
**MID-STATE HEALTH NETWORK
BOARD POLICY COMMITTEE
Meeting Agenda
TUESDAY, MAY 5, 2026 - 4:00 PM**

MyMichigan Medical Center
300 E. Warwick Drive
Alma, MI 48801

Zoom Link: <https://zoom.us/j/3797965720> **Meeting ID: 379 796 5720**
Call Number: 1.312.626.6799 Meeting ID Number: 379 796 5720#

**Note: Anyone, including members of the public, can attend this meeting
by clicking the link above**

1. CALL TO ORDER
2. PUBLIC COMMENT
3. **ACTION ITEM: APPROVAL OF AGENDA**
MOTION TO APPROVE THE AGENDA OF THE MAY 5, 2026 BOARD POLICY COMMITTEE MEETING
4. **ACTION ITEM: NEW POLICY FOR REVIEW:**
CHAPTER: INFORMATION TECHNOLOGY
 1. APPLICATION PROGRAMMING INTERFACE**MOTION TO RECOMMEND THE NEW POLICY UNDER REVIEW TO THE BOARD OF DIRECTORS**
5. **ACTION ITEM: POLICIES UNDER REVIEW:**
CHAPTER: COMPLIANCE
 1. DISQUALIFIED INDIVIDUALS POLICY
CHAPTER: CUSTOMER SERVICE
 1. ADVANCE DIRECTIVES
 2. CUSTOMER HANDBOOK
 3. CUSTOMER SERVICE
 4. ENROLLEE RIGHTS
 5. INFORMATION ACCESSIBILITY/LIMITED ENGLISH PROFICIENCY (LEP)

6. MEDICAID BENEFICIARY APPEALS/GRIEVANCES
7. REGIONAL CONSUMER ADVISORY COUNCIL
8. SUD RECIPIENT RIGHTS

MOTION TO RECOMMEND THE POLICIES UNDER REVIEW TO THE BOARD OF DIRECTORS

6. **ACTION ITEM:** APPROVAL OF THE FY2026 POLICY COMMITTEE MEETING CALENDAR

MOTION TO APPROVE THE FY2026 POLICY COMMITTEE MEETING CALENDAR AS PRESENTED.

7. NEW BUSINESS

A. GENERAL MANAGEMENT POLICY AND PROCEDURE DEVELOPMENT PROCEDURE

8. PUBLIC COMMENT

9. ADJOURN

Chapter:	Information Technology		
Title:	Application Programming Interface Policy		
Policy: <input checked="" type="checkbox"/>	Review Cycle: Biennial	Adopted Date: 12.01.2025	Related Policies:
Procedure: <input type="checkbox"/>	Author: Chief Information Officer	Review Date:	
Page: 1 of 2			

Purpose

The purpose of this policy is to ensure Mid-State Health Network (MSHN) is in compliance with the rules published by the Centers for Medicare and Medicaid Services (CMS) related to availability and use of the application programming interface as required by Michigan Department of Health and Human Services (MDHHS).

Policy

MSHN is committed to following the rules for implementing the Provider Directory Application Programming Interface (API) as specified in 42 Code of Federal Regulations (CFR) §438.10 and the Client Data API as specified in 42 CFR §431.60 and 42 CFR §438.242. MSHN will ensure all stored data elements identified in 45 CFR §170.213 also known as the United States Core Data for Interoperability (USCDI) are accessible via the API and in compliance with the requirements as defined by 42 CFR §438.10 and §431.60, including;

- Having client data available within 24 hours of MSHN receiving the data.
- Having provider directory data available within 30 days of MSHN receiving the data.
- Having instructions for both members and API programmers easily available.
- Staying current on the data elements that are required for each area.

Applies to

- All Mid-State Health Network Staff
- Selected MSHN Staff, as follows:
 - MSHN’s CMHSP Participants: Policy Only Policy and Procedure
 - Other: Sub-contract Providers

Definitions

- API:** Application Programming Interface
- CFR:** Code of Federal Regulations
- CMS:** Centers for Medicare and Medicaid Services
- MDHHS:** Michigan Department of Health and Human Services
- MSHN:** Mid-State Health Network
- USCDI:** United State Core Data for Interoperability

Other Related Materials

N/A

References/Legal Authority

N/A

Change Log:

Date of Change	Description of Change	Responsible Party
12.01.2025	New Policy	Chief Information Officer

POLICIES AND PROCEDURE MANUAL

Chapter:	Compliance		
Title:	Disqualified Providers		
Policy: <input checked="" type="checkbox"/>	Review Cycle: Biennial	Adopted Date: 07.09.2019	Related Policies: Provider Network Management Disclosure of Ownership, Control, and Criminal Convictions; Credentialing/Recredentialing
Procedure: <input type="checkbox"/>	Author: Chief Compliance & Quality Officer	Review Date: 11.07.2023	
Page: 1 of 10			

Purpose

To ensure individual providers are eligible to participate in federal and state health care programs (e.g.: Medicaid and Medicare) and are not excluded from participation based on federal and state regulations.

Policy

MSHN and its provider network shall not employ, contract with, authorize services for, reimburse services for, or seek reimbursement for services delivered, prescribed, or ordered by any individual if:

1. The individual has received a criminal history screening indicating a mandatory disqualifying conviction identified in 42 USC 1320a-7(a);
2. The individual has been the subject of a substantiated finding; or
3. The individual has direct access, or provides direct services, to program participants in a prescribed setting (inpatient hospital and specialized residential) and the individual has received a criminal history screening indicating a time-limited disqualifying conviction for which the time limitation has not yet been satisfied (MCL 20173a, MCL 330.1134a, MCL 400.734b).
4. The individual does not possess the appropriate/required degree, certification, training, etc. to perform their job functions.

Reporting:

1. All employees, directors, administrators, managers, and individuals with any other type of employment or consulting arrangement with MSHN are required to report the following to Human Resources within five (5) days of conviction or assessment imposition:
 - a. Any criminal conviction, felony or misdemeanor; and/or
 - b. The imposition of civil money penalties or assessments imposed under Subsection 1128A of the Social Security Act (~~Exclusion Regulations https://www.ssa.gov/OP_Home/ssact/title11/1128A.htm~~).
2. Criminal conviction resulting in disqualifications are to be disclosed to MSHN’s Compliance Officer by the [Community Mental Health Service Program](#) CMHSP participants and MSHN direct contracted entities with regard to those offenses as detailed in Subsections 1128(a) and 1128(b)(1), (2), of (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under Subsection 1128A of the Act. The report to MSHN will be made within 15 business days of the discovery of the disqualification through electronic submission.
3. MSHN will notify, as required, the appropriate regulatory body that may include the Michigan Department of Health and Human Services (MDHHS) Behavioral [Health and Developmental Disabilities Administration](#) and [Physical Health and Aging Services Administration](#) (BPHASDDA) Division of Program Development, Consultation and Contracts, Licensing and Regulatory Affairs (LARA) and the Office of Inspector General (OIG) when disclosures are made by providers regarding any offenses detailed in Subsections 1128(a) and 1128(b) (1), (2) or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under Subsection 1128A of the Act.

Mandatory and Time-Limited Disqualifications:

The tables below identify disqualifications for participation in a provider capacity in Medicare, Medicaid or any other Federal health care programs.

The following table applies to all personnel at MSHN and the Provider Network.

Disqualifications related to the Social Security Act, subsections 1128(a), 1128(b)(1), (2), and (3); 1128A; Title V, XX, XXI, XVII, and XIX; MCL 333.18263; 42 USC 1320a – 7(a); Medicaid Provider Manual (General Information for Providers: Section 6 – Denial of Enrollment, Termination and Suspension)
Mandatory Disqualifications Persons with the following convictions are <u>Excluded</u> from participating in Medicare and State health care programs
1. Any criminal convictions related to the delivery of an item or service under Medicare (Title XVIII), Medicaid (Title XIX) or other state health care programs (e.g., Children’s Special Health Care Services, Healthy Kids), (Title V, Title XX, and Title XXI).
2. Any criminal convictions under federal or state law, relating to neglect or abuse of patients in connection with the delivery of a health care item or service.
3. Felony convictions occurring after August 21, 1996, relating to an offense, under federal or state law, in connection with the delivery of health care items or services or with respect to any act or omission in a health care program (other than those included in number 1 above) operated by or financed in whole or in part by any federal, state, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.
4. Felony convictions occurring after August 21, 1996, under federal or state law, related to unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
5. The provider is convicted of violating the Medicaid False Claims Act, the Health Care False Claims Act, a substantially similar statute, or a similar statute by another state or the federal government.
6. The provider is excluded from participating in a provider capacity in Medicare, Medicaid or any other Federal health care programs.
7. Termination on or after January 1, 2011 2011, under Medicare or the Medicaid program, or the Children's Health Insurance Program (CHIP) of any other state.
Disqualifications related to the Medicaid Provider Manual (General Information for Providers: Section 6 – Denial of Enrollment, Termination and Suspension)
Time-Limited Disqualifications Time Requirement*: 10 Years
The provider has a federal or state felony conviction within the preceding 10 years of their provider enrollment application, including but not limited to, any criminal offense related to:
1. Murder, rape, abuse or neglect, assault, or other similar crimes against persons
2. Extortion, embezzlement, income tax evasion, insurance fraud, and other similar financial crimes
3. The use of firearms or dangerous weapons
<u>4. A felony conviction of theft.</u>
<u>4.5.</u> Any felony that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
Disqualifications related to the Medicaid Provider Manual (General Information for Providers: Section 6 – Denial of Enrollment, Termination and Suspension)
Time-Limited Disqualifications Time Requirement*: 5 Years
The provider has a federal or state misdemeanor conviction within the preceding five years of their provider enrollment application, including but not limited to, any criminal offense related to:
1. Any misdemeanor crime listed as a permissive exclusion in 42 USC 1320a-7(b);
2. Rape, abuse or neglect, assault, or other similar crimes against persons;
3. Extortion, embezzlement, income tax evasion, insurance fraud, or other similar

financial crimes;
<u>4. A misdemeanor conviction of theft.</u>
<u>4.5. Any misdemeanor that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.</u>

Applied Behavioral Analysis Technicians and Specialized Residential Settings

The following tables include additional disqualifications that apply to all staff working in a Specialized Residential Setting (adult foster care homes) and Applied Behavioral Analysis Technicians (ABA Techs). ~~That includes an individual that has direct access, or provides direct services, to program participants in a prescribed setting and the individual has received a criminal history screening indicating a time limited disqualifying conviction for which the time limitation has not yet been satisfied.~~

Disqualifications related to MCL 333.20173a, MCL 330.1134a and MCL 400.734b
Time-Limited Disqualifications Time Requirement*: 15 years
1. A felony that involves the intent to cause death or serious impairment of a body function, that results in death or serious impairment of a body function, that involves the use of force or violence, or that involves the threat of the use of force or violence
2. A felony involving cruelty or torture.
3. A felony under chapter XXA of the Michigan penal code, 1931 PA 328, MCL 750.145m to 750.145r (Vulnerable Adults chapter). https://www.legislature.mi.gov/(S(sigap145p0xoam2bb0t0kxrp))/documents/mcl/pdf/mcl-328-1931-XXA.pdf
4. A felony involving criminal sexual conduct.
5. A felony involving abuse or neglect.
6. A felony involving the use of a firearm or dangerous weapon.
7. A felony involving the diversion or adulteration of a prescription drug or other medications.
Time-Limited Disqualifications Time Requirement*: 10 years
1. Convicted of a felony or attempt or conspiracy to commit felony, other than those described under the mandatory and the 15-year time limited disqualifications sections.
Time-Limited Disqualifications Time Requirement*: 10 years
1. A misdemeanor involving the use of a firearm or dangerous weapon with the intent to injure, the use of a firearm or dangerous weapon that results in a personal injury, or a misdemeanor involving the use of force or violence or the threat of the use of force or violence.
2. A misdemeanor under chapter XXA of the Michigan penal code, 1931 PA 328, MCL 750.145m to 750.145r (Vulnerable Adults chapter).
3. A misdemeanor involving criminal sexual conduct.
4. A misdemeanor involving cruelty or torture unless otherwise provided under the 5-year time limited disqualification section.
5. A misdemeanor involving abuse or neglect.
Time-Limited Disqualifications Time Requirement*: 5 years
1. A misdemeanor involving cruelty if committed by an individual who is less than 16 years of age.
2. A misdemeanor involving home invasion.
3. A misdemeanor involving embezzlement.

4. A misdemeanor involving negligent homicide or a violations of section 601d (10 of the Michigan vehicle code, 1949 PA 300, MCL 257.601d.
5. A misdemeanor involving larceny unless otherwise provided under the 1-year time limited disqualification section.
6. A misdemeanor of retail fraud in the second degree unless otherwise provided in the 1-year time limited disqualification section.
7. Any other misdemeanor involving assault, fraud, theft, or the possession or delivery of a controlled substance unless otherwise provided in the 1, 3, and 10-year time limited disqualifications sections.
Time-Limited Disqualifications Time Requirement *: 3 years
1. A misdemeanor for assault if there was no use of a firearm or dangerous weapon and no intent to commit murder or inflict great bodily injury.
2. A misdemeanor of retail fraud in the third degree unless otherwise provided under the 1-year time limited disqualification section.
3. A misdemeanor under part 74 (MCL 333.74- offenses related to controlled substances) unless otherwise provided under the 1-year time limited disqualification section.
Time-Limited Disqualifications Time Requirement*: 1 year
1. A misdemeanor under part 74 (MCL 333.74 – offenses related to controlled substances) if the individual, at the time of conviction, is under the age of 18.
2. A misdemeanor for larceny of retail fraud in the second or third degree if the individual, at the time of the conviction, is under the age of 16.

* **Time requirement means the time required for completing all terms and conditions of sentencing, parole, and probation for the conviction prior to the date of application for employment or clinical privileges.**

Applies to

- All Mid-State Health Network
- Staff Selected MSHN Staff, as follows:
- MSHN’s Affiliates: Policy Only Policy and Procedure Other: Sub-contract Providers

Definitions

A. ABA Techs: [Applied Behavioral Analysis Technicians](#)

A.B. Behavioral Health: refers to individuals with a Mental Health, Intellectual Developmental Disability and/or Substance Use Disorder or children with Serious Emotional Disturbances

B.C. BPHASDDA: Behavioral [and Physical Health](#) and [Developmental Disabilities-Administration](#)[Aging Services Administration](#)

C.D. CMHSP: Community Mental Health Service Provider

D.E. Conviction: For purposes of the laws mentioned above, an individual or entity is considered to have been convicted of a criminal offense when:

1. A judgment of conviction has been entered against the individual or entity by a federal, state, tribal or local court, regardless of whether there is an appeal pending:
2. A finding of guilt against the individual or entity by a federal, state, tribal or local court,
3. A plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, tribal or local court.

E.F. Direct Access: Means access to an individual, an individual’s property, or an individual’s personal financial information (checking account information, credit cards, bank statements, etc.).

F.G. LARA: Licensing and Regulatory Affairs

G.H. MDHHS: Michigan Department of Health and Human Services

H.I. MSHN: Mid-State Health Network

H.J. OIG: Office of Inspector General

H.K. Personnel: For purposes of this policy, “personnel” means, employees, contractors, volunteers, interns, and any other staff.

H.L. Provider Network: Refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through CMHSP subcontractors.

H.M. Subcontractors: refers to an individual or organization that is directly under contract with a CMHSP to provide services and/or supports.

Other Related Materials

Medicaid Service Administration (MSA) Policy Bulletin 18-09: Home Help Agency Provider Standards

References/Legal Authority

42 U.S.C 1320a-7

Michigan Mental Health Code - MCL 330.1134a Public Health Code - MCL 400.734b

Michigan Public Health Code - MCL 333.20173a Public Health Code -MCL 333.18263

42 CFR 441.570

1128 A of the Social Security Act

1128 B of the Social Security Act

Medicaid Provider Manual: General Information for Providers: Section 6 – Denial of Enrollment, Termination and Suspension

Senate Bill No. 184 (revisions to ABA technician exclusions in the Michigan Public Health Code)

Attachment A: Excluded Convictions Worksheet

Change Log:

Date of Change	Description of Change	Responsible Party
04.25.2019	New Policy	Director of Compliance, Customer Service & Quality
09.2019	Updates based on Medicaid Provider Manual Revisions	Director of Compliance, Customer Service & Quality
10.2019	Added clarification for substantiated recipient rights complaints	Director of Compliance, Customer Service & Quality
12.2019	Added clarification for reporting disqualifications to MSHN and for substantiated recipient rights complaints	Director of Compliance, Customer Service & Quality
08.2021	Bi-Annual Review; Updated references; Added language consistent with Medicaid Provider Manual; added reference on staff qualifications	Chief Compliance and Quality Officer
08.2023	Biennial Review; Updates under “Reporting” section	Chief Compliance and Quality Officer
<u>01/16/2026</u>	<u>Revised to include changes to the Medicaid Provider Manual</u>	<u>Chief Compliance and Quality Officer</u>

Attachment A

Lookback Periods:

- Reference the date of conviction in relation to the date of application or enrollment (i.e., within X years preceding the date of application/enrollment)
- An exception is felonies for **Specialized Residential Staff and ABA Techs**, which are in reference to the date of completion of “all of the terms and conditions of his or her sentencing, parole and probation for that conviction”.

An individual or entity is considered to have been convicted of a criminal offense when:

- a judgment of conviction has been entered against the individual or entity by a federal, state, tribal or local court regardless of whether there is an appeal pending;
- there has been a finding of guilt against the individual or entity by a federal, state, tribal or local court; or
- a plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, tribal, or local court.
- (for behavioral technicians) a final conviction, the payment of a fine, a plea of guilty or nolo contendere if accepted by the court, or a finding of guilt for a criminal law violation or a juvenile adjudication or disposition by the juvenile division of probate court or family division of circuit court for a violation that if committed by an adult would be a crime.

The MSHN network providers are responsible for reviewing and verifying provider disqualifications within the sources provided. Sources below include additional details and descriptions of crimes that may fall into similar categories that may not be listed on the grid below.

Enrolled-All Medicaid Prov.		
CHECK	Automatic Disqualification <small>ns</small>	Law or Rule Reference
<input type="checkbox"/>	Termination on or after Jan 1, 2011 2011, under Medicare, Medicaid or Children's Health Insurance Program (CHIP) of any other state	A
<input type="checkbox"/>	Exclusion from participation in a provider capacity in Medicare, Medicaid or any other Federal health care programs	A
<input type="checkbox"/>	<u>Any conviction r</u> elated to the delivery of an item/service under Medicare or Medicaid <u>or any state health care program.</u>	A, C
<input type="checkbox"/>	<u>Any conviction related to patient abuse/neglect in connection with delivery of a health care item or service.</u>	A, C
<input type="checkbox"/>	<u>Any felony conviction relating to and offense in connection with the delivery of healthcare items or services or with respect to any act or omission in a health care program (other than those listed above) operated by or financed in whole or part by federal, state, local government agency consisting of fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.</u>	A, C
<input type="checkbox"/>	<u>Felony conviction related to controlled substance – unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.</u>	A

☐	<u>Conviction for violating Violation of the Medicaid False Claims Act, the Health Care False Claims Act, a substantially similar statute, or a similar statute by another state or the federal gov't</u>	A
☐	<u>Failure to Comply w Enrollment & Screening Requirements: Failure to submit timely and accurate information; cooperate with MDHHS screening methods; submit sets of fingerprints as required within 30 days of a CMS or MDHHS request; permit access to provider locations for site visits; and/or comply with Medicaid policies regarding submission of claims and billing Medicaid beneficiaries. Falsification of information provided on the enrollment application or subsequent information requests. Inability to verify their identity</u>	A, B

All Medicaid Prov.			Additional Req'ts for ABA Techs/ <u>Specialized Residential</u>			Law or Rule Reference
CHECK	Felony	Misdemeanor	Felony	Misdemeanor		
<input type="checkbox"/>	w/in 10 yrs	w/in 5 yrs			<u>Any conviction that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.</u>	A, D
				w/in 1 year	<u>Subject to an order or disposition of not guilty by reason of insanity</u>	D, H
<u>Related to fraud, theft, embezzlement, breach of fiduciary responsibility, financial misconduct</u>						
	After Aug-21, 1996	After Aug-21, 1996			<u>Related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct [related to government programs]: in connection with the delivery of a health care item or service; OR</u>	A, C
	After Aug-21, 1996	After Aug-21, 1996			<u>with respect to any act or omission in a health care program (other than Medicaid & Medicare) operated by or financed in whole or in part by any Federal, State, or local government agency; OR</u>	A, C
		After Aug-21, 1996			<u>with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency</u>	A, C
<input type="checkbox"/>	w/in 10 yrs	w/in 5 yrs	w/in 15 yrs after completion of parole/probation		Extortion, <u>theft</u> , income tax evasion, insurance fraud, and other similar financial crimes	A, D
	w/in 10 yrs	w/in 5 yrs	w/in 15 yrs after completion of parole/probation	w/in 5 yrs	Embezzlement	A, D
<input type="checkbox"/>				<u>w/in 5 yrs Larceny- if committed when <16 yrs, then w/in 1 yr/w/in 5 yrs</u>	Larceny, <u>fraud or theft not otherwise addressed in this section.</u>	D
<input type="checkbox"/>				w/in 5 yrs. if committed when <16 yrs, then w/in 1 yr	Retail Fraud in the 2 nd Degree	D

<input type="checkbox"/>				w/in 3 yrs. if committed when <16 yrs old, then w/in 1 yr	Retail Fraud in the 3 rd Degree	D
				w/in 5 yrs	Fraud or theft not otherwise addressed in this list	D
<input type="checkbox"/>				w/in 5 yrs	Home invasion	D
					Subject to an order or disposition of not guilty by reason of insanity	D, H
	w/in 10 yrs		w/in 15 yrs after completion of parole/probation		Murder	A, D
				w/in 5 yrs	Negligent homicide or a moving violation that is proximate cause of death of another person or serious impairment of body function	D, G

Enrolled-All Medicaid Prov.		Additional Req'ts for ABA Techs/ <u>Specialized Residential</u>				Law or Rule Reference
CHECK	Felony	Misdemeanor	Felony	Misdemeanor		
<u>Abuse, Assault, Crimes related to harming others/Endangerment</u>						
<input type="checkbox"/>	w/in 10 yrs		w/in 15 yrs after completion of parole/ probation		<u>Murder</u>	A, D
<input type="checkbox"/>				w/in 5 yrs	<u>Negligent homicide or a moving violation that is proximate cause of death of another person or serious impairment of body function</u>	D, G
<input type="checkbox"/>	w/in 10 yrs		Includes attempts/ conspiracy to commit; w/in 15 yrs after parole/ probation	w/in 10 yrs*	Use of firearms or dangerous weapons *Additional info for misdemeanors for ABA Techs: ...with the intent to injure, the use of a firearm or dangerous weapon that results in a personal injury, or a misdemeanor involving the use of force or violence or the threat of the use of force or violence	A, D
<input type="checkbox"/>			Includes attempts/ conspiracy to commit; w/in 15 yrs after completion of parole/ probation		Involving intent to cause death or serious impairment of a body function, that results in death or serious impairment of a body function, that involves the use of force or violence, or that involves the threat of the use of force or violence.	D
<input type="checkbox"/>			Includes attempts/ conspiracy to commit; w/in 15 yrs after completion of parole/ probation	w/in 10 yrs. if committed when <16 yrs old, then w/in 5 yrs	<u>A felony involving cruelty</u> Cruelty or torture	D
<input type="checkbox"/>	w/in 10 yrs	w/in 5 yrs	w/in 15 yrs after completion of parole/ probation	w/in 5 yrs. if no weapon and no intent to murder/ inflict great bodily injury, w/in 3 yrs	Assault or other similar crimes against persons	A, D
<input type="checkbox"/>	w/in 10 yrs	w/in 5 yrs	<u>Includes attempts/ conspiracy to commit; w/in 15 yrs after completion of parole/ probation</u> w/in 15 yrs after completion of parole/	w/in 10 yrs	Rape or other similar crimes against persons <u>involving criminal sexual conduct</u>	A, D

			probation			
			Includes attempts/ conspiracy to commit; w/in 15 yrs after completion of parole/ probation	w/in 10 yrs	Involving criminal sexual conduct	D
<input checked="" type="checkbox"/>					Related to neglect or abuse of patients in connection with the delivery of a health care item or service.	A, C
<input type="checkbox"/>	w/in 10 yrs	w/in 5 yrs	Includes attempts/ conspiracy to commit; w/in 15 yrs after completion of parole/ probation	w/in 10 yrs	Abuse or neglect	A, D
<input type="checkbox"/>			Includes attempts/ conspiracy to commit; w/in 15 yrs after completion of parole/ probation	w/in 10 yrs	<p>Substantiated finding of neglect, abuse, or misappropriation of property by a state or federal agency (regarding long term care facilities) related to chapter XXA of the Michigan penal code, 1931 PA 328, MCL 750.145m to 750.145r:</p> <ul style="list-style-type: none"> • <u>Caregiver who intentionally causes serious physical harm or serious mental harm to a vulnerable adult</u> • <u>Reckless act or reckless failure to act of the caregiver or other person with authority over the vulnerable adult causes serious physical harm or serious mental harm</u> • <u>An operator/employee/individual acting on behalf of an unlicensed facility that is subject to licensure, who violates the adult foster care facility licensing act or public health code or rules and whose violation is a proximate cause of the death of a vulnerable adult</u> <p>Caregiver/person with authority over vulnerable adult or licensee convicted of felony due to repeated misdemeanor violations of the adult foster care licensing act regarding funds, retaliation against staff/ residents, obstruction, falsifying info, etc.</p>	D, E

Enrolled-All Medicaid Prov.			Additional Req'ts for ABA Techs/Specialized Residential			Law or Rule Reference
CHECK	Felony	Misdemeanor	Felony	Misdemeanor		
					Substantiated finding of neglect, abuse, or misappropriation of property by a state or federal agency (regarding long term care facilities)	D, I
			Includes attempts/ conspiracy to commit; w/in 15 yrs after completion of parole/probation	w/in 10 yrs	Related to chapter XXXA of the Michigan penal code, 1931 PA 328, MCL 750.145m to 750.145r: <ul style="list-style-type: none"> Caregiver who intentionally causes serious physical harm or serious mental harm to a vulnerable adult Reckless act or reckless failure to act of the caregiver or other person with authority over the vulnerable adult causes serious physical harm or serious mental harm An operator/employee/individual acting on behalf of an unlicensed facility that is subject to licensure, who violates the adult foster care facility licensing act or public health code or rules and whose violation is a proximate cause of the death of a vulnerable adult Caregiver/person with authority over vulnerable adult or licensee convicted of felony due to repeated misdemeanor violations of the adult foster care licensing act regarding funds, retaliation against staff/ residents, obstruction, falsifying info, etc. 	D, E
Medication, Prescriptions, Controlled Substances						
<input type="checkbox"/>	After Aug. 21, 1996	w/in 5 yrs		in 5 yrs. if committed when <18 yrs old, then w/in 1 yr	Relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance (Per MSA provider enrollment on 02/14/20 excludes possession)	A, C
<input type="checkbox"/>				w/in 3 yrs. if committed when <18 yrs old, then w/in 1 yr	<ul style="list-style-type: none"> Manufacturing, creating, delivering, or possessing with intent to manufacture, create, or deliver a controlled substance, prescription form, or counterfeit prescription form Dispensing, prescribing, or administering controlled substance outside the scope of practice of a practitioner, licensee, or applicant 	D, F
<input type="checkbox"/>			Includes attempts/ conspiracy to commit; w/in 15 yrs after parole/probation		A felony involving the diversion <u>Diversion</u> or adulteration of a prescription drug or other medications	D
<input type="checkbox"/>				w/in 5 yrs	Possession or delivery of a controlled substance	D

					<p><u>Failure to Comply w Enrollment & Screening Requirements:</u> Failure to submit timely and accurate information; cooperate with MDHHS screening methods; submit sets of fingerprints as required within 30 days of a CMS or MDHHS request; permit access to provider locations for site visits; and/or comply with Medicaid policies regarding submission of claims and billing Medicaid beneficiaries. Falsification of information provided on the enrollment application or subsequent information requests. Inability to verify their identity</p>	A, B
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A = Michigan Medicaid Manual; General Information for All Providers; Section 6 – Denial of Enrollment, Termination and Suspension; 6.1 Termination or Denial of Enrollment

B = Social Welfare Act, Public Act 280 of 1939 (MCL 400.111b -111e) and 42 CFR 455.416

C = 42 USC 1320a-7 Exclusion of certain individuals and entities from participation in Medicare and state health care programs

D = Public Act 19 of 2020 (Public Health Code revision) Section 18263 regarding behavioral technicians

E = Chapter XXA of the Michigan penal code, 1931 PA 328, MCL 750.145m to 750.145r regarding vulnerable adults

F = Public Health Code 333.7401 “Part 74” regarding controlled substances

G = Michigan vehicle code, 1949 PA 300, MCL 257.601d

H = Code of Criminal Procedure MCL 769.16b regarding not guilty by reason of insanity

I = 42 USC 1395i-3a: Protecting residents of long-term care facilities

POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	Advance Directives		
Policy: <input checked="" type="checkbox"/> Procedure: <input type="checkbox"/> Page: 1 of 3	Review Cycle: Biennial Author: Chief Compliance and Quality Officer, Customer Service Committee	Adopted Date: 09.02.14 Review Date: 07.02.2024	Related Policies: Customer Service Policy

Purpose

To ensure that adult beneficiaries of Mid-State Health Network (MSHN), receive information on advance directives in accordance with 42 Code of Federal Regulations (CFR) 422.128 and 42 CFR 438.3.

Policy

MSHN delegates the responsibility for providing adult beneficiaries with information related to advance directives to its Community Mental Health Service Program (CMHSP) Participants/Substance Use Disorder (SUD) Provider Network.

1. CMHSP Participants/SUD Provider Network must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving care by or through the organization;
2. CMHSP Participants/SUD Provider Network:
 - A. Are not required to provide care that conflicts with an advance directive; and
 - B. Are not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive.
 - C. Are prohibited from conditioning the provision of care based on whether or not the individual has executed an advance directive.
3. MSHN Standards for Advance Directives shall ensure that the CMHSP Participants/SUD Provider Network:
 - A. Provides adult beneficiaries with written information on advance directives at the time of initial enrollment;
 - B. Supplies information that includes a description of applicable state law and rights under applicable laws;
 - C. Document in a prominent part of the individual’s current medical record whether or not the individual has executed an advanced directive;
 - D. Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

- E. Continuously updates written information to reflect any changes in state law as soon as possible but no later than 90 days after it becomes effective; and
- F. Informs individuals that grievances concerning noncompliance with the advance directive requirements may be filed with Customer Services.

Applies to:

- All Mid-State Health Network Staff
- Selected MSHN Staff, as follows:
- MSHN CMHSP Participants: Policy Only Policy and Procedure
- Other: Sub-contract Providers

Definitions:

Advance Directive: Document(s) or documentation allowing a person to give directions about future medical care and/or psychiatric care or to designate another person(s) to make medical decisions if the individual loses decision making capacity. Advance directives may include living wills, durable powers of attorney for health care, do-not-resuscitate (DNRs) orders, and right to die or similar documents listed in the Patient Self-Determination Act that express the individual’s preferences

CFR: Code of Federal Regulations

CMHSP: Community Mental Health Service Program

CMHSP Participants/SUD Provider Network: refers to a CMHSP Participant and all Substance Use Disorder Prevention and Treatment Providers that are directly under contract with PIHP MSHN to provide services and/or supports through direct operations or through the CMHSP’s subcontractors.

DNR: Do Not Resuscitate

MSHN: Mid-State Health

Network PIHP: Pre-paid

Inpatient Health Plan SUD:

Substance Use Disorder

Other Related Materials:

N/A

References/Legal Authority:

1. State of Michigan/PIHP Contract: Schedule A: Statement of Work Contract Activities: Q. Observance of State and Federal Laws: 4. Advance Directives Compliance
2. Balanced Budget Act 438.3(j)
3. Center for Medicare and Medicaid Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans- A Protocol for Determining Compliance with 42 CFR.
4. Michigan Mental Health Code 330.1433 & 330.1469a
5. Federal Patient Self-Determination Act Part 489
6. 42 CFR 422.128 and 42 CFR 438.3(j)

Change Log:

Date of Change	Description of Change	Responsible Party
09.2014	New Policy	Chief Compliance Officer
11.2015	Annual Review	Director of Compliance, Customer Service and QI
11.21.2016	Annual Review	Customer Service Committee
12.18.2017	Annual Review	Customer Service Committee
12.03.2018	Annual Review, addition of requirements	Customer Service Committee
03.16.2020	Annual Review, Reference/Legal Authority reference correction	Customer Service Committee
11.15.2021	Bi-annual Review, language added to meet contract requirements	Customer Service Committee
01.22.2024	Biennial Review, no changes	Customer Service Committee
<u>01.26.2026</u>	<u>Biennial Review, no changes</u>	<u>Customer Service Committee</u>

Chapter:	Customer Service		
Title:	Customer Handbook		
Policy: <input checked="" type="checkbox"/>	Review Cycle: Biennial	Adopted Date: 12.03.2013	Related Policies: Customer Service
Procedure: <input type="checkbox"/>	Author: Chief Compliance and Quality Officer, Customer Service Committee	Review Date: 07.02.2024	
Page: 1 of 3			

Purpose

To ensure that all customers ~~that~~-who are served by the Community Mental Health Service Program (CMHSP) Participants and the Substance Use Disorder (SUD) Provider Network for Mid-State Health Network (MSHN) are provided a Regional Customer Handbook/Guide to Services that includes federal, and state of Michigan information required for mental health and substance use disorder services.

Policy

MSHN shall create, publish, and maintain a Customer Handbook/Guide to Services (referred to in the policy as the “Customer Handbook”), the core of which is uniform throughout the region.

- All customers and/or their legally responsible parties who request services shall be provided with a Customer Handbook within a reasonable time from when they first come into service, annually, and when there are significant changes in the handbook content. Confirmation of receipt and/or offer of the Customer Handbook shall be in the customer’s record. The Customer Services Handbook will be provided to the beneficiary by one of the following:
 - giving a copy to the beneficiary in person
 - mailing a printed copy to the beneficiary’s mailing address,
 - emailing an electronic version after obtaining the beneficiary’s written approval,
 - notifying the beneficiary by providing a written statement that identifies where the handbook can be found on the website,
 - other alternate distribution methods based on the request of the beneficiary or that can reasonably be expected to result in the individual receiving the information.

- If/when Michigan Department of Health and Human Services (MDHHS) contractual requirement updates are made to the Customer Handbook, the CMHSP Participants and the SUD Provider Network shall provide supplemental materials (inserts, stickers) to customers receiving services to reflect the changes. To the extent possible, customers will be provided with at least 30 days’ notice before the intended effective date of any change that the State defines as significant in the information specified in 42 Code of Federal Regulations (CFR) 438.10(g)(2).

- Any customer, natural support, community member, or agency, including any external credentialing or payer agencies, may request and receive a copy of the Customer Handbook

at any time.

- The Customer Handbook and the Prepaid Inpatient Health Plan (PIHP) Provider Directory shall be posted and/or linked on the MSHN website. Additionally, the respective Customer Handbook and the Local Provider Directory shall be posted on each CMHSP Participant website.

- The Customer Handbook shall be published and updated by MSHN to ensure compliance with specific Michigan Department of Health and Human Services (MDHHS) technical requirements regarding content, and with specific federal requirements found in 42 CFR 438.10. Customer Handbooks shall include the date of publication and revision by MSHN.
- Although the Customer Handbook is standardized to include the MDHHS and MSHN required content, CMHSP Participants may tailor approved portions of the Customer Handbook to include local content.
- Customer Handbooks will be reviewed with consumer advisory councils and CMHSP Participants, and the SUD Provider Network for feedback. MSHN shall maintain approval authority for changes to the Customer Handbook.
- Using MDHHS prescribed templates, the Customer Handbook shall include federal, and state required topics. MSHN will ensure approval is obtained from MDHHS and/or Centers for Medicaid and Medicare (CMS) for publication revisions prior to publishing the revised customer handbook.
- CMHSP Participants and the SUD Provider Network shall provide accommodations to the Customer Handbooks and the Provider Directory where required for customers where English is not their primary spoken language, or for impairments to visual, auditory, and/or literacy capabilities in accordance with federal and state laws, rules, and guidelines. Efforts will be made to ensure all information in the Customer Handbook is easily understood.
- MSHN shall provide monitoring and oversight to ensure that CMHSP Participants and the SUD Provider Network provide the Customer Handbook to individuals who are served according to the established standards.

Applies to:

- All Mid-State Health Network Staff
- Selected MSHN Staff, as follows:
 - MSHN's CMHSP Participants: Policy Only Policy and Procedure
 - Other: Sub-contract Providers

Definitions/Acronyms:

CFR: Code of Federal Regulations

CMHSP: Community Mental Health Service Program

CMS: Centers for Medicaid and Medicare

Customer: Refers to individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably.

Customer Handbook: The handbook is a required set of information that must be provided to Medicaid beneficiaries at the start of treatment and at least annually.

Local Provider Directory: The Customer Handbook includes local CMHSP information, including the provider directory for that CMHSP county/counties of service

MDHHS: Michigan Department of Health and Human Services

MSHN: Mid-State Health Network

PIHP: Prepaid Inpatient Health Plan

SUD: Substance Use Disorder

SUD Provider Network: Refers to a SUD Provider that is directly under contract with the MSHN PIHP to provide services and/or supports.

References/Legal Authority:

1. 42 CFR 438.10 Information requirements
State of Michigan/PIHP Contract: Schedule A: Statement of Work, Section 1. General Requirements, B. Customer Services Standards, 4. Customer Services Handbook Requirements

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New policy	Customer Services Committee
12.08.14	Annual review, format consistency	Customer Services Committee and Chief Compliance Officer
11.2015	Annual Review	Director of Compliance, Customer Services & Quality Improvement
11.21.2016	Annual Review	Customer Service Committee
12.18.2017	Annual Review	Customer Service Committee
12.03.2018	Annual Review	Customer Service Committee
03.16.2020	Annual Review, language revised to match Attachment P6.3.1 language	Customer Service Committee
11.15.2021	Bi-annual Review, language updates to match contract requirements	Customer Service Committee
01.22.2024	Biennial Review, language updates to match contract requirements	Customer Service Committee
<u>01.26.2026</u>	<u>Biennial Review, minor updates</u>	<u>Customer Service Committee</u>

POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	Customer/Consumer Service		
Policy: <input checked="" type="checkbox"/> Procedure: <input type="checkbox"/> Page: 1 of 3	Review Cycle: Biennial Author: Chief Compliance and Quality Officer, Customer Service Committee	Adopted Date: 12.03.2013 Review Date: 07.02.2024	Related Policies: Customer Service

Purpose

To ensure that primary and secondary consumers, as customers of Mid-State Health Network (MSHN), receive timely, accurate, understandable, and culturally appropriate services.

Policy

MSHN delegates the responsibility for Customer/Consumer Services to its Community Mental Health Services Program (CMHSP) Participants and Substance Use Disorder (SUD) Provider Network. The CMHSP Participants/SUD Provider Network shall convey an atmosphere that is welcoming, helpful, and informative for its customers.

MSHN Standards of Customer/Consumer Service ensure that CMHSP Participants/SUD Provider Network shall:

- A. Establish a Customer Services Unit that meets the needs of the Consumer/Customer served. The Customer Services Unit will provide Customer Services as defined by the Michigan Department of Health and Human Services (MDHHS) Pre-Paid Inpatient Health Plan (PIHP) Customer Services Standards. Customer Services must convey an atmosphere that is welcoming, helpful, and informative, where individuals are oriented to the services and benefits that are available, including providing the Provider Directory Listing in accordance with the MSHN Provider Network Directory – Information Requirements policy. These standards apply to the CMHSP Participants/SUD Providers and to any entity to which they have delegated their customer service function;
- B. When providing information electronically, it must be in a form that is readily accessible; it must be on the website in a location that is prominent and readily accessible; it must be in an electronic form that can be electronically retained and printed; Customer/Consumer must be informed that the information is available in paper form without charge and provided within five (5) business days upon request;
- C. Ensure materials are written at the 6.9 grade reading level when possible (i.e., in some situations, it is necessary to include required terminology, medications, diagnosis, and conditions that do not meet the grade level criteria);
- D. Provide information about how to access benefits, including authorization requirements, for mental health, primary healthcare, substance use disorder treatment and prevention, and other community-based services;

- E. Provide information on available treatment options and alternatives. Provide information on the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure beneficiaries understand the benefits to which they are entitled and the extent to which, and how, after-hours crisis services are provided;
- F. Provide information on cost-sharing, as appropriate;
- G. Provide information on how to access the various recipient rights processes;
- H. Upon request, assist customers with problems and inquiries regarding benefits; with local complaint and grievance processes; and local appeal and fair hearings processes, including expected timelines;
- I. Provide the rules for emergency and post-stabilization services;
- J. Provide information on quality and performance indicators and enrollee satisfaction;
- K. Track and report patterns of potential problem areas for the organization;
- L. Material must not contain false, confusing, and/or misleading information;
- M. Make a good faith effort to give written notice of termination of a contracted provider, by the later of 30 calendar days prior to the effective date of the termination, or within 15 days after receipt or issuance of the termination notice, to each beneficiary who received his or her primary care from, or was seen on a regular basis by, the terminated provider;
- N. Annually (e.g., at the time of person-centered planning) provide to the beneficiary the estimated annual cost of each covered support and service he/she is receiving; and
- O. Provide an Explanation of Benefits (EOBs) to 5% of the consumers receiving services. The EOB distribution must comply with the State and Federal regulations regarding release of information as directed by MDHHS.

Applies to:

- All Mid-State Health Network Staff
- Selected MSHN Staff, as follows:
- MSHN's Affiliates: Policy Only Policy and Procedure
- Other: Sub-contract Providers

Definitions/Acronyms:

CFR: Code of Federal Regulations

CMHSP: Community Mental Health Service Program

Consumer/Customer: Refers to individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably

EOB: [Explanation of Benefits](#)

MDHHS: Michigan Department of Health and Human Services

MSHN: Mid-State Health Network

PIHP: Prepaid Inpatient Health Plan

Primary Consumer: An individual who receives or has received services from MDHHS or CMHSP Participant(s): This includes those who receive or have received the equivalent mental health services from the private sector

Secondary Consumer: A family member, guardian, or advocate of an individual who receives or has received services from MDHHS or a CMHSP. This includes family members, guardians, or advocates of a person who has received the equivalent mental health services from the private sector

SUD: Substance Use Disorder

SUD Provider Network: Refers to a Substance Use Disorder Provider that is directly under contract with the MSHN PIHP to provide services and/or supports

References/Legal Authority:

1. 42 CFR 438.10: Information Requirements
2. 42 CFR 438.400 Appeals and Grievances
3. State of Michigan/PIHP Contract: Schedule 1. General Requirements, M. Beneficiary Services, 2. Written Materials, b. Additional Information Requirements
4. State of Michigan/PIHP Contract: Schedule 1. General Requirements, B. Customer Services Standards

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New policy	Customer Services Committee
11.2015	Annual review, format consistency	Director of Compliance, Customer Services & Quality Improvement
11.21.2016	Annual Review	Customer Service Committee
12.18.2017	Annual Review	Customer Service Committee
12.03.2018	Annual Review	Customer Service Committee
03.16.2020	Annual Review, language added to meet reference requirements	Customer Service Committee
11.15.2021	Biennial Review, language added to meet contract requirements	Customer Service Committee
01.22.2024	Biennial Review, language added to meet contract requirements, removed content is present in the MSHN LEP Policy	Customer Service Committee
<u>01.26.2026</u>	<u>Biennial Review, no changes</u>	<u>Customer Service Committee</u>

POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	Enrollee Rights		
Policy: <input checked="" type="checkbox"/>	Review Cycle: Biennial	Adopted Date:	Related Policies: Consumer Service Policy
Procedure: <input type="checkbox"/>	Author: Chief Compliance and Quality Officer; Customer Service Committee	Review Date: 07.02.2024	
Page: 1 of 3			

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Purpose

To ensure the legal authority and requirements for the rights and the protections for all recipients receiving community mental health and substance use disorder services authorized and/or delivered by the Mid-State Health Network (MSHN) Provider Network.

Policy

1. General rule:
 - a. Each Community Mental Health Service Program (CMHSP) and Substance Use Disorder (SUD) Provider Network participant shall comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its employees and contracted providers observe and protect those rights.
2. Guaranteed enrollee rights -
 - a. Receive information in accordance with 42 Code of Federal Regulations (CFR) 438.10 - Information requirements.
 - b. Be treated with respect and with due consideration for his or her dignity and privacy.
 - c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
 - i. The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in 42 CFR 438.10(g)(2)(ii)(A) and (B).
 - d. Participate in decisions regarding his or her health care, including the right to refuse treatment.
 - e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

- f. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.
 - g. An enrollee of a CMHSP/SUD Provider Network Participant has the right to be furnished health care services in accordance with 42 CFR 438.206 through 438.210.
3. Free exercise of rights.
- a. The CMHSP /SUD Provider Network Participant ensures that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the CMHSP/SUD Provider Network Participant treats the enrollee.
4. Compliance with other Federal and State laws.
- a. Each CMHSP /SUD Provider Network Participant shall comply with any other applicable Federal and State laws (including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

Applies to:

- All Mid-State Health Network Staff
- Selected MSHN Staff, as follows:
- MSHN's Affiliates: Policy Only Policy and Procedure
- Other: Sub-contract Providers

Definitions:

CFR: Code of Federal Regulations

CMHSP: Community Mental Health Service Program

Enrollee: A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program. 42 CFR 438.2.

MCO: [Managed Care Organization](#)

MSHN: Mid-State Health Network

PAHP: [Pre-paid Ambulatory Health Plan](#)

PCCM: [Primary Care Case Management](#)

PIHP: Pre-paid Inpatient Health Plan

Provider Network: Refers to a CMHSP Participant and all Substance Use Disorder Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP/SUD Provider subcontractors.

SUD: Substance Use Disorder

Other Related Materials:

None

References/Legal Authority:

1. 42 CFR 438.10 Information requirements
2. 42 CFR 438.100 Enrollee Rights
3. 42 CFR 438.206 Availability of services.
4. 42 CFR 438.207 Assurances of adequate capacity and services.
5. 42 CFR 438.208 Coordination and continuity of care.
6. 42 CFR 438.210 Coverage and authorization of services.
7. 45 CFR PART 160 – General Administrative Requirements
8. 45 CFR PART 164 – Security and Privacy

Change Log:

Date of Change	Description of Change	Responsible Party
03/16/2020	New policy	Director of Quality, Compliance, and Customer Service; Customer Service Committee
11.15.2021	Bi-annual Review, no recommended changes	Customer Service Committee
01.22.2024	Biennial Review, no significant changes	Customer Service Committee
<u>01.26.2026</u>	<u>Biennial Review, no changes</u>	<u>Customer Service Committee</u>

POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	Information Accessibility/Limited English Proficiency (LEP)		
Policy: <input checked="" type="checkbox"/>	Review Cycle: Biennial	Adopted Date: 07.01.2014	Related Policies: Customer Service Policy
Procedure: <input type="checkbox"/>	Author: Chief Compliance and Quality Officer, Customer Service Committee	Review Date: 07.02.2024	
Page: 1 of 4			

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Purpose

Mid-State Health Network (MSHN) and its provider network will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) due to ~~literary~~-literacy or impairment reasons have meaningful access and equal opportunity to participate in the services, activities, programs, and other benefits.

Policy

- A. MSHN delegates the responsibility for ensuring meaningful communication with LEP consumers/customers and their authorized representatives involving their medical conditions, benefits, and supports/services to the Community Mental Health Services Program (CMHSP) Participants and Substance Use Disorder (SUD) providers, with oversight and monitoring by MSHN. This includes client-specific and/or general information about:
1. Managed care;
 2. Excluded populations;
 3. Covered benefits;
 4. Cost sharing (if any);
 5. Service area;
 6. Availability of interpreters
- B. CMHSP Participants/SUD Provider Network, to ensure sufficient resources for persons with LEP, shall:
1. Establish a methodology for identifying the prevalent non-English languages spoken by beneficiaries likely to be served in their service area;
 2. Determine the frequency ~~that~~-with which LEP persons may come in contact with their programs;
 3. Estimate the available resources required to meet the identified needs;
 4. Develop procedures for timely and effective communication between staff and persons with LEP.

C. CMHSP Participants/SUD Provider Network will ensure:

1. All materials are available in language(s) appropriate to the people served within the [Pre-Paid Inpatient Health Plan's \(PIHP's\)](#) area for specific non-English languages that ~~is~~ are spoken as the primary language by more than 5% of the population in the PIHP's region. Such materials shall be available in any language

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alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2002, Federal Register Vol. 65, August 16, 2002).

~~2.~~ 2. All materials are available in alternative formats in accordance with the Americans with Disabilities Act (ADA).

~~3.~~ 3. ~~Vital W~~ritten materials critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, are available in the prevalent non-English language(s) within the service area and must include taglines, printed in a conspicuously-visible font size, explaining the availability of written translations or oral interpretation along with the toll-free telephone number of the entity providing services as required by 42 Code of Federal Regulations (CFR) 438.71(a) and 42 CFR 438.10(d)(2). ~~Taglines must be printed in a conspicuously-visible font size~~ Conspicuously visible is defined as a font greater than the minimum font size of 12 point, is not a large font, and is more pronounced than the adjacent font.

~~4.~~ 4. ~~Beneficiaries may access~~Written materials ~~in~~will use easily understood language and format, use a font size ~~with a minimum font of no smaller than~~ 12 point ~~and, 6.9 reading level, and be available~~ in large print ~~in a font size no smaller than 18 point.~~

- D. The CMHSP Participants/SUD Provider Network shall ensure that beneficiaries are notified of how to access alternative formats, that oral interpretation is available for any language, and written information is available in prevalent languages. This includes interpretation services for the deaf, hard of hearing, and deaf/blind populations.
- E. The CMHSP Participants/SUD Provider Network shall ensure that beneficiaries have timely access to support and services in their preferred language based on their language skills and in accordance with the Access Standards.
- F. The CMHSP Participants/SUD Provider Network shall ~~assure~~ensure ~~that~~ designated employees and members of its provider network can obtain appropriate interpretation, translation, and/or communication services or technical equipment to meet the needs of beneficiaries in their service areas. This includes written materials and face-to-face or phone communications.
- G. All interpreters, translators, and other aids needed to comply with this policy shall be provided without cost to the person being served.
- H. The CMHSP Participants/SUD Provider Network shall have a local procedure in place that complies with the Michigan Department of Health and Human Services (MDHHS) Information Accessibility for Beneficiaries with LEP requirements, as well as the ADA.
- I. The CMHSP Participants/SUD Provider Network must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic

backgrounds and those who are Deaf, Hard of Hearing, and Deaf and Blind. Treatment will be modified to effectively serve individuals who are deaf, hard of hearing, and deaf and blind, ~~as determined by~~ based on their language skills and preferences.

- J. The CMHSP Participants/SUD Provider Network may only use Video Remote Interpreting (VRI) in emergencies, extenuating circumstances, or during a state or national emergency as a temporary solution until the provider can secure a qualified interpreter, and in accordance with the R 393.5055 VRI standards, usage, limitations, educational, legal, medical, and mental health standards.
- K. The CMHSP Participants/SUD Provider Network shall comply with the Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it affects persons with LEP, 45 CFR 92.201, and Section 1557 of the Patient Protection and Affordable Care Act. It is expected that reasonable steps will be taken to provide meaningful access to each individual beneficiary with LEP, such as language assistance services, including but not limited to oral interpretation and written translation.

Applies to:

- All Mid-State Health Network Staff
 Selected MSHN Staff, as follows:
 MSHN's Affiliates: Policy Only Policy and Procedure
 Other: Sub-contract Providers

Definitions:

ADA: Americans with Disabilities Act.

CFR: Code of Federal Regulations

CMHSP: Community Mental Health Service Program

Communication: The effective transmission of messages using spoken language, Braille, American Sign Language, or available technology as necessary.

Consumer/Customer: Refers to individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably.

Interpretation: The oral transmittal of a message from one language to another, considering dialect, culture, and nuance.

Limited English Proficiency (LEP): Means being limited in the ability or unable to speak, read, and/or write the English language well enough to understand and be understood without the aid of an interpreter.

MDHHS: Michigan Department of Health and Human Services

MSHN: Mid-State Health Network

PIHP: Pre-paid Inpatient Health Plan

Population/Service Area: Includes any Medicaid beneficiary who may potentially receive services from MSHN and its provider network.

Prevalent: means a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.

Readily Accessible: means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

SUD: Substance Use Disorder

SUD Provider Network: Refers to a SUD Provider directly under contract with PIHP MSHN to provide services and/or supports.

Translation: The written interpretation of a message from one language to another, conveying the original meaning of the text with linguistic precision.

VRI: Video Remote Interpreting

Other Related Procedures:

N/A

References/Legal Authority:

1. 42 CFR 438.10 Information Requirements
2. 42 CFR 438.400 Appeals and Grievances
3. State of Michigan/PIHP Contract: Schedule 1. General Requirements, M. Beneficiary Services, 2. Written Materials, b. Additional Information Requirements
4. State of Michigan/PIHP Contract: 1. General Requirements, Q. Observance of State and Federal Laws and Regulations, 8. Limited English Proficiency
5. Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2002, Federal Register Vol. 65, August 16, 2002).
6. Office of Civil Rights Policy Guidance on Title VI "Language, Assistance to Persons with Limited English Proficiency"
7. The MICHIGAN DEPARTMENT OF CIVIL RIGHTS DIVISION ON DEAF AND HARD OF HEARING QUALIFIED INTERPRETER – GENERAL RULES (By authority conferred on the division on deaf and hard of hearing by section 8a of the deaf persons' interpreters act, 1982 PA 204, MCL 393.508a, section 9 of the division on deafness act, 1937 PA 72, MCL 408.209, and ERO 1996-2, MCL 445.2001, ERO 2003-1, MCL 445.2011, and ERO 2008-4, MCL 445.2025.)

Change Log:

Date of Change	Description of Change	Responsible Party
07.01.2014	New policy	Chief Compliance Officer
04.2016	Annual Review/Update	Customer Service & Recipient Rights Specialist
11.21.2016	Updated according to MDHHS/PIHP contract	Customer Service Committee
12.18.17	Annual Review	Customer Service Committee
12.03.18	Annual Review, additional language added	Customer Service Committee

03.16.2020	Annual Review, additional language added, edit to conform to definitions	Customer Service Committee
11.15.2021	Bi-annual Review, updated language from contract	Customer Service Committee
05.15.2023	Policy updates to include updated language from the PIHP contract	Customer Service Committee
01.22.2024	Biennial review, no changes	Customer Service Committee
<u>01.26.2026</u>	<u>Biennial review, revisions due to language changes from the PIHP Customer Service Standards</u>	<u>Customer Service Committee</u>

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Chapter:	Customer Service		
Title:	Medicaid Enrollee Appeals/Grievances		
Policy: <input checked="" type="checkbox"/>	Review Cycle: Biennial	Adopted Date: 07.01.2014	Related Policies: Consumer Services Policy
Procedure: <input type="checkbox"/>	Author: Chief Compliance and Quality Officer, Customer Service Committee	Review Date:	
Page: 1 of 5			

Purpose

To establish a process to resolve complaints and ensure recipient notification of a person’s right to file appeals and grievances, including internal appeals, grievances, and administrative hearings related to dissatisfaction with services authorized and/or delivered by Mid-State Health Network’s (MSHN) Provider Network.

Policy

MSHN delegates the responsibility for the appeals/grievance processes consistent with federal and state guidelines to the Community Mental Health Service Program (CMHSP) Participants and Substance Use Disorder (SUD) providers, with oversight and monitoring by MSHN, including:

1. Local Appeal process for recipients, guardians, or subcontracted providers to challenge an Adverse Benefit Determination by the CMHSP Participants/SUD Provider Network or its agents regarding a consumer’s services;
2. The right to concurrently file a local Appeal of an Adverse Benefit Determination and a Grievance regarding other services complaints;
3. Access to the State Fair Hearing process after a local Appeal denial of an Adverse Benefit Determination is received;
4. The right to request and have Medicaid covered benefits continued during the local Appeal and/or the State Fair Hearing if the request for continuation of benefits is timely (on or before the latter of 10 calendar days from the date of the notice of Adverse Benefit Determination, or the intended effective date of the proposed Adverse Benefit Determination); customers may be asked to pay for a portion of the services received during the appeal and/or Fair Hearing process if the outcome upholds the decision being appealed;
5. A local grievance process for any recipient of the Pre-Paid Inpatient Health Plan (PIHP) to express dissatisfaction about any matter other than those that meet the definition of an “Adverse Benefit Determination” or those that meet the definition of a Recipient Rights issue;
6. Complaints should be resolved at the level closest to service delivery when possible, but information regarding access to all complaint resolution processes will be provided to the Medicaid Enrollee;
7. With the written consent from the Enrollee, the right to have a provider or other authorized representative acting on the Enrollee's behalf file an Appeal or Grievance or request a State

Fair Hearing. The provider may file a Grievance or request a State Fair Hearing on behalf of the Enrollee since the State permits the provider to act as the Enrollee's authorized representative in doing so. Punitive action may not be taken against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so;

8. All processes will promote the resolution of concerns and improvement of the quality of care;
9. Each CMHSP Participant/ SUD Provider shall have a local procedure in place that is in compliance with the Michigan Department of Health and Human Services (MDHHS), Grievance and Appeal Technical Requirement, and 42 Code of Federal Regulations (CFR) 438 Subpart F – Grievance and Appeal System.

Applies to:

- All Mid-State Health Network Staff
- Selected MSHN Staff, as follows:
- MSHN's CMHSP Participants: Policy Only Policy and
- Procedure
- Other: Sub-contract Providers

Definitions:

Adverse Benefit Determination (ABD): A decision that adversely impacts a Medicaid Enrollee's claim for services due to: (42 CFR 438.400)

- a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 42 CFR 438.400 (b)(1).
- b. Reduction, suspension, or termination of a previously authorized service. 42 CFR 438.400(b)(2).
- c. Denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an ABD. 42 CFR 438.400(b)(3).
- d. Failure to make a standard Service Authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service. 42 CFR 438.210(d)(1).
- e. Failure to make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization. 42 CFR 438.210(d)(2).
- f. Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the PIHP. 42 CFR 438.400(b)(4).
- g. Failure of the PIHP to resolve standard appeals and provide notice within **30 calendar days** from the date of a request for a standard appeal. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).
- h. Failure of the PIHP to resolve expedited appeals and provide notice within **72 hours** from the date of a request for an expedited appeal. 42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).
- i. Failure of the PIHP to resolve grievances and provide notice within **90 calendar days** of

the date of the request. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*

- j. For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network. *42 CFR 438.400(b)(6).*
- k. Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. *42 CFR 438.400(b)(7).*

Adequate Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to deny or limit authorization of Medicaid services requested, which notice must be provided to the Medicaid Enrollee on the same date the Adverse Benefit Determination takes effect. *42 CFR 438.404(c)(2).*

Advance Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to reduce, suspend or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid Enrollee at least **10 calendar days prior** to the proposed date the Adverse Benefit Determination is to take effect. *42 CFR 438.404(c)(1); 42 CFR 431.211.*

Appeal: A review at the local level by a PIHP of an Adverse Benefit Determination, as defined above. *42 CFR 438.400.*

Authorization of Services: The processing of requests for initial and continuing service delivery. *42 CFR 438.210(b).*

[CFR: Code of Federal Regulations](#)

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

CMHSP: Community Mental Health Service Program

Enrollee: A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program. *42 CFR 438.2.*

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by an Enrollee or the Enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the Enrollee requests the expedited review, the PIHP determines if the request is warranted. If the Enrollee's provider makes the request, or supports the Enrollee's request, the PIHP must grant the request. *42 CFR 438.410(a).*

Grievance: ~~Enrollee's~~ Expression of dissatisfaction about ~~PIHP/CMHSP service issues, any matter other than an Adverse Benefit Determination. Possible subjects for grievances~~ ABD. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships between such as rudeness of a service provider and the Enrollee, or employee, or failure to respect the Enrollee's beneficiary's rights regardless of whether remedial action is requested, or an Enrollee's. Grievance includes a beneficiary's right to dispute regarding an extension of time proposed by the PIHP to make a service authorized an authorization decision. *42 CFR 438.400.*

Grievance Process: Impartial local level review of an Enrollee's Grievance.

Grievance and Appeal System: The processes the PIHP implements to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them. *42 CFR 438.400.*

MDHHS: Michigan Department of Health and Human Services

Medicaid Services: Services provided to an Enrollee under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

MSHN: Mid-State Health Network

Notice of Resolution: Written statement of the PIHP of the resolution of a Grievance or Appeal, which must be provided to the Enrollee as described in *42 CFR 438.408*.

PIHP: Prepaid Inpatient Health Plan.

Recipient Rights Complaint: Written or verbal statement by aan Enrollee, or anyone acting on behalf of the Enrollee, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

Service Authorization: PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to *42 CFR 438.210*.

State Fair Hearing: Impartial state level review of a Medicaid Enrollee's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

SUD: Substance Use Disorder

SUD Provider Network: Refers to a SUD Provider that is directly under contract with PIHP MSHN to provide services and/or supports

Other Related Procedures:

N/A

References/Legal Authority:

The following federal and state statutes establish the standards for MSHN's Appeals and Grievance procedures for Medicaid Recipients:

1. 42 CFR 438.10: Information Requirements
2. 42 CFR 431.200 Fair Hearings
3. 42 CFR 438.400 Appeals and Grievances
4. State of Michigan/PIHP Contract: Schedule 1. General Requirements, L. Grievance and Appeals Process for Beneficiaries
5. State of Michigan/PIHP Contract attachment: Appeals and Grievances Technical Requirements (P.6.3.1.1)
6. Michigan Mental Health Code (MHC) MCL 330.1772 (Recipient Rights Complaints)
7. Michigan Mental Health Code (MHC) MCL 330.1705 (Medical Second Opinion)

Change Log:

Date of Change	Description of Change	Responsible Party
07.01.2014	New policy	Chief Compliance Officer
04.2016	Annual Review/Formatting Update	Customer Service and Rights Specialist
11.21.2016	Annual Review, language edition	Customer Service Committee
10.16.2017	Annual Review, revised definitions	Customer Service Committee

12.3.2018	Annual Review	Customer Service Committee
03.16.2020	Annual Review	Customer Service Committee
11.15.2021	Bi-annual Review, updated language from contract	Customer Service Committee
01.22.2024	Biennial Review, no changes	Customer Service Committee
<u>01.26.2026</u>	<u>Biennial Review, minor changes</u>	<u>Customer Service Committee</u>

DRAFT

Chapter:	Customer Service		
Title:	Regional Consumer Advisory Council		
Policy: <input checked="" type="checkbox"/>	Review Cycle: Biennial	Adopted Date: 12.03.2013	Related Policies: Customer Service Policy
Procedure: <input type="checkbox"/>	Author: Chief Compliance and Quality Officer, Customer Service Committee	Review Date: 07.02.2024	
Page: 1 of 5			

Purpose

To ensure Mid-State Health Network (MSHN) integrates consumerism into policy development, service delivery provision, service delivery system evaluation, and quality assurance/performance improvement practices.

Policy

MSHN shall facilitate meaningful, region-wide consumer involvement in its policy development, service development, service delivery, service evaluation, and quality improvement activities by establishing a MSHN Regional Consumer Advisory Council (RCAC) for Prepaid Inpatient Health Plan (PIHP) operations that links to local Community Mental Health Service Program (CMHSP) Participant Consumer Advisory Councils to facilitate consumer participation.

A. Charter

1. The MSHN RCAC is an advisory group of MSHN primary and secondary consumers. This group assists MSHN in identifying issues and areas of concern related to regional service delivery and managed care operations. It is a primary source of consumer input into the development of policies, procedures and operations where recipients of service may make recommendations for quality improvement.
2. The MSHN RCAC will also focus on region-wide political and advocacy issues to ensure there is a public basis for management of the mental health and substance use disorder delivery system.
3. The MSHN RCAC will also focus on region-wide opportunities for stigma reduction related to mental health and substance use disorder issues.

B. Membership

1. The RCAC shall be comprised of 24-36 voting members made up of primary and secondary consumers. RCAC shall also include 12 non-voting CMHSP Participant staff liaisons and staff support from the MSHN Customer Service and Rights Manager. The RCAC shall report directly to the MSHN Board of Directors through the MSHN Deputy Director.
2. RCAC Primary and Secondary Consumer Membership:
 - i. Each CMHSP Participant shall be represented on the RCAC with 2-3 consumer representatives. Each CMHSP Participant shall independently choose the method to appoint its members to the RCAC.
 - ii. The RCAC shall have a diverse and proportional membership representing the following populations: Adults with mental illness, adults with developmental

disabilities, children with mental illness, children with developmental disabilities, and individuals with substance use disorders. Further, at least half of RCAC membership shall be primary consumers. Thus, it shall be necessary for MSHN to coordinate CMHSP's appointees to the RCAC to ensure that it represents the populations served.

- iii. For issues that require a vote, each voting member shall have one vote. The outcome of a vote is determined by the majority of those present.
3. RCAC Leadership:
 - i. The RCAC shall elect officers, including a chairperson and vice-chairperson from within its voting membership. The MSHN Customer Service and Rights Manager will provide staff support to the RCAC; however, he/she shall not be a voting member. MSHN staff will assist in developing RCAC meeting agendas, facilitation of meetings, and any needed follow-up.
 4. RCAC-CMHSP Participant Staff Liaisons:
 - i. Each CMHSP Participant shall choose a staff liaison to maximize linkages to local CMHSP consumer advisory councils, performance improvement processes and administrative bodies, and other CMHSP staff for any necessary problem resolution.

C. Responsibilities

1. RCAC Member Responsibilities

- i. Regularly attend RCAC meetings to be held bi-monthly. The meetings may be held by a combination of in-person, teleconference, or other technology. MSHN staff and CMHSP Participant staff liaisons shall monitor attendance and will address the membership with any identified issues.
- ii. MSHN will reimburse RCAC members for pre-approved travel expenses for each meeting attended and a reasonable stipend for meeting attendance per protocols developed by MSHN.
- iii. Members will actively participate in RCAC discussions.
- iv. Members will provide input and make informed decisions as a representative of all the individuals served at their local CMHSP rather than act as a representative of themselves (i.e. avoid personal agendas).
- v. Review aggregate reports received from the Quality Assessment and Performance Improvement Program (QAPIP), provide recommendations, and give guidance and suggestions regarding consumer-related managed care processes.
- vi. Serve as the link between the RCAC and the local CMHSP Participant Consumer Advisory Council. Each member shall represent and vote in the best interests of the local consumers in a manner that embodies the local majority opinion.
- vii. Share ideas and activities that occur at the local CMHSP level and create an environment that fosters networking, idea sharing, peer support, best practices, and resource sharing.
- viii. Provide feedback for regional initiatives intended to encourage person-centered planning, self-determination, independent facilitation, anti-stigma initiatives, community integration, recovery and other consumer-directed goals.

2. MSHN Responsibilities
 - i. Reimburse MSHN RCAC members for approved mileage and meeting attendance stipend as determined by a developed protocol.
 - ii. Provide initial orientation and on-going education to MSHN RCAC members to foster informed decision making.
 - iii. Facilitate the development of an open, non-judgmental environment in which RCAC members are comfortable sharing opinions and ideas.
 - iv. Provide pertinent reports and information to MSHN RCAC members.
 - v. Share MSHN RCAC's minutes, recommendations/actions and suggestions with pertinent MSHN Councils and the MSHN Board of Directors. MSHN will develop a routine feedback loop to RCAC members on how feedback was used or the reasons that feedback was not used.
 - vi. Ensure that the communication/links between the RCAC and the local CMHSP Consumer Advisory Council are effective and beneficial. MSHN will also ensure that immediate, CMHSP-specific needs or problems are brought to the attention of the local CMHSP Chief Executive Officers (CEOs) in a timely manner.
 - vii. Promote the efforts and achievements of MSHN RCAC through special recognition and appreciation.

3. CMHSP Participant Staff Liaison to RCAC Responsibilities
 - i. Assist RCAC CMHSP member representatives with the communication of pertinent regional information to local CMHSP Participant Consumer Advisory Councils, obtain feedback, and ensure attendance of its CMHSP representatives to MSHN RCAC.
 - ii. Each CMHSP Participant staff liaison will assist its RCAC CMHSP member representatives in linking to local processes that ensure consumers' voices are heard, considered, and acted upon as appropriate.
 - iii. CMHSP Participant staff liaisons will assist MSHN staff with problem-solving immediate local issues introduced by its representatives at the MSHN RCAC.

4. Council Process
 - i. The RCAC shall receive and review reports from MSHN staff or their designee(s) on a regular basis.
 - ii. The RCAC will report quarterly to the MSHN Board of Directors and identify RCAC recommendations for Board consideration.
 - iii. The RCAC shall make recommendations to the MSHN Board of Directors based on a simple majority vote of RCAC members.
 - iv. The MSHN staff representative and officers will communicate decisions and recommendations of the MSHN Board of Directors to RCAC members.

Applies to:

- All Mid-State Health Network Staff
 Selected MSHN Staff, as follows:
 MSHN’s CMHSP Participants: Policy Only Policy and Procedure
 Other: Sub-contract Providers

Definitions/Acronyms:

CEO: Chief Executive Officer

CMHSP: Community Mental Health Service Program

CMHSP Consumer Advisory Council: The advisory council was established to serve in an advisory capacity to CMHSP Boards

Consumerism: Means active promotion of the interests, service needs, and rights of consumers receiving mental health and/or substance use disorder services

Consumer/Customer: Refers to individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of MSHN policy, these terms are used interchangeably

Informed Choice: Providing information to individuals to ensure understanding of their options that will inform their decision-making related to service provision

Local Consumer Advisory Council: Local CMHSP advisory group of primary and secondary consumers providing input into local CMHSP Participant service delivery, service evaluation, advocacy efforts, and performance improvement opportunities. The Local Consumer Advisory Councils are connected to the Regional Consumer Advisory Council to maximize local input into service delivery, service evaluation, advocacy efforts, and performance improvement opportunities within the region

MDHHS: Michigan Department of Health and Human Services

MSHN: Mid-State Health Network

Primary Consumer: An individual who receives or has received services from MDHHS or CMHSP Participant(s). This includes those who receive or have received the equivalent mental health services from the private sector

PIHP: Prepaid Inpatient Health Plan

QAPIP: Quality Assessment and Performance Improvement Plan

RCAC/Regional Consumer Advisory Council: Region-wide advisory group of primary and secondary consumers from all CMHSP Participants to provide input into MSHN PIHP service delivery, service evaluation, advocacy efforts, and performance improvement opportunities. The Regional Consumer Advisory Council (RCAC) is connected to the CMHSP Local Consumer Advisory Councils to maximize local input into PIHP service delivery, service evaluation, advocacy efforts, and performance improvement opportunities

Secondary Consumer: A family member, guardian, or advocate of an individual who receives or has received services from the MDHHS or a CMHSP. This includes family members, guardians, or advocates of a person who has received the equivalent mental health services from the private sector

References/Legal Authority:

1. Michigan Department of Health and Human Services Medicaid Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY19, including the “Consumerism Practice Guideline”.
2. Act 258, Section 116(e), Public Acts of 1974 as amended, being MCL 330.1116, 1704, 1708.

Change Log:

Date of Change	Description of Change	Responsible Party
12.03.2013	New Policy	Customer Service Committee
11.2015	Annual Review	Director of Compliance, Customer Services and QI
11.21.2016	Annual Review	Customer Service Committee
12.18.2017	Annual Review	Customer Service Committee
12.03.2018	Annual Review	Customer Service Committee
03.16.2020	Annual Review	Customer Service Committee
11.15.2021	Bi-annual Review	Customer Service Committee
01.22.2024	Biennial Review, minor changes	Customer Service Committee
<u>01.26.2026</u>	<u>Biennial Review, no changes</u>	<u>Customer Service Committee</u>

POLICIES AND PROCEDURE MANUAL

Chapter:	Customer Service		
Title:	Recipient Rights for Substance Use Disorder Recipients		
Policy: <input checked="" type="checkbox"/>	Review Cycle: Biennial	Adopted Date:	Related Policies: Consumer Service Policy
Procedure: <input type="checkbox"/>	Author: Chief Compliance and Quality Officer; Customer Service Committee	Review Date: 07.02.2024	
Page: 1 of 3			

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

To ensure the legal authority and requirements for the rights and the protections for all recipients receiving substance use disorder (SUD) services authorized and/or delivered by the Mid-State Health Network (MSHN) Provider Network.

Policy

- 1) A program shall have a policy and procedure to ensure compliance with recipient rights requirements as set forth in R 325.1391 to R 325.1399 of the Administrative Rules for Substance Abuse Program in Michigan. The recipient rights policies and procedures shall be reviewed at least annually to consider any revisions that might be necessary
- 2) A program’s recipient rights policy and procedure shall address all of the following requirements:
 - a) Require a program to identify a staff member to function as the program rights advisor who shall do all of the following:
 - i) Attend training concerning recipient rights procedures.
 - ii) Receive and investigate all recipient rights complaints.
 - iii) Communicate directly with the Mid-State Health Network (MSHN) regional rights consultant when a complaint cannot be resolved at the program level.
 - b) Outline the method of filling recipient requests to review, copy, or receive a summary of recipient treatment or prevention service case records.
 - c) Provide simple mechanisms for notifying recipients of their rights, reporting apparent rights violations, determining whether in fact violations have occurred, and for ensuring that firm, consistent, and fair remedial action is taken in the event of a violation of these rules.
- 4) Copies of recipient rights policies and procedures shall be provided to staff. Each staff member of the program shall review the policies and procedures and shall sign a form provided by the department which indicates that he or she understands, and shall abide by, the policies and procedures. A signed copy shall be maintained in the staff personnel file ~~and a signed copy shall be retained by the staff member.~~
- 5) A treatment program may choose to restrict specific rights of a recipient based on the program policies and procedures. These restrictions are permissible only when there is a documented therapeutic purpose and timeframe in the recipient’s record. A restriction shall not be for more than 30 days without being renewed in writing in the recipient record and shall be signed by a licensed health professional.
- (6) As part of the admission procedure to a program, a recipient shall receive all of the following:

- a) If incapacitated, receive the procedures described in this subrule as soon as feasible, but not more than 72 hours after admission to an approved service program.
 - b) A written description of the recipient rights.
 - c) A written description of any restrictions of the rights based on program policy.
 - d) An oral explanation of the rights in language which is understood by the recipient.
 - e) A form that indicates that the recipient understands the rights and consents to specific restrictions of rights based on program policy. The recipient shall sign this form. A copy of the form shall be provided to the recipient and also become a part of the recipient's record.
 - f) A recipient rights complaint violation form shall be provided to the recipient after completing the consent form.
- 7) Rights of recipients shall be displayed on a poster provided by the department in a public area of all licensed programs. The poster shall indicate the program rights advisor's name and phone number.
- 8) Mid-State Health Network (MSHN), the regional entity, shall designate a staff member of MSHN to act as the recipient rights consultant for the region. The designation shall be renewed annually. The MSHN recipient rights consultant shall conduct recipient rights activities ~~in accordance with the procedures outlined by~~ the department's procedures.

Applies to:

- All Mid-State Health Network Staff
- Selected MSHN Staff, as follows:
 - MSHN's Affiliates: Policy Only Policy and Procedure
 - Other: Sub-contract Providers

Definitions:

Department: means the department of licensing and regulatory affairs (LARA).

MSHN: Mid-State Health Network

PIHP: Pre-paid Inpatient Health Plan

Provider Network: Refers to a CMHSP Participant and all Substance Use Disorder Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP/SUD Provider subcontractors.

Regional Entity: means an agency designated by the state to coordinate substance use disorder services in a specified region.

SUD: Substance Use Disorder

Other Related Materials:

Recipient Rights definitions found within Mich Admin Code. R 325.1301

References/Legal Authority:

1. Mich Admin Code, R 325.1391 to R 325.1399. Administrative Rules Substance Use Disorders Service Program
2. Michigan Public Health Code Act 368 of 1978, Article 6, Substance Abuse
3. Michigan Public Health Code Act 258 of 1974, Chapter 2A, Substance Use Disorder Services

Change Log:

Date of Change	Description of Change	Responsible Party
12/03/18	New policy	Director of Quality, Compliance, and Customer Service
03.16.2020	Annual Review; revisions to match Mich Admin Code revisions	Customer Service Committee
11.15.2021	Bi-annual Review, minor language updates	Customer Service Committee
01.22.2024	Biennial Review, language updates based upon changes in the Administrative Code	Customer Service Committee
<u>01.26.2026</u>	<u>Biennial Review, minor language updates</u>	<u>Customer Service Committee</u>

DRAFT



TENTATIVE

**FY2026 MID-STATE HEALTH NETWORK
REGIONAL BOARD OF DIRECTORS POLICY COMMITTEE
MEETING CALENDAR**

(All meetings are scheduled to convene at 4:00 p.m. unless otherwise noted)

Meeting Date	Meeting Location
May 5, 2026	MyMichigan Medical Center 300 E. Warwick Dr. Alma, MI 48801
July 7, 2026	MyMichigan Medical Center 300 E. Warwick Dr. Alma, MI 48801
September 1, 2026	MyMichigan Medical Center 300 E. Warwick Dr. Alma, MI 48801

Calendar is tentative until Committee approved

Mid-State Health Network | 530 W. Ionia Street, Suite F | Lansing, MI 48933 | 517.253.7525

www.midstatehealthnetwork.org

Please contact Sherry Kletke, Executive Assistant, with questions related to the MSHN Board of Directors at sheryl.kletke@midstatehealthnetwork.org

POLICIES AND PROCEDURE MANUAL

Chapter:	General Management		
Title:	Policy and Procedure Development		
Policy: <input type="checkbox"/> Procedure: <input checked="" type="checkbox"/> Page: 1 of 4	Review Cycle: Biennial Author: Deputy Director	Adopted Date: 11.26.2014 Review Date: 09.10.202403.06.2026	Related Policies: Policy and Procedure Development Consent Agenda

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

The MSHN Board makes an important distinction between *Board Policy* and *Operating Procedures*. Board policies establish the broad parameters within which Board, leadership and staff will operate. Operating Procedures, developed and implemented by the Chief Executive Officer and MSHN staff outline the specifics of how the organization and staff will operate within the Board policy. Each functional area of the Prepaid Inpatient Health Plan (PIHP) must develop and maintain Operating Procedures related to their area of responsibility to ensure that Board Policy is carried out in a standard and uniform manner.

Procedure

Policy and Procedure Development:

MSHN personnel shall maintain operating procedures for all important organizational processes. Procedures shall be developed and reviewed within a routine approved timeline, not less than biennially. Procedures shall be accessible and shall be communicated to involve personnel and MSHN’s provider network as part of the regular professional development/training and contract management practices. Any changes in procedures shall be consistent with and supportive of associated MSHN policy.

Policy and Procedure Approval and Review:

MSHN Policies and Procedures shall be established/reviewed by the responsible MSHN employee; reviewed by the designated councils/committees in the MSHN Organization structure (as appropriate); and vetted by the Board’s Policy Committee (as appropriate) in accordance with the policy and procedure review schedule. Policies are not effective until formal Board action has occurred. After approval and posting to the official website, MSHN policies and procedures are in effect unless a specific date on which they become effective is noted.

- A. Board Policy states that all MSHN Policies will be reviewed on a biennial basis. Following is the process for Policy Review:
 1. The Executive Support Specialist sends the related chapter due for biennial review to the assigned leadership member responsible.
 2. The assigned leader shall review the policies and include recommended edits in tracked changes.
 3. The revised policies are disseminated by the assigned leader to the related councils and committees for an opportunity to review and comment;
 4. The assigned leader gathers all feedback and presents the tracked changes version to the Leadership team for review.
 5. Once all feedback is gathered, the assigned leader submits the policies to the Deputy Director in tracked changes.
 6. The Deputy Director sends the policies Operations Council for a first review via email distribution (2) two weeks prior to the Operations Council meeting with suggested edits via

email response within (1) one week. Note: Substance Use Disorder (SUD) or MSHN only policies are not distributed to Operations Council, move to step 9.

7. An item is placed on the Operations Council agenda to allow discussion or education regarding the policy undergoing review, if there are substantive edits recommended by members of the Operations Council. Revisions are made based on consensus. The MSHN CEO shall have the final authority over matters of disagreement;
 8. When there is agreement of all members of the Operations Council, the final product shall be scheduled for review by the Board Policy Committee;
 9. The Policy Committee typically conducts policy review virtually with a first reading to obtain recommended changes and edits;
 10. Following the Policy Committee's first reading, policies are placed on the Policy Committee agenda for final review and approval.
 11. Following the Policy Committee's approval, policies are placed on the Consent Agenda for Routine Board meetings and shall be acted on in accordance with the Consent Agenda Policy;
 12. Following Board approval of the Policy, the Executive Support Specialist will document the date of policy approval or review, disseminate the final Policy to the Operations Council, and will facilitate upload to the MSHN website;
 13. The Executive Support Specialist or Deputy Director will notify MSHN employees, Operations Council and SUD Providers (via constant contact) of new or newly revised policies.
- B. Following is the process for MSHN's Procedure Review:
1. The Executive Support Specialist sends the related chapter due for biennial review to the assigned leadership member responsible .
 2. The assigned leader shall review the procedures and include recommended edits in tracked changes.
 3. The revised procedures are disseminated to consulting committees and councils as determined appropriate by the assigned leader;
 4. The assigned leader gathers all feedback and presents the tracked changes version to the Leadership team for review.
 5. Once all feedback is gathered, the assigned leader submits the procedures to the Deputy Director in tracked changes.
 6. The Deputy Director sends the procedures to Operations Council for a first review of the revised procedures via email distribution (2) two weeks prior to the Operations Council meeting with suggested edits via email response within (1) one week. Note: SUD or MSHN only procedures are not distributed to Operations Council, move to step 9.
 7. The Operations Council shall have an opportunity to review and comment on procedures that are relevant to the work of the region.
 8. An item is placed on the Operations Council agenda to allow discussion or education regarding the procedure undergoing review, if there are substantive edits recommended by members of the Operations Council. Revisions are made on a consensus. The MSHN CEO shall have the final authority over matters of disagreement;

9. When there is agreement of all members of the Operations Council and/or MSHN CEO, the final procedure will be forwarded to the Executive Support Specialist, who will post on the MSHN website;
10. The Deputy Director or Executive Support Specialist will notify MSHN employees, Operations Council and SUD Providers (via constant contact) of new or newly revised procedures.

The MSHN Staff member responsible for the focus of a specific policy and/or procedure shall be responsible to inform his/her staff members of pertinent changes in MSHN policy or procedure.

Applies to:

- All Mid-State Health Network Staff
- Selected MSHN Staff, as follows:
- MSHN CMHSP Participants: Policy Only Policy and Procedure
- Other: Sub-contract Providers

Definitions:

CEO: Chief Executive Officer
CMHSP: Community Mental Health Service Programs
MSHN: Mid-State Health Network
SUD: Substance Use Disorder

Other Related Materials:

General Management: Policy and Procedure Development and Approval Policy
 Policy and Procedure Review Schedule

References/Legal Authority:

N/A

Change Log:

Date of Change	Description of Change	Responsible Party
11.26.2014	New Procedure	Executive Assistant
03.2015	Annual Review – revisions made	Executive Assistant
04.07.2015	Board Approved as Amended	Chief Executive Officer
01.26.2018	Annual Review	Deputy Director
01.29.2019	Annual Review	Deputy Director
07.18.2019	Change in Procedure Review	Deputy Director
06.24.2022	Biennial Review	Deputy Director
12.05.2023	Updated Review Chart	Deputy Director
07.01.2024	Biennial Review	Deputy Director
<u>03.06.2026</u>	<u>Amend Policy & Procedure Review Chart</u>	<u>Deputy Director</u>

MSHN Policy and Procedure Renewal by Department

Review Schedule	January	February	March	April	May	June	July	August	September	October	November	December
Board of Directors (Executive) 2026	NO POLICY APPROVAL		NO BOARD POLICY REVIEW		Provider Network		Utilization Mgmt.		Customer Service		General Mgmt.	
2027	Service Delivery System		Population Health		Quality		Finance		Human Resources		Information Technology	
Policy Committee (Deputy Director) 2026	NO POLICY COMMITTEE MEETING		Provider Network		Utilization Mgmt.		Customer Service		General Mgmt.		Service Delivery System	
2027	Population Health		Quality		Finance		Human Resources		Information Technology		Compliance	
Operations Council (Deputy Director) 2026	Provider Network		Utilization Mgmt.		Customer Service		General Mgmt.		Service Delivery System		Population Health	
2027	Quality		Finance		Human Resources		Information Technology		Compliance		NO OPS POLICY REVIEW	
Lead Council Committee (Leadership) 2026		Utilization Mgmt.		Customer Service		General Mgmt.		Service Delivery System		Population Health		Quality
2027		Finance		Human Resources		Information Technology		Compliance		NO COUNCIL POLICY REVIEW		Provider Network

Revised 03.06.2026

MSHN Policy and Procedure Renewal by Department

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Board of Directors (Executive) 2024	NO BOARD POLICY REVIEW		Provider Network		Utilization Mgmt.		Customer Service		General Mgmt.		Service Delivery System	
2025	NO BOARD POLICY REVIEW		Quality		Finance		Human Resources		Information Technology		Compliance	
Policy Committee (Deputy Director) 2024		Provider Network		Utilization Mgmt.		Customer Service		General Mgmt.		Service Delivery System		NO POLICY COMMITTEE MEETING
2025		Quality		Finance		Human Resources		Information Technology		Compliance		NO POLICY COMMITTEE MEETING
Operations Council (Deputy Director) 2024	Provider Network		Utilization Mgmt.		Customer Service		General Mgmt.		Service Delivery System		NO OPS POLICY REVIEW	
2025	Quality		Finance		Human Resources		Information Technology		Compliance		NO OPS POLICY REVIEW	
Lead Council Committee (Leadership) 2024		Utilization Mgmt.		Customer Service		General Mgmt.		Service Delivery System		NO COUNCIL POLICY REVIEW		Quality
2025		Finance		Human Resources		Information Technology		Compliance		NO COUNCIL POLICY REVIEW		Provider Network

Revised 12.5.23