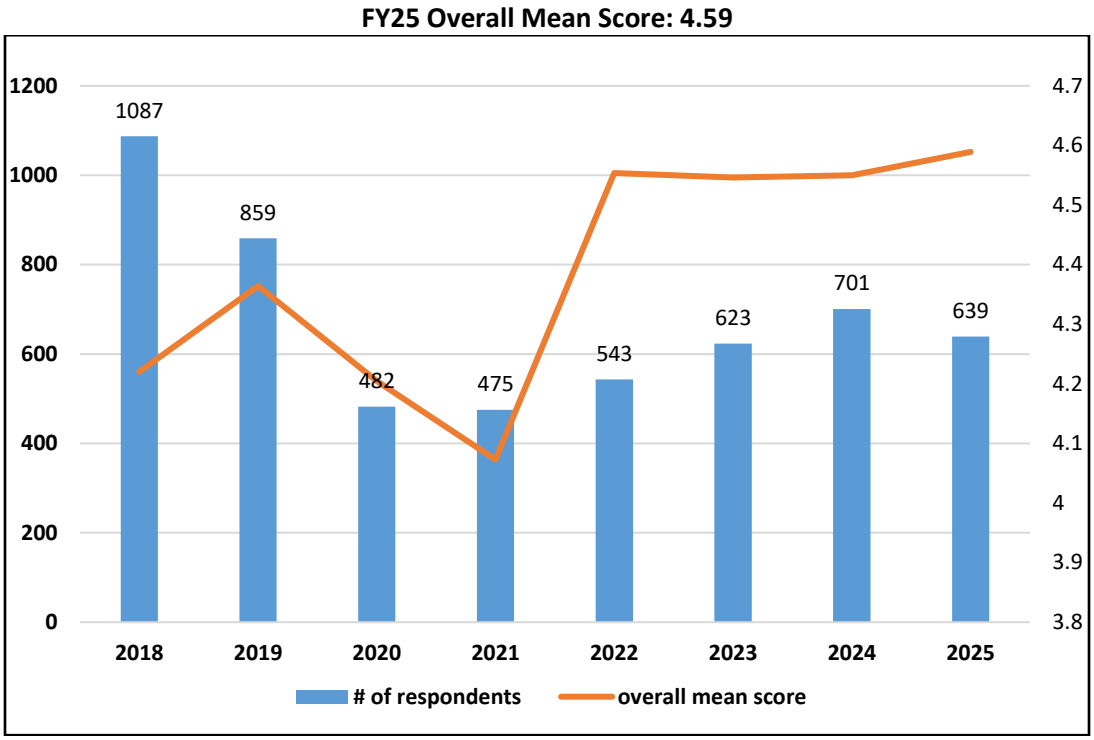
Improvement Efforts Made in FY25

Survey outcomes were available earlier to stakeholders as multiple SWMBH staff assisted in manual survey entry in FY25. SWMBH reviewed the survey outcomes and process with Regional SUD Director's Workgroup to determine the most relevant data points to be used for trend identification and analysis and requested the development of quality improvement efforts. The individual score from FY23-FY25 for survey questions in each subcategory was included to assist in determining potential action steps, especially for individual providers, as regional domain scores appear to have plateaued in recent years. Improvement plans were requested from SUD Providers based on individual survey results, which SWMBH will review and monitor in FY26. These efforts help ensure improvements in the quality of health care and services for people in recovery, service delivery, and health outcomes over time. Targeted areas of improvement based on FY24 results by some individual providers included Involvement and Diversity in Treatment.

FY25 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	FY25	Eval Score	FY26 Recommendations
Increase survey participation compared to the previous year, as evidenced by more participating providers and/or more completed surveys.	QMC, SUD Directors Subgroup	Annually	701 surveys	639 surveys	**3**	Goal was not met in FY25 and will continue in FY26.
Achieve at least 90% consumer satisfaction with SUD services as indicated by survey results.	QMC, SUD Directors Subgroup	Annually	Met	Met	**5**	Goal was met in FY25 and will continue to be monitored in FY26.

RSA-r Survey Regional Results

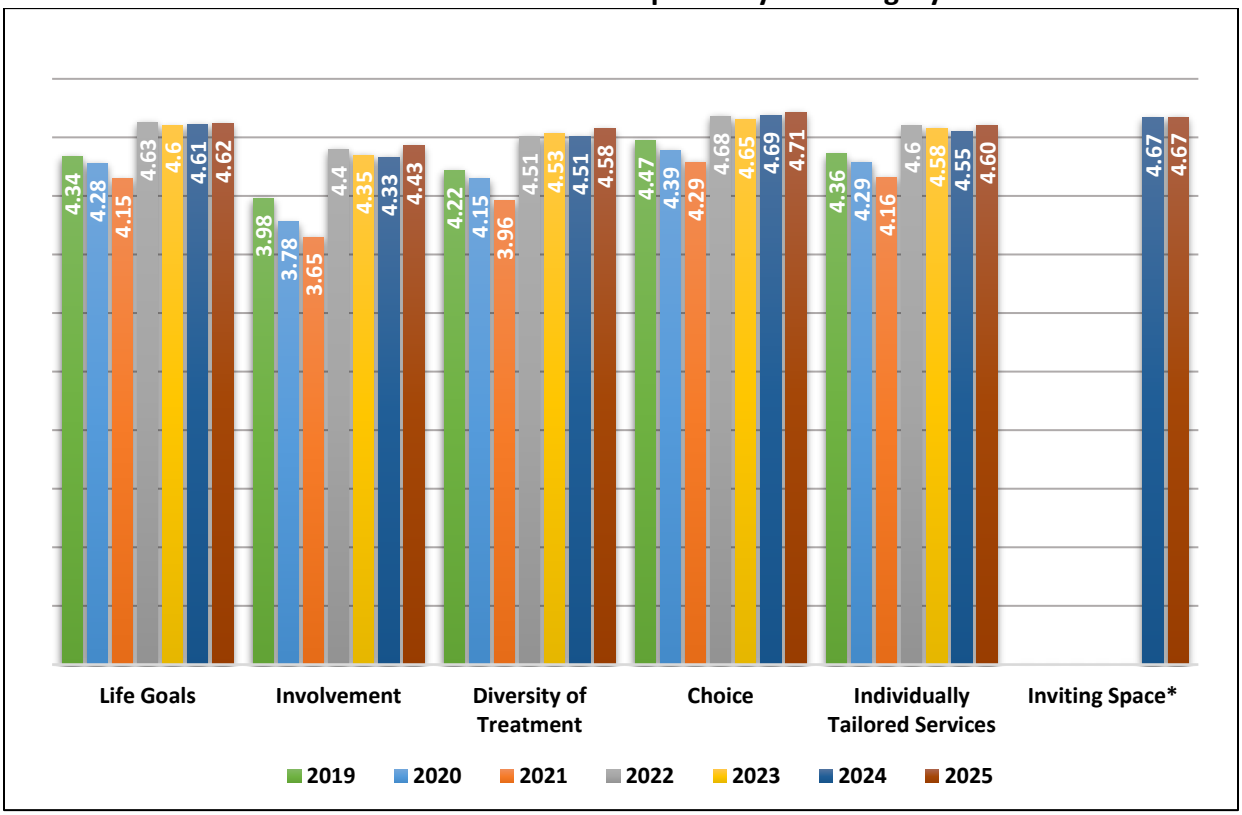


SUD Provider and CMHSP Participation and Respondent in Agreement Analysis

	No. of Respondents	Overall Mean Score
Barry CMHA	1	4.53
Integrated Services of Kalamazoo	3	5.00
Pines Beh Health	9	4.61
Pivotal	53	4.57
Riverwood Center	110	4.37
Summit Pointe	25	4.57
Van Buren CMHA	6	4.70
Woodlands Beh Health	26	4.63
Harbortown Treatment Center	118	4.60
Meridian Health Services	7	4.23
Recovery Institute of SW Michigan	30	4.52
Recovery Services Unlimited	150	4.97
Sacred Heart Rehabilitation Center	52	4.39
Victory Clinic	49	4.16

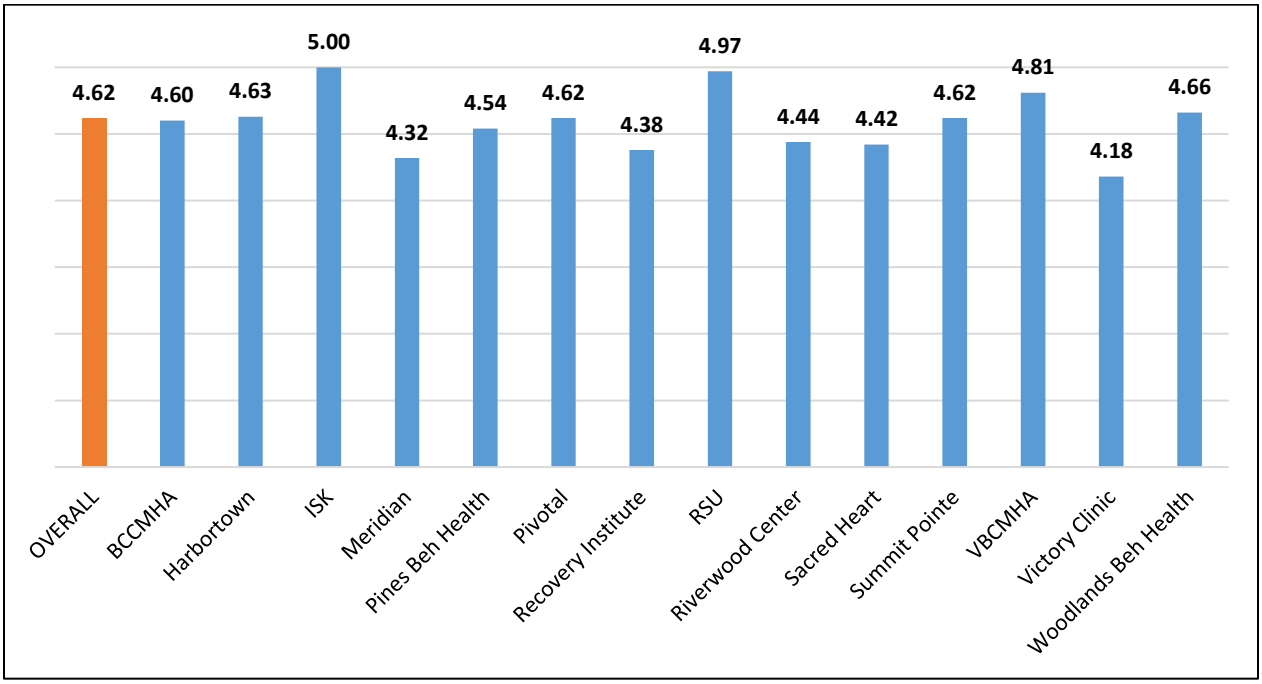
*Shading identifies CMHSP vs. SUD Providers

SWMBH Annual Mean Response by Subcategory



*Inviting Space newly added domain in FY24. Questions in this domain were previously included in the Individually Tailored Services domain.

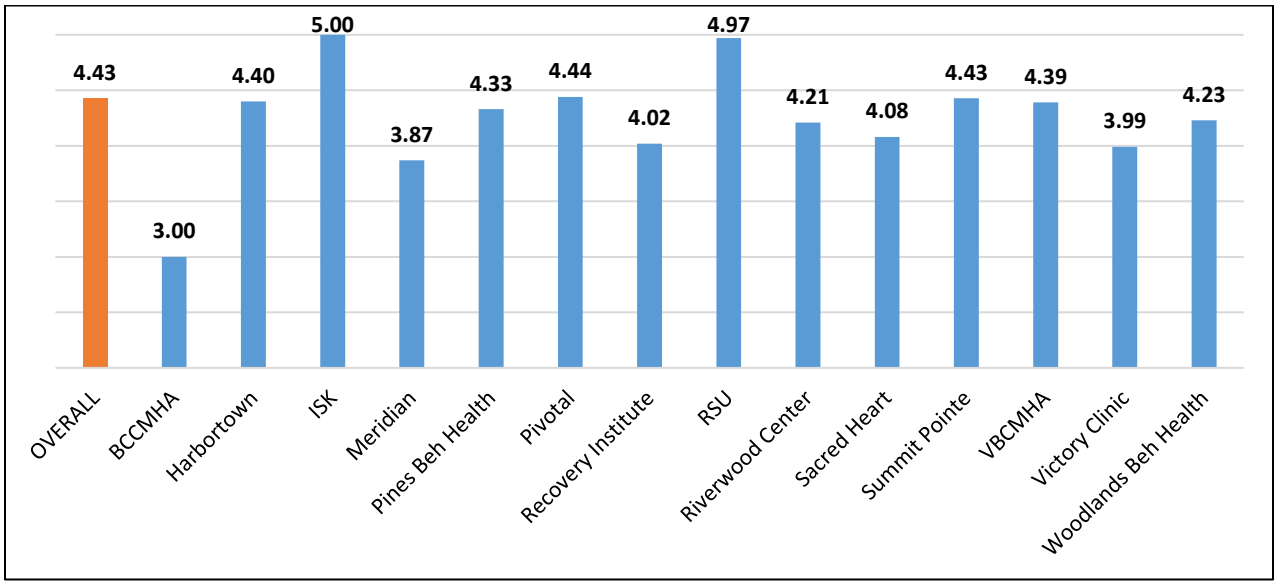
Subcategory: Life Goals



The SWMBH mean score for the Life Goals subcategory in FY25 slightly increased to 4.62 compared to FY24's mean of 4.61. The table below includes questions associated with this domain as it measures how the provider encourages people in recovery to pursue goals and interests.

Question	**FY25 Mean Score**	FY24 Mean Score	FY23 Mean Score
7. Staff believe in the ability of program participants to recover.	4.79	4.83	4.79
3. Staff encourage program participants to have hope and high expectations for their recovery.	4.74	4.78	4.71
9. Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.	4.70	4.71	4.67
16. Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g. employment, education physical fitness, connecting with family and friends, hobbies).	4.68	4.68	4.67
28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.	4.64	4.59	4.60
32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	4.62	4.60	4.63
31. Staff are knowledgeable about special interest groups and activities in the community.	4.60	4.58	4.61
8. Staff believe that program participants have the ability to manage their own symptoms.	4.59	4.65	4.59
12. Staff encourage program participants to take risks and try new things.	4.49	4.46	4.44
18. Staff actively help program participants to get involved in non-mental health/addiction related activities, such as church groups, adult education, sports, or hobbies.	4.49	4.44	4.49
17. Staff routinely assist program participants with getting jobs.	4.35	4.31	4.26

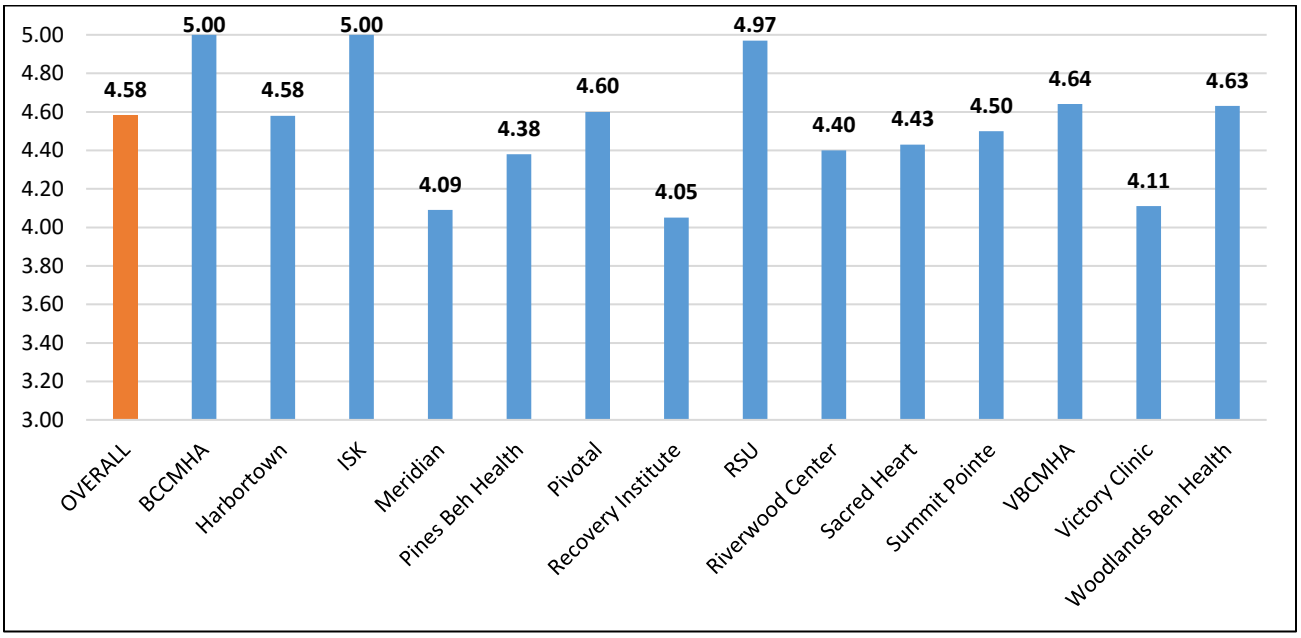
Subcategory: Involvement



The SWMBH average was 4.43 for the Involvement subcategory in FY25, which was a large and statistically significant increase compared to the FY24 average of 4.33. Involvement is historically the lowest scoring domain each year, but the six-year average remains lower, at 4.16, indicating general improvement during this period. Providers mean scores for this category are included above. The table below includes questions associated with the Involvement subcategory as they measure how the provider involves the people in recovery in their recovery process.

Question	**FY25 Mean Score**	FY24 Mean Score	FY23 Mean Score
Q24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.	4.52	4.46	4.53
Q22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).	4.46	4.35	4.39
Q23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.	4.41	4.25	4.28
Q29. Persons in recovery are involved with facilitating staff trainings and education at this program.	4.37	4.34	4.29
Q25. People in recovery are encouraged to attend agency advisory boards and management meetings.	4.37	4.2	4.19

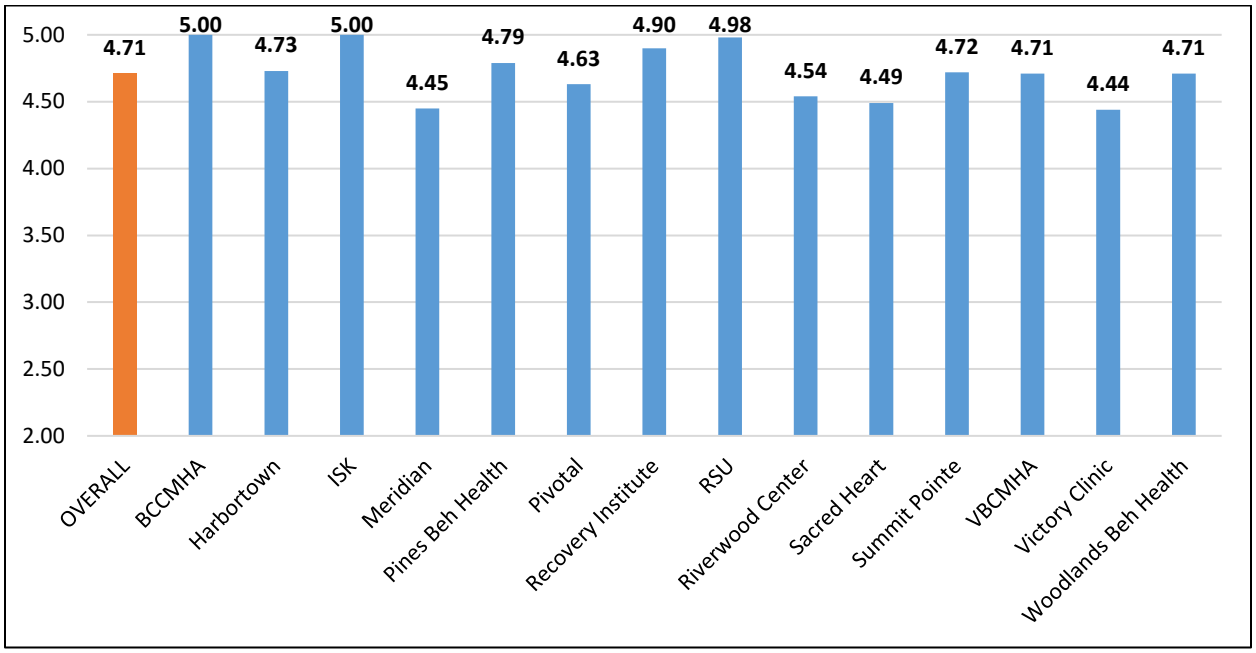
Subcategory: Diversity of Treatment



The SWMBH average was 4.58 in FY25 for the Diversity of Treatment subcategory as in FY24, the average was 4.51. The table below includes questions associated with the Diversity of Treatment subcategory and the mean score for each question for FY23 through FY25. These questions aim to measure how well the provider offers a range of treatment options and styles to cater to the needs and preferences of persons in recovery.

Question	**FY25 Mean Score**	FY24 Mean Score	FY23 Mean Score
Q14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.	**4.64**	4.58	4.62
Q21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.	**4.63**	4.60	4.65
Q26. Staff talk with program participants about what it takes to complete or exit the program.	**4.56**	4.49	4.53
Q20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	**4.55**	4.44	4.51
Q15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.	**4.48**	4.39	4.32

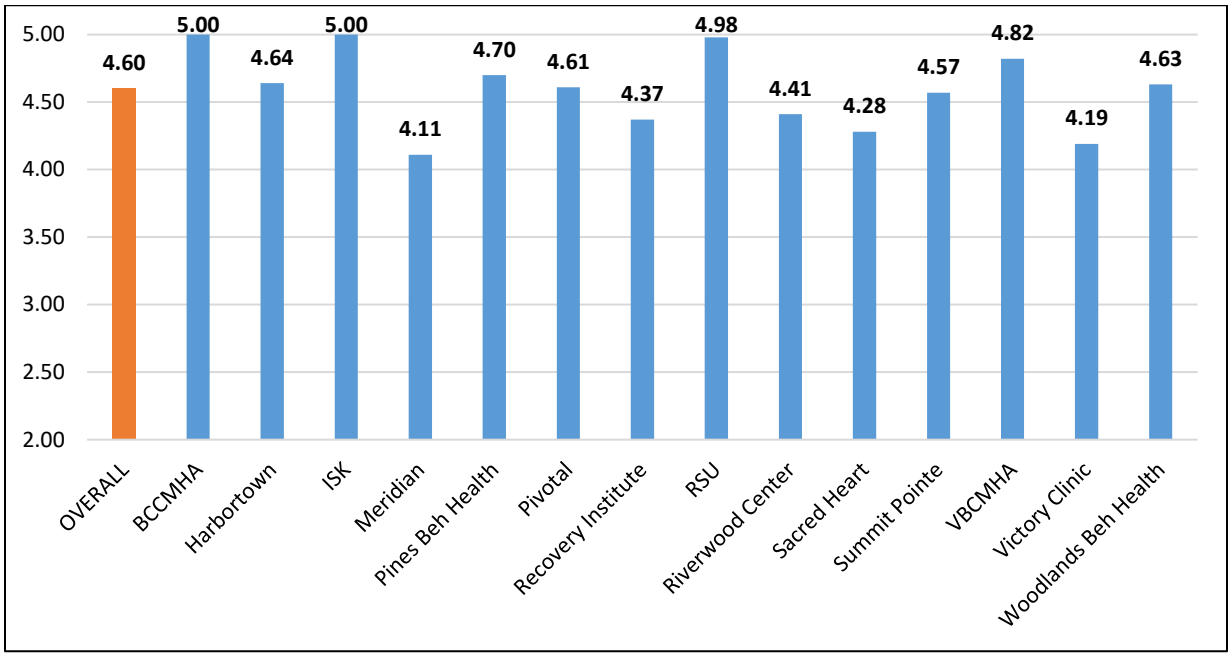
Subcategory: Choice



The Choice subcategory measures how the provider considers the preferences and choices of persons in recovery during their recovery process. The regional average increases this year to 4.71 (from 4.69). This subcategory continues to have the highest score out of all six. Questions associated with the Choice subcategory and the mean scores for the last three years are included below.

Question	**FY25 Mean Score**	FY24 Mean Score	FY23 Mean Score
Q6. Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.	**4.80**	4.79	4.72
Q10. Staff listen to and respect the decisions that program participants make about their treatment and care.	**4.75**	4.71	4.71
Q4. Program participants can change their clinician or case manager if they wish.	**4.69**	4.66	4.59
Q5. Program participants can easily access their treatment records if they wish.	**4.66**	4.66	4.59
Q27. Progress made towards an individual's own personal goals is tracked regularly.	**4.66**	4.61	4.62

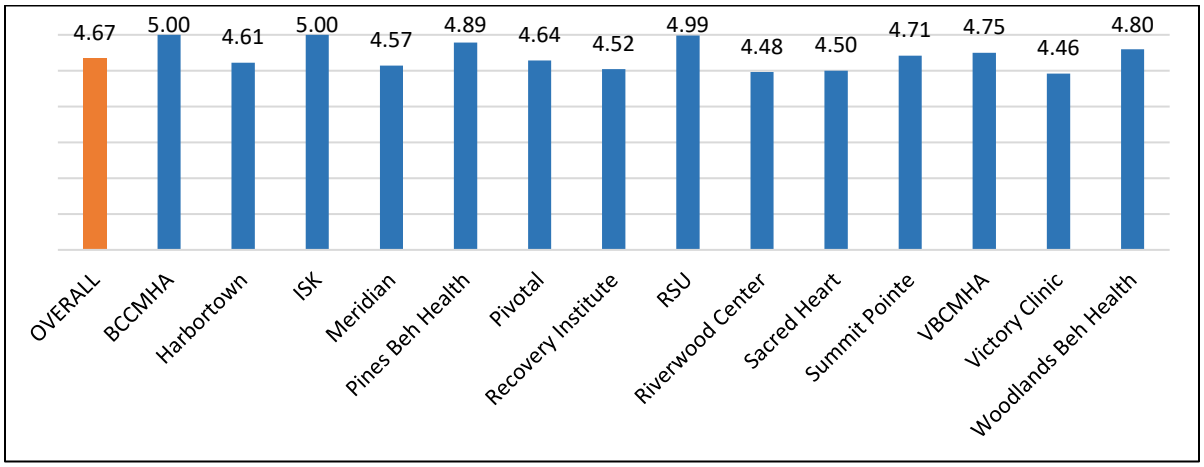
Subcategory: Individually Tailored Services



The Individually Tailored Services subcategory measures how the provider helps people in recovery tailor their treatment programs to their individual needs. Contrary to the previous year, FY25 indicated a statistically significant increase in this subcategory's mean score going from 4.55 to 4.60. The table below includes questions associated with this domain and the mean score for each question.

Question	**FY25 Mean Score**	FY24 Mean Score	FY23 Mean Score
19. Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).	**4.65**	4.56	4.63
Q30. Staff listen, and respond, to my culture, ethnicity, lifestyle, and interests.	**4.62**	4.60	4.65
11. Staff regularly ask program participants about their interests and the things they would like to do in the community.	**4.58**	4.58	4.50
13. This program offers specific services that fit each participant's unique culture and life experiences.	**4.57**	4.46	4.54

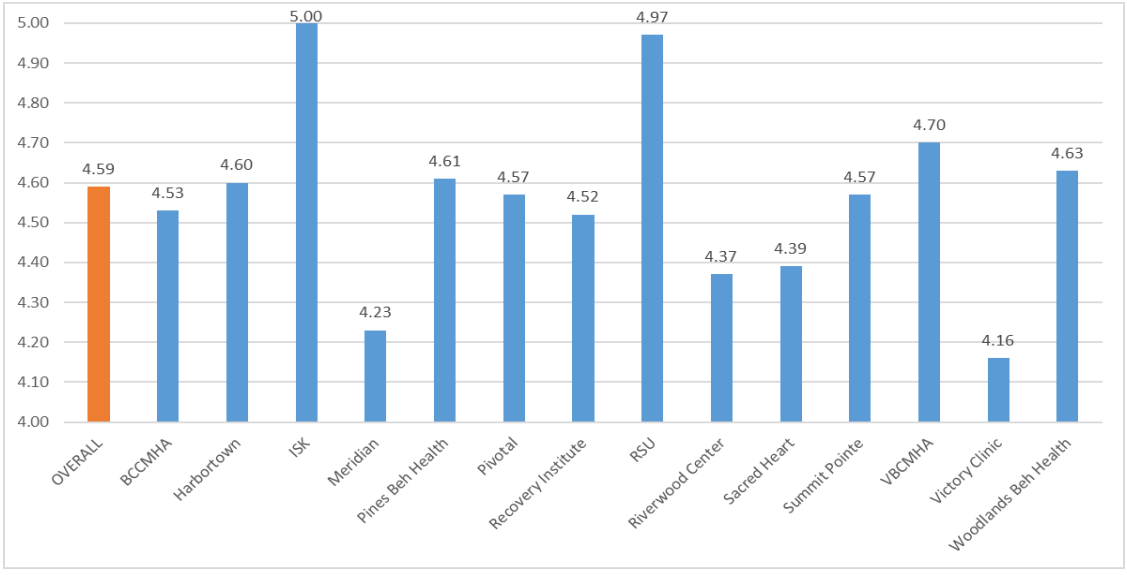
Subcategory: Inviting Space



The Inviting Space subcategory is intended to measure how welcoming the facility and its staff are to the individuals in recovery. While this subcategory was new in FY24, it is comprised of two questions that have always been included in the 32-question set but previously associated with the Individually Tailored Services domain. The Inviting Space subcategory mean score stayed the same in FY25 at 4.67. The questions and mean scores are included below for the last three years.

Question	**FY25 Mean Score**	FY24 Mean Score	FY23 Mean Score
Q1. Staff welcome me and help me feel comfortable in this program.	**4.80**	4.80	4.70
Q2. The physical space of this program (e.g. the lobby, waiting rooms, etc.) feels inviting and dignified.	**4.55**	4.54	4.46

FY25 Overall Mean Score by Provider



F. Verification of Medicaid Services

Description

SWMBH's Program Integrity and Compliance Department performed the Medicaid Services Verification (MSV) review to verify whether services reimbursed by Medicaid were furnished to beneficiaries by its CMHSPs, providers, and subcontractors. This review was performed pursuant to MDHHS-PIHP Master Contract Schedule A Section C.4 and in conformity with the MDHHS Medicaid Verification Process technical requirement. SWMBH performed this review on a quarterly basis, immediately following the end of each Fiscal Year Quarter giving the opportunity to have real time results and to effectuate change quickly. SWMBH submitted the Medicaid Services Verification Report to MDHHS, which includes the overall findings, deficiencies, follow-up activities, and improvement plans. These efforts helped ensure improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time. SWMBH utilized the random number function of the Office of Inspector General's (OIG) statistical software package, RAT-STATS, to select random samples and conduce quarterly audits of claim encounters for each CMHSP, contracted SUD providers and participant CMHSPs' network providers. SWMBH utilized a standardized verification tool to evaluate all selected claim encounters, which included the following elements:

1. Was the person eligible for Medicaid coverage on the date of service?
2. Is the code billed eligible for payment under Medicaid?
3. Was the service identified included in the beneficiary's individual plan of service/treatment plan?
4. Does the treatment plan contain a goal/objective/intervention for the service billed?
5. Is there documentation on file to support that the service was provided to the beneficiary?
6. Was the provider qualified to deliver the services provided?
7. Is the appropriate claim amount paid (contracted rate or less)?

FY25 Identified Barriers and Analysis

SWMBH reviewed a total of 1,968 claim encounters, with 1,865 verified to be a valid service reimbursable by Medicaid. Given the overall compliance rate of 94.77% and given that all samples reviewed achieved a compliance rate greater than or equal to 90%, a formal CAP was not required; however, SWMBH will continue efforts to improve service claim processes. SWMBH identified opportunities for improvement which include the areas of coordination of benefits, treatment plan requirements, and proper billing and documentation of face-to-face service time reporting. SWMBH will provide ongoing education and training focused on those areas in FY26. The SWMBH Executive Officer, Chief Compliance Officer, Corporate Compliance Oversight Committee and Board Regulatory Compliance Committee will also review the findings and identify any additional strategies needed to improve the findings.

Improvement Efforts Made in FY25

Over the course of FY25, SWMBH reviewed the service documentation and claims processing procedures of each participant CMHSP to ensure that both the applicable delegated and non-delegated functions follow Medicaid regulations and SWMBH policies.

Regarding the deficiencies noted pertaining to Coordination of Benefits (COB), SWMBH continued to work with CMHSPs and contracted providers to ensure understanding of the COB requirements. SWMBH will continue additional, non-MSV audits for FY26 to better monitor the provider network in this area.

Regarding deficiencies noted for Treatment Plans, there were continued issues with ensuring Treatment Plans were completed and signed by the clinician in a timely manner. SWMBH Clinical Quality and Program Integrity/Compliance are working with CMHSPs to ensure Treatment Plans are clinically appropriate and include

the required goals, objectives, and interventions for all authorized services.
In addition to this Medicaid Services Verification Review, SWMBH performed a region wide annual comprehensive qualitative and administrative review process, designed to provide ongoing feedback to both participant CMHSPs and network providers.

SWMBH is committed to improving the effectiveness and efficiency of the PIHP accountabilities in Medicaid fraud and abuse prevention. In Fiscal Year 2026, SWMBH will continue a concerted focus to enhance regional data mining efforts and continue to monitor and educate providers on treatment plan requirements and timeliness, proper recording of face-to-face service start and stop times, proper billing of actual face-to-facetimes without rounding, and Coordination of Benefits requirements. Additionally, SWMBH will perform non-MSV audits and data-mining reviews to better monitor these deficiencies.

FY25 Results

Goal	FY24	FY25	Eval Score	FY26 Recommendations
The overall Medicaid claims verification compliance rate for Region 4 will be above 90%.	95.05%	94.77%	5	Goal was met in FY25 and will continue in FY26.

SWMBH's Compliance Department completed the annual Medicaid Verification review using the Random Number function of the OIG's statistical software package, RAT-STATS, SWMBH selected random samples of encounters and claims on a quarterly basis. A total of 1,968 claims/encounters, representing 18,994 units and $1,825,705.11, were audited for FY25. Of those audited, 1,865 were verified to be a valid service reimbursable by Medicaid, for an overall FY25 compliance rate of 94.77 %. Results on each review element and deficiencies are detailed below:

1. Was the person eligible for Medicaid coverage on the date of the service reviewed? **0 deficiencies**
2. Is the provided service eligible for payment under Medicaid? **16 deficiencies**
3. Is there a current treatment plan on file which covers the date of service? **9 deficiencies**
4. Does the treatment plan contain a goal/objective/intervention for the service billed? **3 deficiencies**
5. Is there documentation on file to support that the service was provided to the beneficiary? **27 deficiencies**
6. Was the service provided by a qualified practitioner and falls within the scope of the code billed/paid? **0 deficiencies**
7. Was the appropriate amount paid (contract rate or less)? **0 deficiencies**

FISCAL YEAR	MEDICAID SERVICES VERIFICATON RESULTS
FY21	95.27%
FY22	94.67%
FY23	92.03%
FY24	95.05%
FY25	94.77%

G. Provider Network

a.) Provider Network Adequacy Evaluation

Description

SWMBH completes an evaluation of the adequacy of its current fiscal year's provider network during the first quarter of the applicable fiscal year, assessing provider network adequacy and accessibility according to the most current MDHHS Network Adequacy Standards. The areas that are assessed include enrollee-to-provider ratios, crisis residential beds-to-enrollee ratios, time and distance standards, SUD services based on American Society of Addiction Medicine Level of Care (ASAM LOC), timely appointments, languages spoken, cultural competence, and physical accessibility. Each section contains a regional analysis and identifies opportunities for improvement that will be addressed throughout the fiscal year. The data from SWMBH's internal network adequacy analysis and opportunities for improvement report is then added to the MDHHS Network Adequacy Reporting Template and submitted to MDHHS by the required due date specified in Schedule E of the MDHHS-PIHP Agreement.

MDHHS contracts with HSAG to conduct the annual performance measures and included network adequacy validation (NAV) activities in FY25 for the second year in a row, ensuring all reported performance indicator rates are calculated following the state's measure specifications and reporting requirements, and that network standards, as defined by the state, were met.

SWMBH also maintains the Provider Directory on behalf of the region, which is located on the SWMBH website. The CMHSPs submit new/update/delete request forms through SWMBH Commons when there has been a change to their network providers and SWMBH updates the directory as appropriate within 30 days.

FY25 Identified Barriers and Analysis

SWMBH chose not to convene a Network Adequacy Remediation Workgroup following the FY25 Network Adequacy Evaluation because the barriers remained the same as FY23 & FY24: 1) Medicaid Enrollee to Provider ratios for children's services – specifically Homebased, which was short 4 full-time employees, however, each CMH with a score of "Standard not met" continued to meet fidelity to the homebased services model; 2) SWMBH's Region being short 1 Clubhouse, which fell back into the "Not Met" category when Van Buren's directly operated clubhouse closed in December 2024, leaving Region 4 with only 2 available Clubhouse locations in the network.

It was noted last year that MDHHS acknowledged the State-issued ratios and standards are being reviewed and revised, and MDHHS held a meeting in Jan 2025 to review its revised Network Adequacy Standards with all 10 PIHPs in Michigan. However, MDHHS did not change the Medicaid Enrollee to Provider ratios that would affect the abovementioned "Not Met" Standards in SWMBH's Region.

A barrier that existed related to the HSAG NAV audit in FY25 was confusion about whether SWMBH should respond to time and distance standard questions, as MDHHS announced in January 2025 MDHHS would calculate these standards for the FY24 Network Adequacy Report. At a 5/7/25 technical assistance webinar, HSAG said PIHPs did not need to answer these questions since MDHHS would handle calculations. However, at a 5/20/25 NAV audit kickoff call, HSAG clarified that PIHPs, including SWMBH, must still answer these questions as they should be calculating time and distance standards

internally. Despite this initial confusion, SWMBH scored 100% on the FY25 HSAG NAV Audit.

In the first quarter of the fiscal year, SWMBH completes an annual internal Network Adequacy report reflecting current network data for the upcoming year. The time and distance standards used for this FY25 report differed from MDHHS's final FY25 standards, which were released after SWMBH's internal report was completed. SWMBH's Health Care Data Analyst was able to calculate the time and distance standards against the revised MDHHS time and distance standards issued in January 2025

Improvement Efforts Made in FY25

Opportunities for improvement were identified in the Regional Provider Network Management Committee (RPNMC) and can be found in the FY25 SWMBH's internal network adequacy analysis and report. Evaluations of those opportunities for improvement are reviewed in the following fiscal year's report.

SWMBH's Provider Network team conducted usability testing of the provider directory with SWMBH's Customer Advisory Committee (CAC) in November 2024 and again in October 2025 to review changes made to the directory based on feedback provided.

In the FY24 HSAG EQR audit it was recommended that SWMBH include a printable version of the provider directory on SWMBH's website. This was completed by the Provider Network team in FY25 and a printable PDF version of SWMBH's provider directory can now be found on the "Find a Provider" page of SWMBH's website.

FY25 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	FY25	Eval Score	FY26 Recommendations
SWMBH will complete an evaluation of provider network adequacy and accessibility according to the most current MDHHS Network Adequacy Standards. The report will be submitted to MDHHS by the MDHHS-required due date.	SWMBH Assessment of Medicaid Network Adequacy Report	Annually	Met	Met	**5**	Continue to monitor.

The FY25 Network Adequacy Report was submitted to MDHHS by the required annual due date of 4/30/25. SWMBH performs the Network Adequacy evaluation during the first Quarter of the Fiscal Year to evaluate the current Fiscal Year's network, identify deficiencies, and effectuate change before the next fiscal year cycle. This poses some challenges with MDHHS reporting template as the MDHHS template is required for the prior fiscal year. SWMBH has communicated with MDHHS and will submit all required information to MDHHS as part of the MDHHS-required report.

b.) Administrative and Delegated Function Site Reviews

Description

SWMBH either directly performs or ensures that its Participant CMHSPs perform annual monitoring of all providers in its network. This monitoring occurs through the annual site review process, during which standardized tools are used to evaluate Participant CMHSPs' and contracted providers' (both SUD and non-SUD) compliance with administrative requirements and clinical service quality. The oversight, monitoring, and corrective actions from the site reviews leads to improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time in the region.

Participant CMHSP Site Reviews

SWMBH performs annual Site Reviews of its Participant CMHSPs. These reviews consist of a review of each CMHSP's administrative processes and procedures in the following functional areas: Access and Utilization Management, Claims, Compliance, Credentialing, Customer Services, Grievances & Appeals, Provider Network, Quality, Staff Training, and SUD EBP Fidelity and Administration.

In addition to reviewing administrative processes, the annual site review also includes file reviews for the following administrative functions:

- Denial File Review (performed quarterly)
- 2nd Opinion File Review
- Credentialing and Re-credentialing File Review
- Grievances File Review (performed quarterly)
- Appeals File Review (performed quarterly)
- MMBPIS and Critical Incident File Review
- Staff Training File Review

To monitor clinical service quality, SWMBH performs a Clinical Quality (non-SUD) clinical record review of CMHSP directly operated services that is focused on a specific population or service (consistent across all Participant CMHSPs). The population or service focus is determined annually by SWMBH's Quality Management and Clinical Outcomes Department based on several factors which may include State or PIHP-audit results, beneficiary complaints, or other identified concerns. SWMBH also performs an SUD Clinical Quality clinical record review of CMHSP directly operated SUD services.

SUD Providers

SWMBH does not allow for subcontracting of SUD services, and therefore directly holds each contract with its network SUD Providers. SWMBH directly performs annual site reviews for each of its contracted SUD providers. These reviews consist of a review of each SUD Provider's administrative operations and includes administrative file reviews of Credentialing and Re-credentialing, and Staff Training, to monitor SUD Provider completion of these activities in compliance with SWMBH Policies, and to ensure that staff are qualified to perform the services being delivered.

To monitor clinical service quality, SWMBH performs a clinical file review as part of the annual site review process.

Network Providers

For non-SUD network providers that are contracted with one or more of SWMBH's Participant CMHSPs, SWMBH ensures that monitoring is performed annually either directly by SWMBH or by a Participant CMHSP. SWMBH directly performs the annual site reviews for the following provider types:

- Autism Service Providers
- Crisis Residential Service Providers
- Inpatient Psychiatric Service Providers (utilizing the State Inpatient Reciprocity Tool and process)
- Financial Management Services (FMS) Providers

SWMBH's Participant CMHSPs perform annual monitoring of the remaining provider types. SWMBH's Regional Provider Network Management Committee (RPNMC) annually reviews standardized network provider review tools which are used for completion of network provider site reviews to ensure consistency and foster reciprocity. The RPNMC also maintains a spreadsheet of all "shared providers", network providers that are contracted with more than one Participant CMHSP and assigns a responsible Participant CMHSP to perform the annual site review each year. This reduces the burden on shared providers and completed reviews are uploaded to SWMBH's Portal, so they are accessible to all Participant CMHSPs.

Network provider site reviews consist of a review of each provider's administrative operations and include administrative file reviews of Credentialing and Re-credentialing and Staff Training, to monitor provider completion of these activities in compliance with SWMBH Policies, and to ensure that staff are qualified to perform the services being delivered and/or perform their job functions (for unlicensed/direct-care staff).

FY25 Identified Barriers and Analysis

CMHSPs and network providers were collaborative and responsive to the Site Review process. One barrier that was identified was the length of time the reviews take from start to finish, which is specifically lengthy for the file reviews and CAP processes. Additionally, it was identified that elements of the CMHSP Site Review overlap with elements of the now annual MDHHS Waiver Review, which can cause additional administrative burden and duplication on the CMHSPs. SWMBH committed to reviewing its CMHSP Site Review timeline in light of the MDHHS Waiver audit moving to an annual cadence, to identify any opportunities to reduce administrative burdens resulting from audits occurring in close succession.

Improvement Efforts Made in FY25

SWMBH continues the use of the cloud-based portal, named "SWMBH Commons" for the FY25 CMHSP Site Reviews, as well as functioning as a repository for network provider Site Review and credentialing reciprocity documentation to be shared amongst CMHSPs. SWMBH received positive feedback from CMHSPs about the functionality and ease of use of SWMBH Commons for these purposes. SWMBH continued quarterly file reviews for Denials, 2nd Opinions, Grievances, and Appeals. Quarterly reviews have allowed for faster identification and remediation of deficiencies. This also allows for more oversight of the processes which is beneficial given the ongoing issues that have been identified. During the FY25 CMHSP Site Reviews, SWMBH used an abbreviated review process, allowing for elements that received a full credit score in the prior review cycle, and met other criteria, to be "skipped" during the FY25 cycle. This was implemented as a way to recognize and reward high quality performance in areas that were not likely to change year over year. Full clinical file reviews were still completed in FY25.

FY25 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	FY25	Eval Score	FY26 Recommendations
SWMBH will complete or ensure completion of site reviews for the region (for Participant CMHSPs, SUD Providers, and Network Providers), and areas of non-compliance will require a corrective action plan.	Site Review Tools and CAP Documents	Annually	Met	Met	5	Continue to monitor as needed, based on the outcome of the MDHHS Competitive Procurement.

FY25 Overall Sections by CMHSP								
Section	**Barry**	**Berrien**	**Branch**	**Calhoun**	**Cass**	**Kalamazoo**	**St. Joseph**	**Van Buren**
Access and Utilization Management	92.86%	81.25%	92.86%	85.7%	83.3%	90%	76.92%	95.83%
Claims Management	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Credentialing	100%	98.2%	100%	94.1%	93.8%	96.2%	100%	100%
Customer Services	100%	87.5%	100%	100%	100%	87.5%	100%	100%
Compliance	100%	100%	100%	100%	83.3%	100%	100%	100%
Grievances and Appeals	75%	81.3%	75%	92.9%	92.9%	85.3%	90.6%	100%
Provider Network	100%	100%	100%	100%	100%	100%	100%	100%
Quality	100%	96.7	100%	96.7%	97.1%	100%	100%	100%
Staff Training	98.9%	100%	98.9%	91%	92.4%	97.8%	88.7%	82.9%
SUD EBP Fidelity and Administration	100%	100%	100%	100%	100%	100%	100%	100%
Overall	96%	94%	96 %	96%	94%	94%	95%	98%

Overall Sections by Year Data is a combined average score for each section from all eight CMHSP Site Reviews.			
Section	**FY23 Scores**	**FY24 Scores**	**FY25 Scores**
Access and Utilization Management	95.5%	89.3%	**87.34%**
Claims Management	96.1%	94.5%	N/A
Compliance	99.3%	99%	97.8%
Credentialing	98%	96.3%	96.9%
Recredentialing	N/A	96%	N/A
Customer Services	94.6%	100%	97.9%
Grievances and Appeals	94%	97.6%	86.6%
Provider Network	97.7%	100%	100%
Quality and Performance Improvement	94.9%	95.8%	98.8%
Staff Training	87.6%	95%	93.8%
SUD EBP Fidelity and Administration	100%	100%	100%
Clinical Administration	92.7%	N/A	N/A

FY25 Clinical Quality Sections by CMHSP								
Sections	**Barry**	**Berrien**	**Branch**	**Calhoun**	**Cass**	**Kalamazoo**	**St. Joseph**	**Van Buren**
Care Coordination	91.8%	82.7%	91.8%	84.4%	93.2%	94%	82.5%	84.7%
Assessment	99.1%	96.5%	99.1%	93.1%	98.3%	95.7%	94.7%	99.1%
Treatment Plan/PCP	95.7%	86.6%	95.7%	89.6%	95.7%	90.9%	87.1%	90.9%
Utilization Management	100%	90.34%	100%	95.2%	95.9%	94.8%	95.7%	93.5
PCP Documentation Requirements	95.2%	96.5%	95.2%	88.1%	95.5%	95.5%	88.9%	91.1%
Behavior Treatment Planning	90.4%	97.2%	90.4%	86.8%	94%	98.5%	94%	98.2%
Overall	94.96%	90.8%	95%	88.6%	95.5%	93.5%	88.4%	92.2%

FY25 SUD Clinical File Sections by CMHSP								
Section	**Barry**	**Berrien**	**Branch**	**Calhoun**	**Cass**	**Kalamazoo**	**St. Joseph**	**Van Buren**
Physician Coordination	90%	100%	81%	100%	100%	80%	58.7%	87%
Assessment	81%	89%	90%	90%	100%	94%	91.7%	100%
Treatment Plan/PCP	76%	92%	76%	88%	98%	78%	89.1%	97%
Progress Notes	99%	87%	99%	94%	100%	96%	69%	100%
Discharge	100%	100%	100%	75%	100%	100%	100%	80%
BHTEDS	73%	86%	73%	N/A	100%	50%	72.7%	86%
MDOC	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Women's Specialty Services	N/A	100%	N/A	N/A	100%	N/A	100%	N/A
Overall	84.8%	91%	84.8%	91%	99%	85.7%	76.5%	94%

SUD Clinical File Sections by Year Data is a combined average score for each section from all eight CMHSP Site Reviews.			
Section	**FY23 Scores**	**FY24 Scores**	**FY25 Scores**
Physician Coordination	91.1%	88.5%	87%
Assessment	75.6%	84.5%	92%
Treatment Plan/PCP	88.9%	87.4%	87%
Progress Notes	93.9%	91.5%	93%
Discharge/BH TEDS	88.8%	88.2%	94%
BH TEDS (starting FY25)	N/A	N/A	77%
MDOC	100%	66.7%	100%
Women's Specialty Services	100%	92.6%	100%

H. Credentialing and Re-Credentialing

Description

SWMBH either directly performed or ensured that the CMHSPs and network providers performed credentialing and re-credentialing in compliance with SWMBH's Credentialing and Re-credentialing policies, which are annually approved by the SWMBH Board of Directors. The credentialing process (inclusive of re-credentialing) ensured that organizations, physicians, and other licensed health care professionals were qualified to perform their services. SWMBH utilized standardized credentialing and re-credentialing applications throughout the Region to ensure consistent application of required standards and the applications are periodically reviewed by the Regional Provider Network Management Committee (RPNMC). These efforts help ensure improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time. Throughout FY25, SWMBH and its Participant CMHSPs participated in and complied with the State's Universal Credentialing process by training and beginning use of the State's CRM system for credentialing activities for specified providers.

SWMBH utilized a checklist to assist in processing credentialing applications. The checklist included, among other things, the following components for re-credentialing files:

- QI Data Check
    - Compliance Fraud/Waste/Abuse or other billing issues
    - Customer Services issues (other than formal Grievances/Appeals)
    - Utilization Management issues/concerns

SWMBH directly performed credentialing for the following in the network:

- Applicable SWMBH employees/contractors (individual credentialing)
- CMHSPs (organizational credentialing)
- SUD Providers (organizational credentialing)
- Autism Service Providers (organizational credentialing on behalf of the Region)
- Financial Management Service Providers (organizational credentialing on behalf of the Region)
- Crisis Residential Providers (organizational credentialing on behalf of the Region)
- Inpatient Psychiatric Service Providers (organizational credentialing on behalf of the Region)
- Large Specialized Residential Providers – Beacon, Residential Opportunities Inc. (ROI), Turning Leaf, and Hope Network
    - SWMBH performed organizational credentialing of each Specialized Residential Site, on behalf of the Region.

SWMBH delegated, under Delegation Memorandums of Understanding (MOUs), credentialing activities to the CMHSPs for the following:

- CMHSP network providers, other than those listed above.

SWMBH included credentialing requirements consistent with policies in the subcontracts with the CMHSPs, SUD providers, and network providers via the CMHSP-provider subcontract boilerplate, for the following:

- Compliance with SWMBH or CMHSP organizational re-credentialing activities, including provider timely submission of credentialing applications and proofs; and
- Provider completion of individual practitioner credentialing of directly employed/contracted staff.

Monitoring Activities - Licensed/Credentialed Staff

SWMBH and the CMHSPs monitored compliance with credentialing requirements through the annual Site Review process. Each Site Review included a file review of a sample of the provider's credentialing files. See the

Provider Network Monitoring section for additional information on the annual Site Review process. Additionally, SWMBH and the CMHSPs required clinician information for any clinician to be listed as a "rendering provider" in the applicable agency's billing system. This is another way SWMBH and the CMHSPs monitored to ensure licensed professionals were qualified to perform their services. While it is not "credentialing", when SWMBH received a request from a provider to have a clinician added to the billing system as a rendering provider, SWMBH performed basic screening checks including exclusions screening and licensure verification to ensure that the clinician was only assigned billing rights to service codes they were qualified to deliver.

Monitoring Activities – Non-Licensed Providers

SWMBH and the CMHSPs monitored non-licensed provider staff qualifications through the annual Site Review process. Standardized Site Review tools for all provider types included a Staff Training file review, which evaluated whether a sample of the provider's staff completed all required trainings within required timeframes. Standardized Site Review tools that were specific to providers employing non-licensed staff (example - Ancillary and Community Services tool) included review elements that evaluate the provider's process for ensuring non-licensed direct care staff met the minimum qualifications to perform their jobs as articulated in the Medicaid Provider Manual.

Through the annual Site Review process SWMBH ensured, regardless of funding mechanism:

- Staff (licensed or non-licensed) possessed the appropriate qualification as outlined in their job descriptions, including the qualifications for the following:
    - Education background
    - Relevant work experience
    - Cultural competence
    - Certification, registration, and licensure as required by law (where applicable)

FY25 Identified Barriers

Barriers, or challenges, identified include the magnitude of process changes. The MDHHS Universal Credentialing system was officially rolled out in early FY25 and is being used in the Region for applicable providers. There remain questions regarding this process, and our Region and MDHHS have been communicative. Additionally, the recredentialing timeframe was extended from two (2) years to three (3) years beginning FY25. This was implemented across the Region.

Improvement Efforts Made in FY25

SWMBH provided training to the region related to credentialing and re-credentialing in the RPNMC meeting on 7/18/25. MDHHS provided training on use of the BH CRM for credentialing for the region on 10/22/24, 10/28/24, and 10/30/24. On 11/13/24 a follow up meeting was held to help answer any remaining questions related to the BH CRM or the universal credentialing process. SWMBH also participates in MDHHS's universal credentialing workgroup. MDHHS updated their credentialing policy at the beginning of FY25 and SWMBH updated its policy and the CMHSP Site Review tool. SWMBH notified network providers of the Universal Credentialing process and resources in January 2025.

FY25 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY24	FY25	Eval Score	FY26 Recommendations
SWMBH will provide training and technical assistance to participant CMHSP staff responsible for completing credentialing.	RPNMC	Annually	Met – Training occurred on 10/20/24, 10/22/24, 10/28/24, and 10/30/24	Met – Training occurred on 07/18/2025; additional State led trainings on universal credentialing occurred	**5**	SWMBH will continue current activities to utilize the MDHHS CRM for Universal Credentialing and provide technical assistance to Participant CMHSPs and network Providers as needed.
The credentialing and re-credentialing requirements will be reviewed for each CMHSP during the administrative and delegated Site Reviews.	Delegated Admin Function Review Tool	Annually	Combined Average from 8 FY24 CMHSP Site Reviews 96.3%	Combined Average from 8 FY25 CMHSP Site Reviews 96.9%	**5**	Continue to monitor.

I. Clinical Practice Guidelines

Description

SWMBH reviews, disseminates, and implements clinical practice guidelines that are consistent with the regulatory requirements of MDHHS Specialty Services Contract and Medicaid Managed Care rules. SWMBH and its Medicaid subcontracted provider network have adopted these guidelines and SWMBH assures that information related to the guidelines is made available to beneficiaries and providers.

It is policy that the employees of SWMBH, the CMHSPs, and the provider network must ensure that decisions with respect to utilization management, beneficiary education, coverage of services, and other areas are consistent with the MDHHS Practice Guidelines, found here:
https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines

SWMBH's Clinical Protocols and Practice Guidelines meet the following requirements:

- Are based upon valid and reliable clinical evidence or a consensus of healthcare professionals in the field.
- Consider the needs of SWMBH beneficiaries.
- Are adopted in consultation with contracting providers and staff who utilize the protocols and guidelines.
- Are reviewed and updated periodically as needed, with final approval by the Medical Director and/or SWMBH's Director of Quality Management and Clinical Outcomes.
- Guidelines are disseminated to all applicable providers through provider orientation/the provider manual, and to beneficiaries upon request.
- Guidelines are posted on the SWMBH website and are referenced in the provider and member handbooks.
- Implementation of new guidelines and/or review of existing guidelines is published in the provider and member newsletters.
- Any decisions with respect to utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

All practice guidelines adopted for use are available on the SWMBH website and include:

- Inclusion Practice Guideline
- Person-Centered Planning Practice Guideline
- Housing Practice Guideline
- Consumerism Practice Guideline
- Personal Care in Non-Specialized Residential Settings Practice Guideline
- Family-Driven and Youth-Guided Policy and Practice Guideline
- The Employment Works! Policy

Practices Guidelines are adopted, developed, and implemented by the SWMBH Regional Clinical Practices Committee (RCP), which consists of representatives from SWMBH and the eight CMHSPs in Region 4. This group works together to decide which guidelines are most relevantly matched to the individuals in this region by eliciting responses from CMHSP representatives who are close to the issues. They ensure that the essence and intention of these guidelines are filtered through the behavioral health system via meaningful discussion, policy, procedure, training, and auditing/monitoring. Practice guidelines are monitored and evaluated through SWMBH's site review process to ensure CMHSP participants and SUD providers, at a minimum, are incorporating mutually agreed upon practice guidelines within the organization via measures agreed upon by leadership across the region.

Audits are conducted and reviewed as part of SWMBH's annual clinical audit process, or delegated to the CMHSPs, as required by SWMBH. Practice Guidelines and the expectation of their use are included in provider contracts. Practice guidelines are reviewed and updated annually or as needed and are disseminated to appropriate providers through relevant committees, councils, and/or workgroups.

FY25 Identified Barriers and Analysis

Practice Guidelines, Standard XI, was evaluated in FY25 as part of the HSAG External Quality Review (EQR) Compliance Review. The standard received 100% and all 7 of the elements within the standard were met. However, there was one recommendation, to ensure that SWMBH has a process to obtain SUD provider feedback, as appropriate, when reviewing and adopting SUD practice guidelines. This recommendation will be addressed in the FY26 QAPIP goals.

Improvement Efforts Made in FY25

The Clinical Quality CMHSP site review tool was updated in FY24 to better evaluate the effectiveness and implementation of the Person-Centered Planning process. The site review elements were assessed for clarity, content, purpose and were aligned with appropriate standards and regulations. All remediation approaches have been focused on systemic improvements across populations and service lines. The RCP Charter includes goals to improve the Person-Centered Planning Process and clinical documentation. Improvement strategies, resources, exemplary case examples, and best practices are shared in this committee to facilitate regional alignment with practice guidelines. These combined efforts have led to improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time in the region. The improvement efforts are further evidenced by the FY25 annual Clinical Quality CMHSP site review results. There was significant improvement in the total scores for 7 of the 8 participant CMHSPs. The average results for the FY25 site review for the Person-Centered Planning section of the site review tool was 90.92% which was a great improvement from FY24, which was 87.55%.

FY25 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY25	Eval Score	FY26 Recommendations
SWMBH will evaluate the region's effectiveness in demonstrating the Person-Centered Planning Practice Guideline during the Administrative and Delegated Function Site Reviews.	Clinical Quality Review Tool	Annually	Met	**5**	The Clinical Quality CMHSP site review tool evaluates implementation of the Person-Centered Planning process. As this is an area that is evaluated and measured annually and will continue to be. Therefore, it is recommended that this be removed as a goal for FY26.
SWMBH, with the CMHSPs, will develop improvement strategies to address any deficiencies and identify goals to improve the Person-Centered Planning Process in FY25.	RCP	Quarterly	Met	**5**	Any area that scores less than 90% requires remediation or corrective action plan development. This is an area that showed great improvement for the region overall. The goal will continue in FY26 so any deficiencies or trends can be evaluated, addressed or remediated collaboratively as a region.

J. Care Management Program

Description

SWMBH provides a robust care management program to all Medicaid beneficiaries with behavioral health needs who require intensive care management, including but not limited to, child and adult beneficiaries who have significant behavioral health issues and complex physical comorbidities.

The purpose of SWMBH's care management program is to help beneficiaries gain optimal health outcomes, improve functional capacity, and support whole-person recovery. Care management includes but is not limited to care planning, preventative health education, patient communication, medication management, risk stratification, and population management. Care coordination between behavioral and physical health providers is an essential competent of care management involving the organization, coordination, and communication of healthcare services for beneficiaries.

SWMBH works with the Medicaid Health Plans (MHPs) to own joint care management responsibilities with shared MHP beneficiaries, consistent with MDHHS policy and contractual direction. Monthly integrated care team (ICT) meetings are held with the MHPs represented in Region 4 to address the needs of beneficiaries with multiple or complex conditions as well as high ED use and inpatient (IP) admissions. Mutually shared beneficiaries are identified through risk stratification conducted in CareConnect 360 (CC360). An Integrated Healthcare Specialist provides comprehensive assessment of the beneficiary's condition, determination of available benefits and resources, and development and implementation of a care management plan with patient-centered goals, monitoring, and follow-up in conjunction with the MHP care management teams. An integrated care plan is created in CC360 to monitor care coordination activities and health outcomes.

Transition of care monitoring is a key component of care management that focuses on closely monitoring and supporting beneficiaries as they move between different care settings, such as moving from an inpatient admission to the community, ensuring a smooth transition and minimizing potential complications by providing coordinated care during these critical periods. Discharge planning is an integral part of treatment. Consideration of the continuum of care and long-term recovery needs of the member should direct transition planning. Transition of care monitoring intends to improve quality of care, improve outcomes and control costs by assuring plan coordination in which primary and specialty mental health, SUD, and healthcare providers inform each other regarding their treatment of an individual and collaboration on beneficiary needs.

To further bolster performance measures including FUH and FUA, SWMBH employs grant funded Transition Navigators. The SWMBH UM department identifies beneficiaries not actively engaged in services with a CMHSP, Certified Community Behavioral Health Clinic (CCBHC), or SUD treatment program that, if not otherwise engaged in aftercare, would have a high risk of readmission following an IP admit or ED visit. Transition Navigators conduct outreach to promote treatment engagement, eliminate barriers to engagement, link beneficiaries to resources as needed, and provide health education.

FY25 Identified Barriers and Analysis

It can be difficult to adequately address some of the MHP-PIHP shared metrics with data exchange limitations. Not all the necessary information is available in CC360 to take meaningful action in the appropriate time frames, specifically regarding the following metrics: Initiation and Engagement of Substance Use Disorder Treatment (IET) and Follow-Up After Emergency Department Visit for Substance Use (FUA). There are also challenges when there are multiple health plans or payers involved and providers and/or hospitals do not have clarity with whom to alert so care coordination may occur timely. SWMBH has taken steps to mitigate some of the challenges with our data analytics team and will further evaluate the regional performance for Initiation and Engagement of

Substance Use Disorder Treatment to identify interventions to improve the metric.

Improvement Efforts Made in FY25

SWMBH uses Relias Population Performance for identifying high risk members with multiple hospitalizations, ED visits, chronic conditions, and/or quality of care concerns (e.g., flagging CMS Core Set metrics and or flagging risk measures such use of an antipsychotic at a higher than recommended dose, concurrent use of opioids and benzodiazepines, or failure to refill antidepressant medications). Care managers can use Relias Population Performance to identify and outreach individuals who need follow-up care or would benefit from care coordination.

As transition of care monitoring is a key component of care management, SWMBH monitors hospital admissions and discharges to ensure immediate outreach and continuity between physical and behavioral health services. The Utilization Management department identifies beneficiaries have a high risk of readmission following an IP admit or ED visit and refers those individuals to the Transition Navigators who help the identified beneficiaries by conducting outreach, promoting treatment engagement, reducing barriers to engagement, linking beneficiaries to, and providing health education. In FY25, Transition Navigators received 719 referrals. A result of the efforts was that 572 beneficiaries attended an aftercare appointment after being discharged from an Inpatient Psychiatric hospitalization, SUD Residential treatment or following and Emergency Department visit.

SWMBH has established joint care processes with each MHP in the Region to ensure clear expectations for referrals, information sharing, and coordination. SWMBH and MHPs jointly use MDHHS's easy risk stratification tool in CareConnect360 to identify members who require joint care plans to monitor care coordination activities and health outcomes. These plans address medical, behavioral, and social determinants of health (SDOH) needs, ensuring that the beneficiary's care team works from a unified, person-centered plan. According to the Joint Care Management Metric on the FY25 Performance Bonsu Incentive Pool (PBIP), SWMBH must document Joint Care Plans for at least 25% of qualified adult enrollees. In FY25, SWMBH set a goal that we would meet or exceed that benchmark. The results are that SWMBH documented 76.92% qualified adult enrollees.

FY25 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY25	Eval Score	FY26 Recommendations
SWMBH will create an audit system to track the number of complex cases identified by risk stratification delineated by MHP, the number of cases presented for discussion in monthly ICT meetings, and the volume of cases having a care plan in CC360. This will aid SWMBH to meet or exceed the benchmark expectation that 25% of complex beneficiaries identified through risk stratification will also have a joint care plan created or updated in CC360.	ICT meetings, RCP, SWMBH Departmental Meetings	Quarterly	Met	**5**	SWMBH will continue to produce a monthly CC360 Adult Easy Tab Risk Stratification member report. SWMBH will assess members with open/closed ICP's and delineate by MHP cases that will be recommended for integrated health care coordination based on CC360 Adult Easy Tab Risk Stratification criteria. Additional assessment of integrated care plans activity will be conducted by producing a monthly CC360 ICP Analysis report that generates the status of all care plans and provides MHP case stratification findings.
SWMBH will create a care coordination procedure detailing use of CC360 risk stratification to identify enrollees 18 and under, shared by both PIHP and MHP, who have significant behavioral health issues and complex physical care needs.	RCP and shared via Provider Newsletter	Annually	Met	**4**	SWMBH will continue to produce a monthly CC360 Child Easy Tab Risk Stratification member report. SWMBH will assess members with open/closed ICP's and delineate by MHP cases that will be recommended for integrated health care coordination based on CC360 Child Easy Tab Risk Stratification criteria. Additional assessment of integrated care plans activity will be conducted by producing a monthly CC360 ICP Analysis report that generates the status of all care plans and provides MHP case stratification findings.

SWMBH will establish a care coordination procedure to facilitate plan-level referrals between both PIHP and MHP which follows the agreed upon workflow created in the PIHP-MHP Referral Subgroup.	RCP, RUM	Annually	Met	**4**	SWMBH utilizes the CareConnect360 Referral job aid regarding case identification - coordination. The purpose of this job aid is to assist Medicaid Health Plan (MHP), Prepaid Inpatient Health Plan (PIHP), and Community Mental Health Service Provider (CMHSP) users with understanding the CareConnect360 Referral process. Each referral's workflow is determined by the type of user who initiated it. The active recipient of an MHP-initiated referral is the CMHSP. Therefore, the CMHSP user can Accept or Return the referral, while the PIHP user has read-only access to the referral. Conversely, the active recipient of a CMHSP or PIHP-initiated referral is the MHP, so the MHP can Accept or Return the referral. SWMBH has a designated Referral Administrator with the ability to access all referrals for the organization. This is presently a manual process that is evaluated on a weekly basis. The present referral data built by MDHHS IT provider Optum does not provide a referral alert. The goal is for both CMHSP and PIHP users to have the ability to Accept or Return an MHP initiated referral. This is planned for a future release, at which time the MDHHS referral training job aid will be updated accordingly.

K. Long-Term Services and Supports (LTSS)

Description

Long term services and supports refers to services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting (42 CFR 438.2). LTSS are provided to persons with disabilities who need additional support due to: (42 CFR §438.208(c)(1)(2)):

- Advancing age; or
- Physical, cognitive, developmental, or chronic health conditions; or
- Other functional limitations that restrict their abilities to care for themselves; and
- Receive care in home and community-based settings or facilities such as nursing homes.

MDHHS identifies Medicare and Medicaid participants in its Home and Community Based Service (HCBS) Waivers as recipients of LTSS. SWMBH manages funding for Michigan's specialty behavioral health Medicaid population through delegation and contracting with the eight CMHSPs and their provider networks in Region 4.

SWMBH is dedicated to ensuring the quality and appropriateness of care to all beneficiaries, however, persons receiving LTSS are some of the most vulnerable beneficiaries, therefore additional quantitative and qualitative analyses of the quality and appropriateness of care for the LTSS populations in Michigan are warranted. The quality, availability, and accessibility of care furnished to beneficiaries receiving LTSS is quantitatively assessed using an analysis of LTSS sections in the annual Customer Satisfaction Survey. SWMBH has incorporated survey questions that help to identify individuals who are receiving LTSS which allows for a separate analysis of the LTSS population.

The annual CMHSP site review tool that is utilized in Region 4 also includes items to monitor the quality and appropriateness of care for beneficiaries receiving LTSS. Aggregated annual audit outcomes are regularly monitored and analyzed by the Quality Management and Clinical Outcomes Department at both the CMHSP and PIHP levels. Results are used to inform annual provider training that is offered to the LTSS provider network. Additional quality improvement training is provided at the CMHSP level as needed or required. Future training topics will include developing a regional approach to assess care between settings. These combined efforts have supported community integration of LTSS beneficiaries and lead to improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time in the region.

FY25 Identified Barriers and Analysis

Establishing a state-wide approach to the following areas would help ensure each PIHP is operating with consistency and maximizes efficiency. Those areas are - having an established definition of LTSS members that is consistent with CMS, standard expectations to assess care between settings, and utilizing any of the CMS defined LTSS specific quality measures. Additionally, having a consistent comprehensive list of all LTSS services and corresponding CPT codes would aid the regions in identifying LTSS recipients and ensure there is a consistent statewide understanding of LTSS services and oversight.

According to the FY25 Customer Satisfaction Survey results, LTSS outcomes were favorable for youth but were not for adults within the Access and Outcomes domains. This was a change from the FY24 Survey results which showed that there were better scores in all domains for adult and child LTSS recipients. It is important to note that results may be due to a survey error leading to potential misclassification of LTSS consumers. However, the reduction in satisfaction for the adult LTSS population will still be evaluated to identify any other contributing factors and areas for improvement.

Improvement Efforts Made in FY25

Aggregated annual CMHSP Site Review outcomes are monitored and analyzed by the Clinical Outcomes and Quality Management department. A comparative analysis of the clinical file reviews was done to evaluate trends between FY24 and FY25. The results are used, in part, to evaluate community integration efforts and assess quality of care. Assessment of care between settings was a consultative item added to the annual CMHSP clinical quality site review tool in FY24 to help establish a better understanding of how CMHSPs are assessing and documenting that and was a scored item during the FY25 site reviews. During the FY25 CMHSP Site Reviews, the service utilization trends were evaluated to ensure that services are delivered in the appropriate amount, scope, and duration as specified in the Person-Centered Plan. The clinical file reviews evaluated whether a level of care assessment was completed at least annually and when there was a significant change in a beneficiary's life, which may include a change in setting for LTSS recipients. CMHSPs that performed under the 90% threshold according to the SWMBH review tool were required to implement corrective action plans in these areas.

Year 2 of the 3-year HSAG External Quality Review (EQR) Compliance Review cycle includes 3 out of 24 elements within Standard XIII, Quality Assessment and Performance Improvement Program, specifically related to the assessment, coordination, and quality of care for LTSS recipients. SWMBH received a score of 100% for Standard XIII in the FY25 EQR Compliance Review audit.

While researching approaches to strengthen the quality and appropriateness of care for members receiving LTSS, SWMBH reviewed materials for a variety of sources that spoke about the role of unpaid caregiving in the lives of LTSS beneficiaries. Many beneficiaries are supported by family members who eventually burn out or become injured. This has impacts on the beneficiary and the family, often resulting in the need for a higher level of care, and facility or institutional placement for the beneficiary. Considering those circumstances, respite support was identified as a highly effective service, as they offered support for unpaid caregivers, reduced the risk of burn-out and injury, and were a cost-effective way to keep people served in their family homes in the community. SWMBH employed approaches to strengthen the use and awareness of respite services as an effort to address components of the national strategy in FY25. In July 2025 an article titled, "The Power of Respite: Supporting Families & Enhancing Lives," was sent with SWMBH's Member Newsletter. The article provided an overview of respite care, how it is used, intended outcomes, and a local member success story.

Adult LTSS consumers reported worse Access & Outcomes scores than non-LTSS adults*

Dark green denotes the percentage of LTSS (long-term social services) consumers in agreement for that construct's items
Gray bars denote the likely range where the true percentage for all LTSS consumers might lie (i.e., margin of error*)

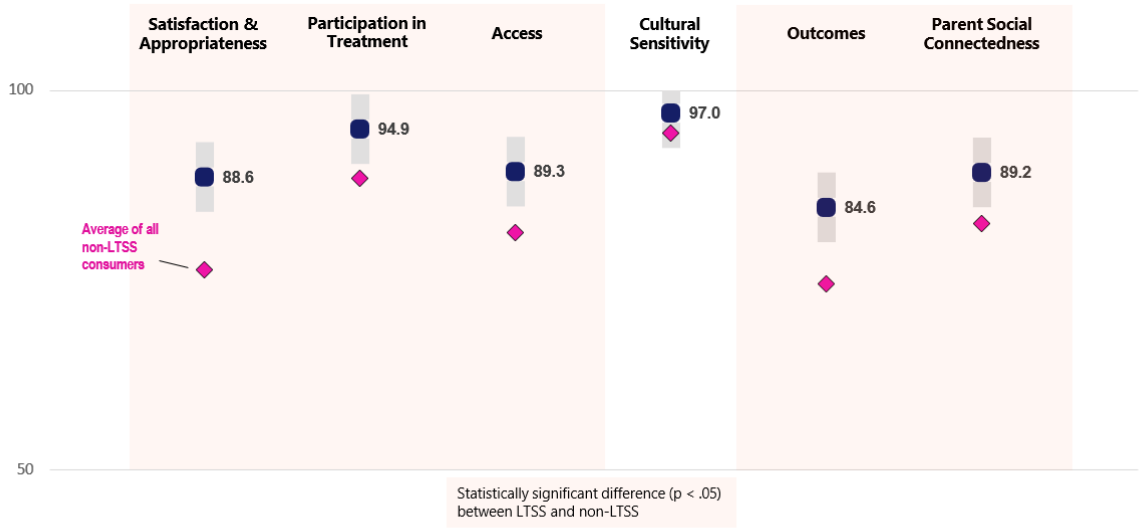
Statistically significant difference (p < .05) between LTSS and non-LTSS

*result may be due to survey error leading to potential misclassification of LTSS consumers

margin of error for **LTSS** adults: ±4.2 pts (n = 536)
margin of error for **non-LTSS** adults: ±3.0 pts (n = 1,067)

Youth LTSS families report better scores in all constructs except cultural sensitivity in the 2025 YSS

Dark blue denotes the percentage of LTSS (long-term social services) consumers in agreement for that construct's items
Gray bars denote the likely range where the true percentage for all LTSS consumers might lie (i.e., margin of error*)



Statistically significant difference (p < .05) between LTSS and non-LTSS

*margin of error for **LTSS** youth: ±4.6 pts (n = 457)
margin of error for **non-LTSS** youth: ±7.1 pts (n = 191)

FY25 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY25	Eval Score	FY26 Recommendations
SWMBH will use the Customer Satisfaction Survey results to assess the quality, appropriateness, availability, and accessibility of care of beneficiaries receiving LTSS. Improvement areas will be identified based on the analysis of the results in Q4 of FY25.	QMC, RCP	Annually	Met	**5**	According to the FY25 Customer Satisfaction Survey results, LTSS outcomes were favorable for youth but were not for adults within the Access and Outcomes domains. It is important to note that results may be due to a survey error leading to potential misclassification of LTSS consumers. The reduction in satisfaction for the adult LTSS population will still be evaluated to identify any other contributing factors and areas for improvement. It is recommended that this goal continue for FY26.
SWMBH will evaluate the number of Respite encounters utilized to establish a baseline of LTSS Respite service utilization. SWMBH will provide education to increase awareness of the benefit of Respite services through Regional Committees and using the member newsletter by providing a description of Respite services, and featuring a beneficiary success story from using Respite supports, by Q4 of FY25.	RCP, RUM, RPNMC, and shared via Member Newsletter	Annually	Met	**4**	Respite service utilization data was evaluated throughout FY25, however the data did include the entire population and not just LTSS members. Regional education was provided and there is no concern that Respite is an underutilized service. This data will continue to be evaluated. It is recommended that the goal does not continue for FY26.

L. Utilization Management (UM)

Description

The purpose of the Utilization Management Program is to maximize the quality of care provided to beneficiaries while effectively managing the Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports Waiver, SED Waiver, Child Waiver, and SUD Community Grant resources of the Plan while ensuring uniformity of benefit. In FY25, SWMBH was responsible for monitoring the provision of delegated UM managed care administrative functions related to the delivery of behavioral health and SUD services to beneficiaries enrolled in Medicaid, Healthy Michigan Plan, Flint 1115 Waiver, Autism Benefit, Habilitation Supports Waiver, SED Waiver, Child Waiver Program, SUD Community Grant, and individuals accessing services at a designated CCBHC. SWMBH ensures adherence to UM related statutory, regulatory, and contractual obligations associated with MDHHS Medicaid Specialty Services and SUD contracts, Medicaid Provider Manual, mental health and public health codes/rules and applicable provisions of the Medicaid Managed Care Regulations, the Affordable Care Act and 42 CFR. Per 42 CFR §438.210(a)(1) the PIHP must identify, define and specify the amount, duration, and scope of each service must be furnished in an amount, duration, and scope for the same services furnished to members under Fee For Service (FFS) Medicaid, as set forth in §440.230, and for members under the age of 21, as set forth in subpart B of part 441.

The utilization management program consists of functions that exist solely to ensure that the right person receives the right service at the right time for the right cost with the right outcome while promoting recovery, resiliency, integrated, and self-directed care. The most important aspects of the utilization management plan are to effectively monitor population health and manage scarce resources for those persons who are deemed eligible while supporting the concepts of financial alignment and uniformity of benefits. Ensuring that these identified tasks occur is contingent upon uniformity of benefit, commonality and standardized application of Intensity of Service/Severity of Illness criteria and functional assessment tools across the Region, authorization and linkage, utilization review, sound level of care and care management practices, implementation of evidenced based clinical practices, promotion of recovery, self-determination, involvement of peers, cross collaboration, outcome monitoring and discharge/transition/referral follow-up.

Utilization Management Activities

Based on an annual review by SWMBH cross collaborative departments utilizing clinical and data model audits, an annual Utilization Management Program is developed, and UM oversight and monitoring activities are conducted across the region and provider network to assure the appropriate delivery of services. Participant CMHSP's are delegated most utilization management functions for mental health under their Memorandum of Understanding (MOU) and some CMHSP's are delegated UM functions for a limited scope of SUD services. SWMBH provides, through a central care management process, UM functions for all services delivered by SUD providers and all acute/high intensity SUD services inclusive of Withdrawal Management, Residential, and Medication for Opioid Use Disorder (MOUD)/Methadone. Based upon the UM Program review, annual audits, and report findings, modifications are made systemically through the UM annual work plan/goals and policy/procedure. Specific changes may be addressed through corrective action plans with the applicable CMHSP's, providers, or SWMBH departments.

Provider Network practitioners and participant CMHSP clinical staff review and provide input regarding policy, procedure, clinical protocols, evidence-based practices, regional service delivery needs, and workforce training. Each CMHSP is required to have their own utilization management/review process. SWMBH's Medical Director and a Physician board-certified in addiction medicine, meet weekly with SWMBH UM staff to review challenging cases, monitor trends in service, and provide oversight of application of medical necessity criteria. Case consultation with the Medical Director, who holds an unrestricted license, is available 24 hours a day. SWMBH provides review of over and underutilization of services and all delegated UM functions. Inter-rater reliability testing is conducted annually for any SWMBH clinical staff making medical necessity determinations through the

centralized care management or outlier management processes.

Coordination and Continuity of Care

SWMBH is committed to ensuring each beneficiary receives services designed to meet each individual specific health need as identified through a functional assessment tool and a Biopsychosocial Assessment. The screening and assessment process contains mechanisms to identify needs and integrate care that can be addressed with specialty behavioral health and SUD treatment services, as well as integrated physical health needs and needs that may be accessed in the community including but not limited to, employment, housing, and financial assistance. The assessment is completed or housed in a uniform managed care information system with collection of common data elements which also contains a functional assessment tool that generates population-specific level of care guidelines. To assure consistency, the tools utilized are the same version across the SWMBH region and include the Level of Care Utilization System (LOCUS) for Adults with Mental Illness or Co-Occurring Disorder, Michigan Child and Adolescent Needs and Strengths (MichiCANS) for identifying the needs of the child/youth and family, and the American Society for Addiction Medicine-Patient Placement Criteria (ASAM-PPC) for persons with a substance use disorder. Effective March 2023, MDHHS made the decision not to renew the contract to continue use of the Supports Intensity Scale (SIS) as a level of care assessment tool for individuals with Intellectual and Developmental Disabilities. The decision was made by MDHHS to utilize the World Health Organization Disability Assessment Schedule (WHODAS); however, this was not planned to be implemented until October 1, 2025, for FY26. Components of the assessments generate a needs list which is used to guide the treatment planning process. Assessments are completed by appropriately trained and credentialed clinical professionals. Treatment plans are developed through a person-centered planning process with the beneficiary's participation and with consultation from any specialists providing care to the individual.

SWMBH ensures adherence to statutory, regulatory, and contractual obligations through four primary Utilization Management Functions.

1. Access and Eligibility: To ensure timely access to services, SWMBH provides oversight and monitoring of local access, triage, screening, and referral (see SWMBH Policy - Access Management). SWMBH ensures that the Access Standards are met, including MMBPIS indicators.
2. Clinical Protocols: To ensure Uniform Benefit for beneficiaries, consistent functional assessment tools, medical necessity criteria, level of care tools, and regional clinical protocols have been or will be identified and implemented for service determination and service provision (see Policy Clinical Protocols and Practice Guidelines).
3. Service Authorization: Service Authorization procedures will be efficient and responsive to beneficiaries while ensuring sound benefit management principles consistent with health plan business industry standards. The service determination/authorization process is intended to maximize access and efficiency on the service delivery level, while ensuring consistency in meeting federal and state contractual requirements. Service authorization utilizes level of care principles in which intensity of service is consistent with severity of illness.
4. Utilization Management: Through the outlier management and level of care service utilization guidelines for behavioral health and outlier management, level of care service utilization guidelines and central care management processes for substance use disorders, an oversight and monitoring process is utilized to ensure utilization management standards are met, such as appropriate level of care determination and medically necessary service provision and standard application of Uniformity of Benefit (see SWMBH Policy - Utilization Management).

The SWMBH Utilization Management plan is designed to maximize timely local access to services for beneficiaries while providing an outlier management process to reduce over and underutilization (financial risk) for each partner CMHSP and the substance use disorder provider network. The Regional Utilization

Management Plan endorses two core functions:

1. Management of identified high cost, high risk service outliers or those with under-utilized services.
2. The Outlier Management process provides real-time service authorization determination and applicable appeal determination for identified service outliers. The policies and procedures meet accreditation standards for the SWMBH Health Plan for Behavioral Health services (Specialty Behavioral Health Medicaid and SUD Medicaid and Community Grant). Service authorization determinations are delivered real-time via a managed care information system or a telephonic review process (prospective, concurrent, and retrospective reviews). Outlier Management and level of care guideline methodology is based upon service utilization across the region. The model is flexible and consistent based upon utilization and funding methodology. Oversight and monitoring of delegated specialty behavioral health UM functions.

The Utilization Review (UR) process uses a monthly review of outlier management reports and an annual review with specialized audit tools that monitor contractual, statutory, and regulatory requirements. The reports and UR tool speak to ensuring intensity of service matching level of care with services and typical service utilization as well as any additional external audit findings (MDHHS, HSAG, etc.). Should any performance area be below the established benchmark standard, the Utilization Review process requires that a Corrective Action Plan be submitted to address any performance deficits. SWMBH staff monitor the implementation of the Corrective Action Plans.

The outlier management process and subsequent reports to manage it, including over- and under-utilization and uniformity of benefit, are based on accurate and timely assessment data and scores of agreed tools and service determination transactions being submitted to the SWMBH warehouse, implementation of level of care guidelines, and development of necessary reports for review. These combined efforts have led to improvements in the quality of health care and services for beneficiaries, service delivery, and health outcomes over time in the region.

FY25 Identified Barriers and Analysis

Throughout FY25, the Regional Utilization Management Committee waited for direction that would impact the PIHPs and CMHSPs across the state related to the HCBS Conflict Free Access and Planning (CFAP) requirements. No clear guidance or implementation plan was provided in FY25. The WHODAS was identified as the SIS replacement and will be used to determine eligibility for the 1915 iSPA benefit. It has not yet been implemented but SWMBH has representation on the steering committee to assist with rolling out the tool effectively.

Quarterly denial file reviews continued with the CMHSPs and meetings were added to individually discuss the findings with each county. With FY25 Qtr. 1, the CMHSPs were requested to self-score their samples on the regional denial file review tool. This was submitted and accepted as a Corrective Action Plan for Health Services Advisory Group (HSAG) for Standard 6. FY25 Qtr. 1, one (1) CMHSP completed the self-review, but by Quarter 4, SWMBH received four (4) out of eight (8) submissions from the region. The purpose of the self-reviews and ongoing meetings following each quarter was to encourage additional internal oversight and monitoring with staff who are consistently making errors being discovered during the review process.

Improvement Efforts Made in FY25

A UM workgroup was created in April 2025 to ensure consistency in Utilization Management practices and uniformity in benefit application. One of the purposes was to review the Level of Care (LOC) thresholds, identify issues that may be related to UM processes, provider or clinical documentation, and analyze the outlier data to evaluate the possible overutilization of some services. As a result of the outlier analysis, the regionally developed LOC Core Service Menu was adjusted to require all CLS authorization requests for code H2015 requires manual review. To help with regional consistency and support clinical justification for CLS

authorizations, population specific CLS calculation tools were developed. The workgroup developed into a regionally supported UM practices quality improvement strategy.

After seeing a lack of improvement in FY24 with the quarterly denial file reviews, the decision was made to schedule quarterly meetings with the CMHSPs to discuss their findings and offer feedback and technical assistance. Through the self-assessments and walking through samples during meetings, the denial file scores saw a substantial improvement. For FY24 Qtr. 4, there was a regional average of 79.48% which increased to 90.15% for FY25 Qtr. 3. Every CMHSP in Region 4 had an increase in their scores.

FY25 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY25	Eval Score	FY26 Recommendations
SWMBH will aggregate and review UM data to identify trends and service improvement recommendations, identify best practice standards and thresholds, to ensure valid and consistent UM data collection techniques through the Annual CMHSP Clinical Quality Site Review Process. SWMBH will identify and/or develop relevant UM Reports to share with the Region to help monitor utilization and uniform benefit using data informed practices.	RUM, RCP	Quarterly	Met	**5**	A quarterly report review schedule was developed to ensure RUM and RCP were regularly discussing UM data to identify trends and improve service delivery. It is recommended that this goal continues for FY26.
SWMBH will ensure regional IRR audits are completed for consistent application and understanding of authorization of uniform benefits and medical necessity benefit criteria. ▪ IRR monitoring will continue during the annual site review process to ensure it is being completed to ensure consistent application and use of the LOCUS. The LOCUS tableau report will be utilized to review trends by assessor by CMHSPs and discussed quarterly in Regional Committees	RUM, RCP	Annually and Quarterly	Met	**5**	The CMHSPs were provided the reports to evaluate. SWMBH met with LOCUS fidelity team to understand best practices and implement consistent practices with LOCUS overrides. IRR monitoring was completed during the annual site review in FY25. Recommending this goal be removed for FY25. It is an ongoing part of the site review process and PIHP CMHSPs have mechanisms to ensure consistent application of review criteria for authorization decisions. The PIHP ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's condition. There is a formal training plan for use of the Level of

					Care Utilization System (LOCUS) and MCG (for pre-admission screenings for hospitalization, crisis residential, and partial hospitalization).
SWMBH will review Service Authorization Denial files for trends, ongoing through the end of FY25. ▪ Service authorization denial trends will be reviewed quarterly. CMHSPs and SWMBH will complete quarterly denial monitoring meetings.	RUM, Regional Customer Service Committee	Quarterly	Met	**5**	SWMBH met with all 8 CMHSPs to discuss the service authorization denial files that were done at the end of quarters 1-3. Quarter 4 data has been received but the data is being reviewed and will not be final and reviewed with each CMH until the end of January. From these efforts there was great improvement across the region. Quarter 4 of FY24, the regional average was 79.48% and Quarter 3 of FY25 the regional average is 90.15%. It is recommended that this goal continues in FY26 to ensure improvements continue as this has proven to be a successful practice.

M. Customer Services

Description

SWMBH's Customer Services Department provides a welcoming environment and orientation to services. This includes providing beneficiaries with information about benefits, available providers in network, and how to access behavioral health, substance use disorder, primary health, and other community resources. Customer Services assists beneficiaries with obtaining information on how to access their due process rights when services are denied, reduced, suspended, or terminated. This includes helping beneficiaries with the Grievance and Appeal (G&A) process. Customer Services tracks and reports patterns of problems for each organization and regionally. This trending information is reviewed quarterly at regional committees and annually with the Board. Customer Service also addresses information requirements and enrollee rights and protections. This includes how materials are presented and provided to beneficiaries. It also ensures beneficiaries receive interpretation services and translated documents when requested. Enrollee rights and protections address how beneficiaries are entitled to be treated.

SWMBH delegates Customer Service functions including information requirements, enrollee rights and protections, due process, grievances, and appeals to the CMHSPs. As such, a MOU between SMWBH and each CMHSP is implemented. The MOU specifies the delegated functions and expectations of the CMHSP. Adherence to the MOU is crucial to ensure all beneficiaries have access to customer service rights. This ensures federal and state requirements are met, while ensuring the services are provided in a uniform manner throughout Region 4 for continuity of care.

SWMBH contracts with a Veteran Navigator. Customer Service has provided oversight of this position since 2023. Their role is to listen, support, offer guidance, and help connect Veterans to services they need. The Veteran Navigator facilitates and attends community outreach events throughout the region to increase awareness and connection to services.

FY25 Identified Barriers

Goal 1:

- SWMBH initiated a project that reviewed intake and member facing materials from all CMHSPs. This project was greatly scaled back due to seven of the eight CMHSPs being CCBHCs and not subject to managed care regulations.
- The announcement of the PIHP competitive bid procurement instilled uncertainty regarding future areas of responsibility. This made it difficult to construct and implement the project.

Goal 2:

- MDHHS Conflict-Free Access and Planning implementation timeline has changed, and the department has not released guidance on the implementation requirements or current timeframe.

Goal 3:

- The DHHS templates contained formulas that had errors.
- Managed Care Program Annual Report (MCPAR) data must be pulled manually.

Improvement Efforts Made in FY25

Goal 1:

- Training was provided by a professional, external company regarding updates to 1557 regulations.
- SWMBH was able to review all intake and member-facing materials of the CMHSPs and provide feedback and recommendations for updates to the materials to meet requirements.

Goal 2:

- This goal was not achievable in FY25 due to a change in implementation timeframe. The goal will be removed until further guidance is received.

Goal 3:

- SWMBH and the regional CMHSPs reviewed data trends quarterly at regional committee meetings.
- Quarterly file reviews are completed with each CMHSP, reviewing a sample of grievance and appeals to ensure compliance with regulations.
- MCPAR data was reviewed at the regional committee meeting for trends for FY24.

FY25 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY25	Eval Score	FY26 Recommendations
Regional Customer Service Committee will ensure all member facing materials meet state and federal requirements, including updates to 1557 by end of FY25. This will include but not limited to all brochures, SWMBH and CMH websites, informational materials, privacy practices, intake paperwork such as consent to treat, all letters and notices provided to members, and 1557 training.	Regional Customer Service Committee	Quarterly	Met	**4**	Ensuring member materials meet federal requirements and contractual obligations will be an on-going area of focus at the regional and local level as long as managed care functions are delegated. This will be monitored though annual site reviews and quarterly file reviews of grievances and appeals.
Plan and implement Conflict-Free Access and Planning (CFAP) requirements to Customer Service such as notices and letters for members as well as any informational materials in FY25. ▪ Review guiding documents from MDHHS when released for customer service (member materials/documents), grievance appeal, veteran navigator, and access requirements. ▪ Identify any oversight and monitoring requirements and create and implement any tracking tools.	Regional Customer Service Committee	Quarterly	n/a		This was not achievable in FY25 as the implementation timeframe has changed. This goal will be removed for FY26.
Committee will review Grievance and Appeal files for trends, ongoing through the end of FY25. ▪ Committee will review G&A trends quarterly. ▪ CMHSPs and SWMBH will complete quarterly G&A monitoring meetings. ▪ Review the Managed Care Program Annual Report (MCPAR) data for trends by the end of March 2025.	Regional Customer Service Committee	Quarterly	Met	**4**	SWMBH will continue to collect, collate, track and trend Medicaid grievance and appeal data. The volume of data reported through the PIHP is expected to be reduced due to the CMHSPs directly reporting CCBHC service data to MDHHS.

During FY25 SWMBH focused on addressing information requirements, 1557 updates, and tracking and trending grievance and appeal data, including a record high level of fair hearings filed and processed. SWMBH contracted with Bromberg and Associates to provide a region-wide training on the updates to 1557 and how they apply to materials for members. A project was subsequently initiated to review and provide feedback to CMHSPs regarding those member materials. SWMBH completed quarterly file reviews for grievance and appeals to ensure CMHSPs

are meeting state and federal regulations. This included collating and reporting CCBHC data to the state. Fair hearings were processed at a record high, including many complex cases requiring complex case collaboration with SWMBH and the CMHSPs. FY26 will focus on meeting contractual and federal requirements.

FY25 Grievances

Grievance Category	Number of Cases Closed	Number of Cases Per 100 Members	Number of Cases Substantiated	Number of Cases Substantiated Per 100 Members	Number of Interventions	Number of Cases Resolved within 90 Calendar Days	Average Number of Days for Resolution*
QUALITY OF CARE	11	0.04	7	0.02	15	11	14
ACCESS AND AVAILABILITY	21	0.07	10	0.03	26	21	22
INTERACTION WITH PROVIDER OR PLAN	93	0.32	54	0.19	107	93	12
MEMBER RIGHTS	3	0.01	1	0.00	4	3	19
TRANSPORTATION	1	0.00	0	0.00	1	1	5
ABUSE, NEGLECT, OR EXPLOITATION	0	0.00	0	0.00	0	0	#DIV/0!
FINANCIAL OR BILLING MATTERS	1	0.00	1	0.00	2	1	82
SAFETY/RISK MANAGEMENT	2	0.01	1	0.00	4	2	45
SERVICE ENVIRONMENT	3	0.01	0	0.00	4	3	32
OTHER	5	0.02	2	0.01	6	5	19
Total	140	0.48	76	0.26	169	140	15

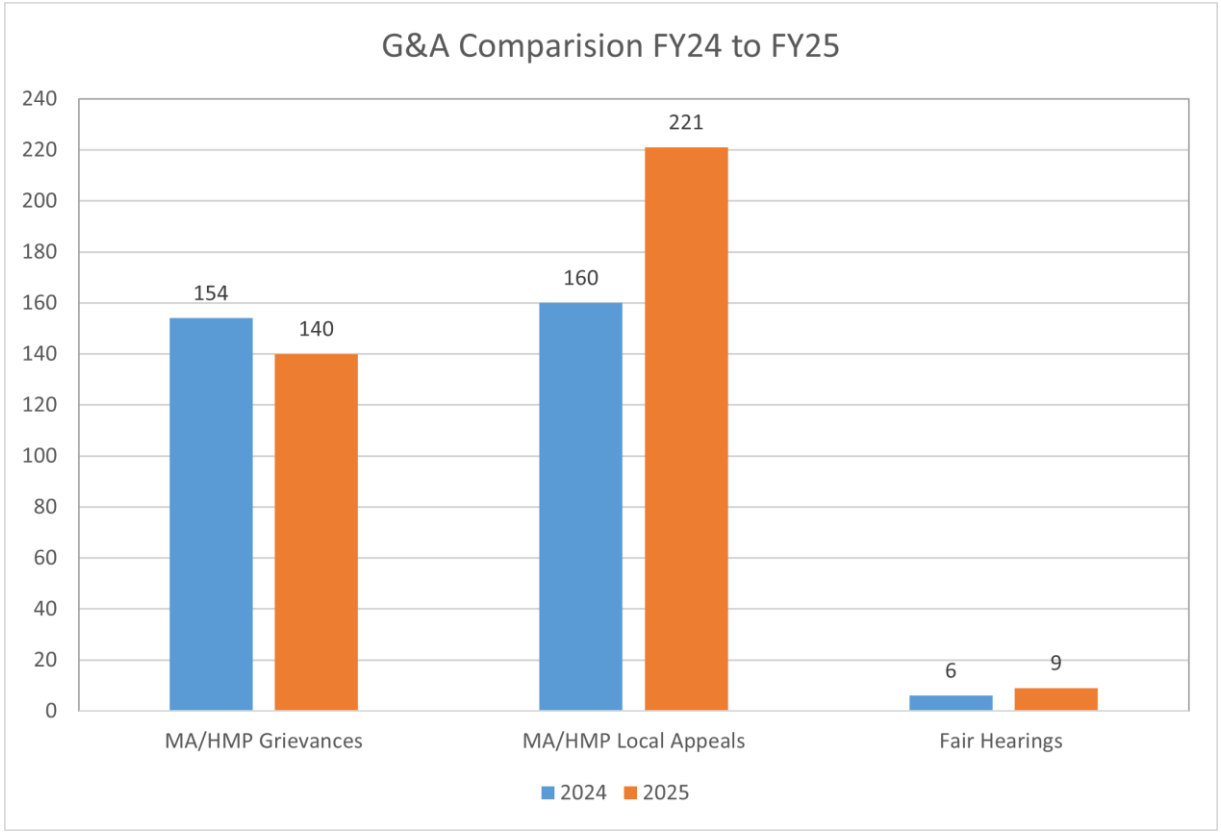
*Field will display "#DIV/0!" if there are no reported cases per category.

FY25 Appeals

Reason for Adverse Decision on Appeal	Number of Cases Closed	Number of Cases Per 100 Members	Number of Decisions Made Timely-Standard	Number of Decisions Made Untimely-Standard	Number of Decisions Made Timely-Expedited	Number of Decisions Made Untimely-Expedited	Percent Timely-All Cases	Percent Untimely-All Cases
MEDICAL NECESSITY CRITERIA NOT MET	83	0.29	81	0	2	0	100%	0%
NOT A PIHP-COVERED BENEFIT	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
CLINICAL DOCUMENTATION NOT RECEIVED	3	0.01	3	0	0	0	100%	0%
TREATMENT/SERVICE PLAN GOALS MET	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
MEMBER NOT ELIGIBLE FOR SERVICES	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
MEMBER NON-COMPLIANT WITH TREATMENT/SERVICE PLAN	10	0.03	10	0	0	0	100%	0%
FAILURE OF THE PIHP/CMHSP/SUD PROVIDER TO RENDER A DECISION TIMELY	0	0.00	0	0	0	0	#DIV/0!	#DIV/0!
OTHER	15	0.05	15	0	0	0	100%	0%
NOT APPLICABLE	110	0.38	106	0	3	1	99%	1%
Total	221	0.76	215	0	5	1	100%	0%

*Field will display "#DIV/0!" if there are no reported cases per category.

	Count	Percentage
Appeals	221	
Appeals Upheld	94	43%
Appeals Overturned	112	51%
Appeals Partially Upheld/Overturned	15	7%


G&A Comparision FY24 to FY25
240
220
200
180
160
140
120
100
80
60
40
20
0
154
140
160
221
6
9
MA/HMP Grievances
MA/HMP Local Appeals
Fair Hearings
2024
2025

N. Integrated Health Initiatives

Description

Health Home models aim to improve the health and well-being of individuals served by using comprehensive and integrated approaches to care. In Region 4, the Certified Community Behavioral Health Clinic (CCBHC), Substance Use Disorder Health Home (SUDHH), and Behavioral Health Home (BHH) models were represented. Each of these models, though different, converge to provide comprehensive mental health and substance use disorder care, coordination between behavioral and physical health, as well as address areas of social need, support service delivery across the lifespan, and improve access to services through interdisciplinary care teams and flexible funding structures.

CCBHC

Effective 10/01/24, seven of the eight CMHSPs within Region 4 are participating as CCBHC demonstration sites. The CMS CCBHC Demonstration requires certified sites to provide nine core services and Michigan CCBHCs have twelve required and seven recommended evidence-based practices they must use. The 9 core services are:

1. Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
2. Screening, assessment, and diagnosis, including risk assessment.
3. Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
4. Outpatient mental health and substance use services.
5. Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
6. Targeted case management.
7. Psychiatric rehabilitation services.
8. Peer support and counselor services and family supports.
9. Intensive, community-based mental health care for beneficiaries of the armed forces and veterans, particularly those beneficiaries and veterans located in rural areas.

CCBHC General Requirements

Throughout 2025, SWMBH adhered to the CCBHC contractual and policy requirements from MDHHS. CCBHCs met the requirements indicated in CCBHC certification. SWMBH and the CCBHCs adhered to the requirements of all Medicaid statutes, policies, procedures, rules, and regulations, and the CCBHC Handbook.

PIHP Requirements

SWMBH shared responsibility with MDHHS for ensuring continued access to CCBHC services. SWMBH was responsible for meeting minimum requirements, distributing payment, facilitating CCBHC outreach and assignment, monitoring, reporting on CCBHC measures, and coordinating care for all populations served by the CCBHC sites in their region (regardless of payor). SWMBH developed a MOU with all CCBHCs in the region and ensured access to CCBHC services for their enrollees. Contracts with CCBHCs permitted authorizing agreements with Designated Collaborating Organization (DCO) entities and reflected the CCBHC scope of services. They also ensured compensation for CCBHC services equated to clinic-specific Prospective Payment System (PPS-1) rates and did not limit the CCBHC's ability to serve all populations with behavioral health needs per CCBHC eligibility requirements. SWMBH was responsible for understanding the CCBHC certification process requirements, including DCO credentialing. MDHHS had recommended that PIHPs provide training and support on this process and help potential CCBHC sites to become certified.

SWMBH distributed data requests from MDHHS for quality metrics, cost reports, level of care data, reconciliation templates, etc. and validated and evaluated CCBHC data as well as communicated any discrepancies to MDHHS prior to submission. SMWBH utilized Michigan claims and encounter data for the CCBHC population, and provided support related to Health Information Technology (HIT) including the Waiver

Support Applications, CC360, the PIHP Electronic Health Record (EHR) and Health Information Exchanges (HIEs). SWMBH worked with CCBHCs to establish timelines for MDHHS reporting deadlines.

SWMBH provided access to CCBHC services through providers certified as a CCBHC. SWMBH paneled CCBHCs to provide SUD services or assisted the CCBHC to develop a DCO agreement with a SUD provider already on the PIHP panel. SWMBH honored intake, access, screening, and authorization for CCBHC services completed by a CCBHC demonstration provider when an individual sought services at a CCBHC (i.e., calling the CCBHC directly or walk-ins). Timely access was provided to new and established recipients according to the CCBHC Handbook and SWMBH paid the CCBHC the full PPS rate for any first encounters.

SWMBH collaborated with CCBHCs who conducted a warm handoff to the PIHP during instances when a CCBHC was required to refer individuals to the PIHP access center. This may include:

- Individuals who require a service that is at a higher level of care than the nine core CCBHC services offered at the CCBHC or their contracted DCO, including SUD services.
- Individuals seeking access to services a CCBHC does not provide.
- Individuals seeking access to services offered through the 1915(c) waivers or 1915(i) services.
- PIHPs cannot require any prior authorizations or additional screening requirements beyond those noted above before an individual can access CCBHC services.

It should be noted that PIHP utilization management of CCBHC services was limited to retrospective review of approved/rendered services to confirm that the care was medically necessary. SWMBH could not delegate retrospective reviews for CCBHC services to a CCBHC or CMHSP.

SWMBH utilized Regional Utilization Management (RUM), the Quality Management Committee (QMC), and Regional Clinical Practices (RCP) to cover CCBHC topics and current metric status. The full list of specific Core Measures and other federal requirements are included in the CCBHC Handbook and measures associated with the Quality Bonus Payment (QBP) program are identified below.

FY25 Identified Barriers and Analysis

At the beginning of FY25 MDHHS added a requirement for the PIHPs to submit an implementation plan using a state developed template within 60 days after the start of the fiscal year. The plan was required to be developed with input from all CCBHCs in the region providing detail as to how the PIHP would meet the following requirements: Access, Authorization, and Utilization Management; Staffing; and Guardrails for PIHP Referrals and Assignments to CCBHCs.

One barrier was that MDHHS was very delayed in providing the template, however, once the completed regional plan was submitted, it was accepted with no required edits. SWMBH had one new CCBHC join the demonstration at the beginning of FY25. The requirements for the plan were things SWMBH was already doing for the existing CCBHCs, so developing the plan was seamless as SWMBH applied lessons learned from the first two cohorts with the new CCBHC.

An additional barrier arose in May 2025 when the Behavioral Health Transformation Division Director of MDHHS notified the PIHPs and CCBHCs that effective October 1, 2025, all oversight responsibilities would shift to MDHHS along with implementation of a direct payment methodology. SWMBH immediately began analyzing how the removal of CCBHC from operations and budget would impact the agency and region. The shift in oversight and responsibilities left many unanswered questions and lingering process changes for both CCBHCs and PIHPs entering FY26.

Improvement Efforts Made in FY25

To ensure the newest CMHSP to join the demonstration had the level of support needed, SWMBHs CCBHC subject matter expert (SME) met with the CMHs administrative team on a weekly basis until such time as the CMH deemed it unnecessary. This SME began attending the existing regional committees to ensure CCBHC-related topics were reviewed and any cross-functional issues were brought to the attention of the other regional committees.

The six CMHs that were part of the CCBHC demonstration in fiscal year 2024 were eligible for up to 5% of their total CCBHC Medicaid FY24 costs. If a metric was not met by a CCBHC, the funds for that metric went into a distribution pool and a CCBHC was eligible for a portion of the pool if they were in the top 25% of performance on the measure.

FY24 QBP outcomes were reported and payments awarded by MDHHS during FY25. All CCBHCs met the benchmark for FUH (Adult and Children) so no funds were available for redistribution.
One of Region 4's CCBHCs lost funds to the distribution pool for SAA-AD. Two met all of the benchmarks and earned their full QBP amount. Two met all the benchmarks and received funds from the distribution pool for SAA-AD as well. One CCBHC met all the benchmarks and received funds from the distribution pool for both SRA-BH-C and SRA-A.

Fiscal Year 2025 QBP Measures (To be awarded in FY26)

Measure Name	State or Clinic Reported	Benchmark	Award Methodology
HBD-AD: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control for Patients with Diabetes	State	Rate is greater than or equal to the 25th percentile of the CCBHC demonstration site average at year end for each sub-measure. HbA1c controlled HbA1c poorly controlled	10% of Eligible QBP
DEP-REM-6: Depression Remission at 6 months	Clinic	Rate is greater than or equal to the 25th percentile of the CCBHC demonstration site average at year end.	5% of Eligible QBP
I-SERV: Time to Services	Clinic	Rate is greater than or equal to the 25th percentile of the CCBHC demonstration site average at year end for each sub-measure: Time to Evaluation Time to Clinical Service Time to Crisis Response	15% of Eligible QBP
FUH-AD: Follow-Up After Hospitalization for Mental Illness, ages 18+	State	30-day: 75% 7-day: 48%	15% of Eligible QBP

FUH-CH: Follow-Up After Hospitalization for Mental Illness, ages 6 to 17	State	30-day: 88% 7-day: 60%	15% of Eligible QBP
IET-AD: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	State	Initiation: 41% Engagement: 14%	10% of Eligible QBP
PCR-AD: Plan All-Cause Readmissions Rate	State	10%	10% of Eligible QBP
SRA-A: Adult Major Depressive Disorder: Suicide Risk Assessment	Clinic	73%	10% of Eligible QBP
SRA-C: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Clinic	57%	10% of Eligible QBP

SUDHH and BHH

Both the SUDHH and BHH models provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. Beneficiaries eligible for SUDHH will have a qualifying diagnosis related to alcohol, stimulant, or opioid use disorder. Beneficiaries eligible for BHH must have as serious mental illness (SMI) or serious emotional disturbance (SED) diagnosis. The models are staffed with an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. Each model must provide six core health services:

1. Comprehensive Care Management
2. Care Coordination
3. Health Promotion
4. Comprehensive Transitional Care
5. Individual and Family Support
6. Referral to Community and Social Support Services

PIHP Requirements

PIHPs operating as the Lead Entity (LE), for both the SUDHH and BHH models, were required to:

- Have the capacity to evaluate, select, and support providers who meet the standards for Health Home Program (HHP)s including:
  - Identification of providers who meet the HHP standards
  - Provision of infrastructure to support HHPs in care coordination
  - Collecting and sharing member-level information regarding health care utilization and medications
  - Providing quality outcome protocols to assess HHP effectiveness
  - Developing training and technical assistance activities that will support HHPs in effective delivery of health home services
- Maintain a network of providers that support the HHPs to service beneficiaries with a substance use disorder (SUDHH) or serious mental illness and serious emotional disturbance (BHH).
- Reimburse HHPs for providing health home services.
- The LE must be contracted with MDHHS to execute the enrollment, payment, and administration of the SUDHH and BHH with providers; MDHHS will retain overall oversight and direct administration of the LE; the LE will also serve as part of the Health Homes team by providing care management and care coordination services.

FY25 SUDHH Quality Metrics

Performance Measure Number	Measure Name and NQF # (if applicable)	Measure Steward	State Baseline	Allocation % of P4P Budget
1	Initiation and engagement of alcohol and other drug (AOD) dependence treatment (0004), Initiation of AOD treatment within 14 days	NCQA	TBD	50%
2	Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence (FUA-AD), Follow-up within 7 days after discharge	NCQA	TBD	30%
3	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	CMS	TBD	20%

FY25 BHH Quality Metrics

Performance Measure Number	Measure Name and NQF # (if applicable)	Measure Steward	Allocation % of P4P Budget
1	Follow up After Hospitalization (FUH-7)	NCQA	50%
2	Increase in Controlling High Blood Pressure (CBP-HH)	NCQA	20%
3	Access to Preventative/Ambulatory Health Services	NCQA	30%

FY25 Analysis Identified Barriers

In FY25, SWMBH advocated to review methodology for SUDHH metric #3 (Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries). Previously, the metric was calculated to include any ED visit that included an associated SUD diagnosis, even if that was not the primary reason for the visit. Additionally, multiple emergency rooms in the SWMBH region have implemented the use of Medication for Opioid Use Disorder (MOUD) in recent years which increased the number of SUDHH customers who attended the ED for an OUD diagnosis. One of the HHPs utilized this MOUD initiation for all SUDHH customers when they were unable to get a new customer in to see a physician at their agency within seven days of their enrollment date. As a result, MDHHS changed their calculations for FY25, allowing all four of SWMBH's HHPs to meet this measure.

FY25 official outcomes for SUDHH are not available until FY26 and therefore not included in this evaluation. FY24 SUDHH outcomes [formerly Opioid Health Homes (OHH)]; however, were delivered during FY25 and all three measures were met, and full Pay for Performance (P4P) withholds were awarded. It can also be noted that all regions were awarded funding for Measure 1 (IET-14) due to state logic changes in FY24.

BHH was new this year and metric outcomes associated with the model were considered the measurement year; like SUDHH, results are not available until FY26. Amounts will be awarded based on comparison of BHH Program metric performance to regional and state level. Full P4P amounts will be awarded should program performance exceed both regional and state performance; however, if the program performance only exceeds one group (i.e. state or regional performance), 75% of the P4P will be awarded for that given metric. SWMBH will provide further education on these measures with providers and assist in monitoring metric outcomes and evaluating processes, as necessary.

Improvement Efforts Made in FY25

SWMBH put in great effort addressing the SUDHH metric #2 [Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence (FUA-AD), Follow-up within seven days after discharge] with HHPs. SWMBH utilized admission, discharge and transfers (ADTs) in Care Connect 360 to inform HHPs of all SUDHH customers who visited the emergency room and the reason for their visit, so providers had real-time information about the visits and could contact the customer and the emergency room for discharge information. This prompted the HHPs to identify customers included in this metric and ensured they were scheduled for a qualifying service within seven days.

O. External Quality Monitoring and Audits

Description

SWMBH is responsible for the coordination, organization, submission, and responses related to all external audit requests. External auditing includes any requests from MDHHS, HSAG, CMS, and other organizations. Audit results are reviewed, analyzed, and shared with relevant SWMBH regional committees and the SWMBH Board of Directors, as appropriate. Regional and internal CAPs are developed for reviews/audits that do not achieve specified benchmarks or established targets.

FY25 Identified Barriers and Analysis

One barrier that existed related to the HSAG NAV audit was confusion surrounding whether SWMBH should respond to time and distance standard questions, as MDHHS announced in January 2025 MDHHS would calculate these standards for the FY24 Network Adequacy Report. At a 5/7/25 technical assistance webinar, HSAG said PIHPs did not need to answer these questions since MDHHS would handle calculations. However, at a 5/20/25 NAV audit kickoff call, HSAG clarified that PIHPs, including SWMBH, must still answer these questions as they should be calculating time and distance standards internally. SWMBH completes an internal Network Adequacy report annually in the first quarter of each new fiscal year reflecting current network data going into the new fiscal year. The time and distance standards used for this report differed from MDHHS's final FY24 standards, which were released after SWMBH's internal report was completed.

Related to EDV, there were discrepancies between HSAG's findings – which indicated a 15% deficiency related to Procedure Code Modifiers – and the results of SWMBH's recent and historical audit and monitoring activities, which have not identified deficiencies at a comparable level. In response, SWMBH requested and received the sample of records reviewed by HSAG, along with their corresponding outcomes, to assess and determine appropriate corrective initiatives. Upon review, SWMBH identified inconsistencies between the documentation originally requested and submitted to HSAG and the materials that were subsequently reviewed. Specifically, of the 25 lines included in HSAG's spreadsheet, 10 contained apparent inaccuracies in the reported date of service and/or procedure codes reviewed. As a result, it is challenging to determine with precision what additional initiatives, if any, would be appropriate at this time.

No specific barriers were identified for the EDV or PMV audits, and the SUD site visit has been moved to every other year therefore it will not occur again until FY26.

Improvement Efforts Made in FY25

In FY25, SWMBH implemented several internal process improvements to strengthen planning and follow-up related to external monitoring audits. For the first time, SWMBH used SmartSuite to develop a comprehensive solution that streamlined responsibilities and submissions for the HSAG EQR audit. The solution maintained a record of past submissions and results for easy reference. A dedicated recommendations section allowed responsible staff to access prior HSAG recommendations as well as track progress related to improvement efforts. All staff involved in the HSAG EQR audit were trained on the new system, and this familiarity has since supported the program's expansion to several other projects. As a result of these efforts, SWMBH achieved a 95% overall score in the HSAG EQR audit – an increase from 80% in FY22, the last time these specific standards were reviewed.

Related to NAV, familiarity and increased guidance from MDHHS resulted in process improvement compared to the FY24 audit.

FY25 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY23	FY24	FY25	Eval Score	FY26 Recommendations
SWMBH will achieve an overall compliance score of >90% or top 2 scoring PIHPs during the 2024 HSAG External Quality Review (EQR).	QMC, SWMBH Senior Leadership Meetings, other Regional Committees	Annually	97%	89%	95%	**5**	SWMBH met 138 of 145 Standards (95%) that were audited during FY25, which was year 2 in the HSAG EQR Audit cycle. It was announced that there will be no EQR year 3 audit, therefore this goal will be removed for FY26.
SWMBH will achieve an overall compliance score of >95% on the annual HSAG Performance Measure Validation Review (PMV).	QMC, SWMBH Senior Leadership Meetings, other Regional Committees	Annually	100%	100%	100%	**5**	SWMBH scored 100% in FY25 for the HSAG PMV audit. SWMBH will review and implement strategies to address the recommendations made by the HSAG review team and will maintain the same goal for the FY26 HSAG PMV audit.
SWMBH will achieve an overall compliance score of >90% during the 2025 HSAG Network Adequacy Validation (NAV) audit.	RPNMC, SWMBH Senior Leadership Meetings, other Regional Committees	Annually	N/A	100%	100%	**5**	SWMBH scored 100% in FY25 for the HSAG NAV audit. SWMBH will review and implement strategies to address the recommendations made by the HSAG review team and will maintain the same goal for the FY26 HSAG NAV audit.
SWMBH will see a reduction in the number of repeat citations during the 2025 MDHHS Waiver Audit, compared to the 2023 audit results.	QMC, RPC, other Regional Committees	Annually	32	N/A	31	**4**	SWMBH met this goal by receiving 31 repeat citations in the FY25 Waiver Audit, compared to 32 repeat citations in FY23. New in FY25, iSPA was added to this audit. SWMBH expects an increase in repeat citations in FY26 related to these additional indicators, therefore this goal will be removed for FY26.

HSAG FY25 EQR Audit Results

The state fiscal year SFY25 compliance review was the first year of the three-year cycle.

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard II—Emergency and Poststabilization Services	13	13	13	0	0	**100%**
Standard VII—Provider Selection	25	25	22	3	0	**88%**
Standard VIII—Confidentiality	22	22	22	0	0	**100%**
Standard IX—Grievance and Appeal Systems	39	39	35	4	0	**90%**
Standard X—Subcontractual Relationships and Delegation	6	6	6	0	0	**100%**
Standard XI—Practice Guidelines	7	7	7	0	0	**100%**
Standard XII—Health Information Systems	9	9	9	0	0	**100%**
Standard XIII—Quality Assessment and Performance Improvement Program	24	24	24	0	0	**100%**
Total	**145**	**145**	**138**	**7**	**0**	**95%**

M = Met; NM = Not Met; NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

HSAG FY25 PMV Audit Results

The following table represents how SWMBH has scored on the HSAG Performance Measure Validation (PMV) Audit over the past 5 years.

Fiscal Year	PMV Result
FY21	90%
FY22	100%
FY23	100%
FY24	100%
FY25	100%

Strengths

HSAG's final report noted strengths within the Region including SWMBH's continued demonstration of adequate oversight across its CMHSPs through methods such as committee meetings, process improvement training, and Tableau dashboard checks and monitoring. Additionally, SWMBH has adequate processes in place to audit and validate performance measure data to ensure accuracy prior to submitting to MDHHS. In addition, SWMBH provides necessary training to provider staff based on findings during the auditing process

Weaknesses

HSAG noted one weakness as the reported rate for indicator #4a for the adult population fell below the 95 percent performance standard, suggesting that persons discharging from a psychiatric inpatient unit may not have received timely follow-up care after an inpatient psychiatric discharge. SWMBH will work to address this weakness in FY26.

HSAG FY25 NAV Audit Results

SWMBH scored 100% on the FY25 HSAG NAV Audit.

Standard Type	Total "Met" Elements	Total "Not Met" Elements	Score	Validation Rating
PIHP – Provider-to-Enrollee Ratios – Behavioral Health	17	0	100%	High confidence
PIHP - Time and Distance – Behavioral Health	18	0	100%	High confidence

HSAG FY25 EDV Audit Results

Analysis	Key Findings
Medical Record Procurement Status	
Medical Record Procurement Rate	• The medical record procurement rate was **100 percent**, indicating that all requested records were successfully procured and submitted.
Second Date of Service Submission Rate	• Among the procured medical records, **63.3 percent** included a corresponding second date of service.
Encounter Data Completeness	
Medical Record Omission Rate	• The *Procedure Code Modifier* data element had a relatively high medical record omission rate at **15.2 percent.** This indicates that the diagnosis codes in the encounter data were not adequately supported by the members' medical records.
Encounter Data Omission Rate	• All key data elements exhibited relatively low encounter data omission rates with *Date of Service* having the highest omission rate at **4.6 percent**.
Encounter Data Accuracy	
Diagnosis Code Accuracy Rate	• The *Diagnosis Code* data element was accurate in **99.7 percent** of instances where codes were present in both the medical records and encounter data, with all errors attributed to inaccurate coding.
Procedure Code Accuracy Rate	• The *Procedure Code* data element was accurate in **99.7 percent** of instances where codes were present in both the medical records and encounter data, with all errors related to inaccurate coding.
Procedure Code Modifier Accuracy Rate	• The *Procedure Code Modifier* data element was accurate in **98.7 percent** of instances where modifiers were present in both the medical records and encounter data.
All-Element Accuracy Rate	• Dates of service with accurate values for all key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were observed in **74.2 percent** of the dates of service present in both data sources (i.e., encounter data and medical records).

MDHHS FY25 SUD Site Visit

SUD site visits have been moved to every other year, therefore did not occur in FY25.

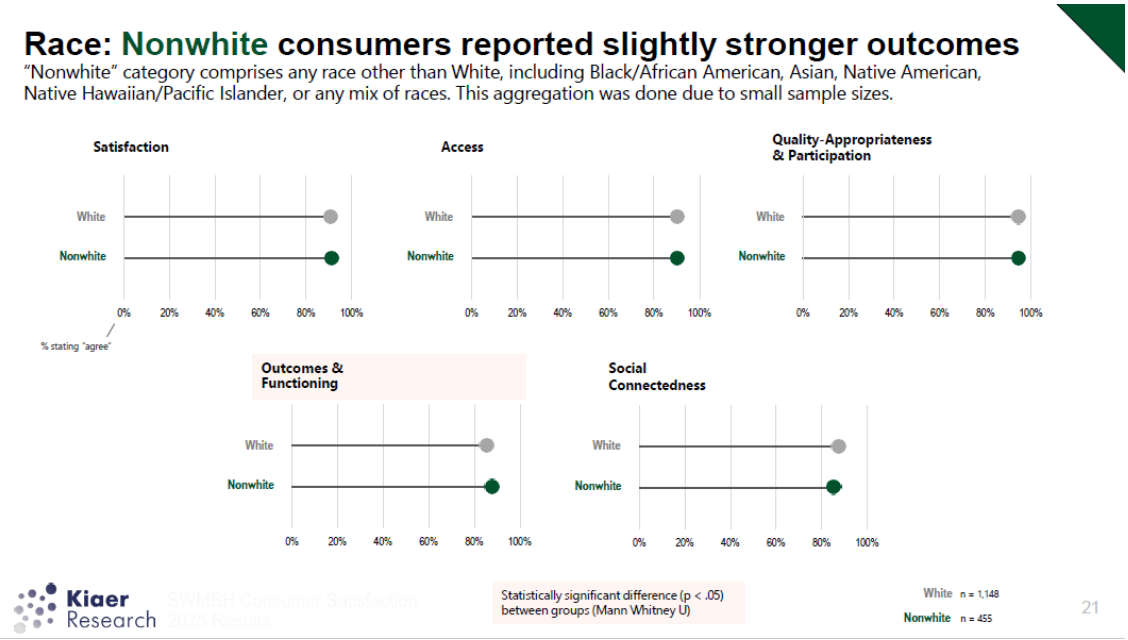
P. Cultural Competency

Description

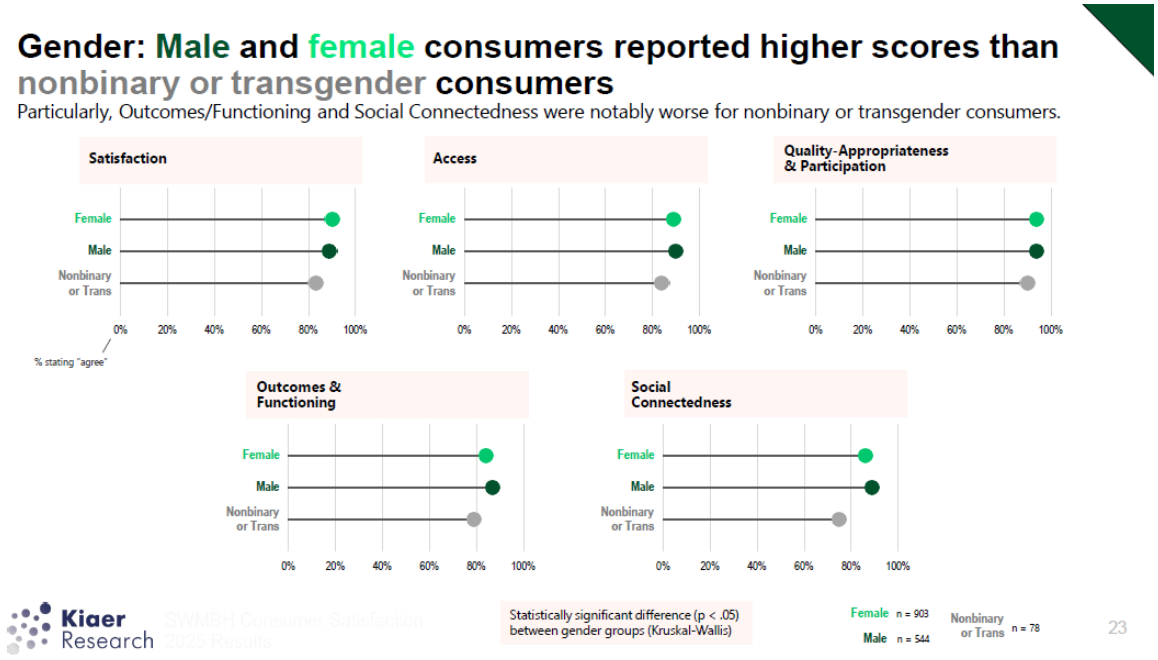
SWMBH remained dedicated to ensuring that the supports and services provided throughout Region 4 demonstrate an ongoing commitment to linguistic and cultural competence that ensured access and meaningful participation for all Members. Such commitment included acceptance and respect for the cultural values, beliefs, and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services. To effectively demonstrate such commitment to cultural competence and demonstrate compliance with the MDHHS/PIHP contract, SWMBH had the following five components in place: Community Assessment, Policy and Procedure, Service Assessment and Monitoring, Ongoing Training, and Culturally Contextual Services/Supports.

Community Assessment

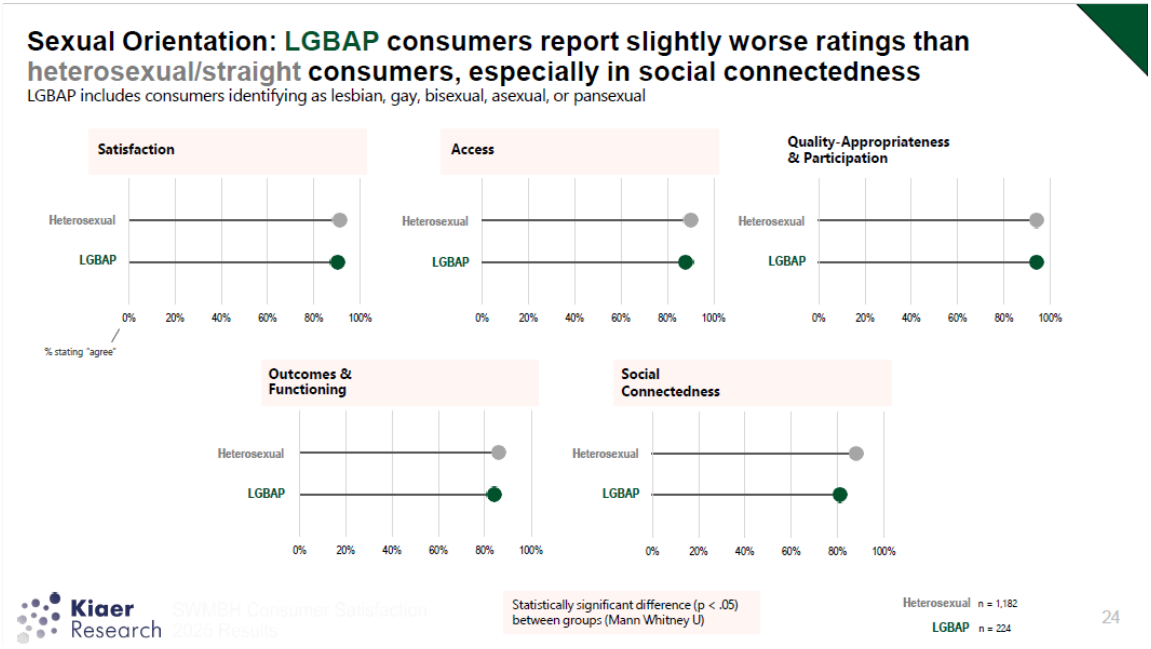
SWMBH used the annual regional Network Adequacy Assessment and the Customer Satisfaction Survey to assess for a culturally competent provider network and consumer involvement throughout the region. Results from the 2025 SWMBH Consumer Satisfaction Survey noted some improvement, as well as areas for continued focus. Non-white adult consumers reported slightly stronger outcomes most notably in areas of Satisfaction and Outcomes & Functioning, which is an improvement from FY24 when scores were slightly lower overall.



Beneficiaries that identify as LGBTQIA+ provided data on some areas in which cultural competence could be improved. Non-binary and transgender adult consumers reported lowers scores with each domain demonstrating a statistically significant difference in all areas with Outcomes & Functioning and Social Connectedness having the lowest scores.



Adult beneficiaries with sexual orientations such as lesbian, gay, bisexual, asexual, or pansexual (LGBAP) also reported statistically significant lower scores than heterosexual or straight beneficiaries in the region.



Languages spoken throughout the provider network were gathered through the Region's credentialing process. According to SWMBH's Provider Directory, Region 4 has a larger provider that speaks Hindi, Malayalam, Portuguese, Sinhalese, Spanish, Tanul, as well as American Sign Language and these languages are listed under each site, which resulted in higher percentages for the counties where the sites are located, as shown in the table below. Branch and St. Joseph Counties also have higher percentages as a larger provider with multiple sites reported Spanish as a secondary language at each site.

County	County Population % Spanish Speaking	# of Provider Sites with 1+ Spanish Speaking Clinician	% of Provider Sites with 1+ Spanish Speaking Clinician
Barry	1.6%	0	0.0%
Berrien	4.0%	8	15.4%
Branch	4.3%	11	64.7%
Calhoun	3.0%	1	2.1%
Cass	1.9%	0	0.0%
Kalamazoo	3.2%	3	3.0%
St. Joseph	6.9%	10	52.6%
Van Buren	8.6%	8	14.0%
Outside of Region 4	~	8	4.3%
SWMBH	3.9%	53	10.7%

SWMBH switched to universal credentialling this year, and the credentialing application ensures data is being collected on physical accessibility of provider office locations. The accessible features of each site are included in SWMBH's online Provider Directory, and SWMBH updates them when notified of changes. SWMBH's online Provider Directory has a search option "Accessibility for Disabilities" with a drop-down menu for "Yes", "Unknown", and "No". The region completes site reviews of each in-network provider on an annual basis and monitors accessibility, ensuring there are business processes for the provision of adaptive equipment and/or environmental modifications.

At the county level, MDHHS requires that each CMHSP conduct a nominal Needs Assessment at least every two years. Michigan also launched as a CCBHC Demonstration state in 2021, and MDHHS requires all local CCBHC sites to have a Needs Assessment. These community health needs assessments provide current demographic data and involve extensive stakeholder surveys spanning both provider agencies and persons served. The CMHSPs analyze stakeholder survey responses alongside data points for a combined qualitative and quantitative view of cultural competence and needs in each county. These data points are discussed, analyzed, and organized via county level workgroups and presentations. Community needs assessments are used to create a foundational equity framework that is specific to the county level.

Policy and Procedure

SWMBH Policy 03.07 Cultural & Linguistic Competency and *SWMBH Procedure 03.07A 2024 SWMBH Cultural Competency Plan* continue to reflect SWMBH's values and practice expectations toward cultural competency. SWMBH has also adopted the Culturally and Linguistically Appropriate Standards (CLAS) as general guidelines for the region. These policies apply to the entire SWMBH network.

Service Assessment and Monitoring

SWMBH employs a Health Equity Project Coordinator position that is entirely dedicated to reducing health equity disparities for minorities. This is a grant funded position that will continue to plan and develop region wide programming to increase the access and participation of minority populations in behavioral health services. In FY25, this position facilitated a Regional Health Equity Focus Group that consisted of representation from all 8 counties in Region 4. The workgroup met quarterly and helped to identify regional and county barriers. Likewise, the workgroup participants brought advice from frontline partnerships for further coordination and support, provided feedback on trainings and anti-stigma campaign efforts.

Cultural competency was further assessed and monitored according to current CCBHC, MMBPIS, and other metrics geared toward ensuring cultural competence and fairness in service delivery. Metrics that center around underserved populations were reviewed by SWMBH's internal Health Equity PIP work group quarterly, to ensure up to date monitoring. This group continued to expand its work in FY25, and these activities are covered in more

detail in the PIP section of this report. SWMBH and the CMHSPs met with local EDs to increase awareness of racial and ethnic disparities in ED follow-up for substance use, but inconsistencies remain in the number of referrals received. SWMBH also participated in quarterly meetings with Medicaid Health Plans (MHPs) to collaboratively monitor fluctuations in performance measures and identify interventions pertaining to disparities.

Training

SWMBH requires ongoing training to ensure that staff are aware of, and able to effectively implement cultural competency policies and procedures. SWMBH requires all in-network providers' staff to have cultural competency training, and this was reviewed as part of the Staff Training File Review of the annual site review process. The findings across the region for FY25 were as follows:

FY25 CMHSP Site Review	Barry	Berrien	Branch	Calhoun	Cass	Kalamazoo	St. Joseph	Van Buren
Cultural Competency Scores	95%	100%	100%	95%	100%	100%	95%	85%

Additionally, data on "Specialties & Cultural Competence" was collected in Organizational Credentialing packets, as well as in Individual Practitioner Credentialing Packets, to ensure SWMBH is collecting this data for in-network organizations.

In FY25 SWMBH offered the following trainings that address aspects of cultural competence free of charge to all provider agencies in Region 4: Veterans Thrive: Resilience Fundamentals, SW Ethics and Pain Management, Implicit Bias, Human Trafficking, Virtual Health Equity Training Series, and Bridging the Gap for a Healthier Future Symposium.

The Virtual Health Equity Training Series was completed in April through May and events included different speaker presentations with topics as follows: Broaching as a Strategy to Address Implicit Bias in Mental Health, Eliminating Disparities and Leading with Health Equity and Justice: Mental Health and Substance Use Disorders in the Hispanic/Latino/x/e Community (two parts), Structural Competence: Understanding Structural Determinants of Health in Mental Health Care (two parts) and Supporting LGBTQ While Navigating a Changing Landscape. This virtual health equity series was geared towards providers in the 8-county region, and registration numbers were 18 to 40 participants per presentation. Post survey results showed at least 83% of surveyed participants agreed that they are more knowledgeable on the disparities of underserved populations after each speaker's presentation.

The Bridging the Gap for a Healthier Future Symposium was an all-day anti-stigma event completed on June 18th at the Western Michigan University Fetzer Center. This event was geared towards local behavioral health providers, and the event included 6 different local speakers and topics including: Bridging Gaps in Healthcare, Practicing Cultural Humility in Behavioral Health, Culturally Responsive Care, a Peer success story, and Exploration of Latino/Hispanic Values and Its Impact on Clinicians. Attendance numbers for the event were 95 total persons. Post survey results showed that 92% of surveyed participants would attend another similar symposium event in the future. Likewise, post survey results showed that 96% of surveyed participants agreed their knowledge on health disparities of underserved populations increased after attending the event.

Culturally Contextual Services/Supports

SWMBH strives to ensure that supports and services are provided within the cultural contexts to all beneficiaries. SWMBH's community-sponsored events were selected by the Community Outreach Committee and Engagement Committee, which is dedicated to finding opportunities to better reach underserved and minority populations. Through the Community Outreach and Engagement Committee, SWMBH sponsored, promoted, and participated in showings of film Old Heart geared towards Veterans and their families. SWMBH employs a Veteran Navigator that provided Military Culturally Competency training to new hires, CMH staff, as well as community members and organizations.

FY25 Results

Goal	Where Progress Was Monitored	Frequency of Monitoring	FY25	Eval Score	FY26 Recommendations
Further develop trainings in 2025 by adding a mixture of free-to-attend virtual trainings and in-person health equity conferences in the region.	Integrated Care Team Meetings	Monthly	Met	**4**	The symposium was held with respondent surveys indicating that participants' cultural competencies were increased through participation. A revised/updated training goal will be included for FY25 with quarterly monitoring recommended. Monitoring discussions occurred in six of the twelve months this fiscal year.
Promote continued education throughout the organization and 8-county region by participating in or contributing to local organizations and public events. Continue to seek culturally relevant, visible opportunities that attract minorities and their allies.	Regional Customer Services Committee, RPNMC, RCP	Annually	Partially Met	**3**	Capacity for events was limited due to budgetary constraints and focused on veterans. While this will continue to be an effort, we do not recommend continuation of this goal for FY25.
SWMBH will evaluate language spoken by network providers vs. enrollees for FY24. SWMBH believes capturing more Provider data regarding languages spoken, cultural competency, and physical accessibility of office space will assist the Provider Network Departments at each CMHSP in ensuring the Region's beneficiary's needs are being met in this capacity.	Regional Customer Services Committee, RPNMC, RCP	Annually	Met	**4**	Survey results were received, and regional committees both reviewed and discussed outcomes on both a county-specific and regional level. Recommend continuing this goal in FY25 with monitoring being done through submission of the report to MDHHS.