MSHN
Mid-State Health Network

MSHN CMH Monitoring of Delegated Managed Care Functions – PSV

Guidance: Complete column by listing the evidence provided to MSHN that meets the standard.

#	Standard	Basis/Source	Evidence of Compliance could include:	Review Guidelines for Reviewer	**Provider to Complete:** List evidence provided and location of evidence for specific standard i.e., page number if applicable
Customer Service					
1.1	All informational materials, including those describing consumer rights, service requirements and benefits are provided in a manner and format that may be easily understood. Informational materials are written at the 6.9 grade reading level when possible (i.e., it may be necessary to include medications, diagnoses and conditions that do not meet criteria).	42 CFR. 438.10(b)(1); 42 CFR 438.10(d)(1)(i); MDHHS Contract. 42 CFR 438.10(b)(3)	Method used to ensure the readability level. Report/tracking of verifying reading level	Please provide evidence of the tracking mechanism used to ensure this standard is met.	
1.2	CMHSP Participants/SUD Provider Network must ensure sufficient resources for persons with LEP by establishing a methodology for identifying the prevalent non-English languages spoken by beneficiaries likely to be served in their service area.	42 CFR § 438.10; MDHHS Contract Schedule A (1)(N)(2)(iv); MSHN Information Accessibility/ Limited English Proficiency (LEP) Policy (B)(1)	Method used and results that identify the percentage of non-English languages spoken by beneficiaries likely to be served in the service area.	Please provide evidence of the method used to calculate percentages for non-English languages spoken by members serviced to ensure this standard is met.	
24/7/365 Access					
2.1	Required demographics and clinical/functional information are documented in PIHP Managed Care Information System	Access System Standards Technical Requirement *CMHSP Responsibilities for 24/7/365 Access*	MCIS entry review		

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		for Individuals w/ Primary SUD #7			
2.2	Referrals to SUD care providers are appropriate based on the screening	Access System Standards Technical Requirement *CMHSP Responsibilities for 24/7/365 Access for Individuals w/ Primary SUD #8*	Referral logs		
2.3	CMHSP engages with community coalitions and other SUD prevention collaborative by: • Assigning responsibility for one or more CMHSP-employed individual to perform the function • Identifying opportunities where existing MH prevention efforts can be expanded to integrate SUD prevention General community education and awareness related to BH prevention, access, and treatment including outreach	Access System Standards Technical Requirement *CMHSP Responsibilities for 24/7/365 Access for Individuals w/ Primary SUD*	Meeting Minutes Identified Staff/Job Description Sample Outreach Documentation Evidence of Collaboration		
SERVICE AUTHORIZATION & UTILIZATION MANAGEMENT (UTILIZATION MANAGEMENT)					
3.1	Mechanisms are in effect to ensure consistent application of review criteria for authorization decisions;	42 CFR 438.210(b)(2)	CMHSP UM Plan Policy & procedure for authorization decisions; Evidence of	Ensure that IRR activities are conducted at all levels of service (i.e., decisions made by UM, emergency services, and access, including	

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			interrater reliability activities; Case Vignettes	eligibility determinations, inpatient and outpatient services, waiver services, etc.) that includes standardized test case scenarios in which staff review, apply criteria, and render a decision. (HSAG recommendation)	
3.2	The involved provider is informed verbally or in writing of the action if a service authorization request was denied or services were authorized in an amount, duration or scope that was less than requested.	42CFR438.404(b)(2) 42CFR438.404(b)(3) 42 CFR 438.210(c); MDHHS Contract	Policy/procedure(s) Documentation in the consumer chart of communication with the provider (telephone call log, non-billable progress note, etc.)	HSAG recommended enhanced monitoring of implementation, not just policy & procedure review	
3.3	The CMHSP consults with the requesting provider for medical services when appropriate.	42 CFR §438.210(b)(2)(ii) 42 CFR §457.1230(d) MDHHS Contract	Policies and Procedures UM Authorization Criteria Provider Materials such as Provider Manual Documentation of Peer-to-peer Consultation	New standard- as part of HSAG review recommendations	
QUALITY IMPROVEMENT & ENSURING HEALTH & WELFARE/OLMSTEAD					
4.1	Quality Improvement plans are completed for MDHHS established performance indicators and HEDIS metrics when minimum MDHHS benchmark performance standards are	MDHHS QAPIP TR Section VI MSHN QAPIP Plan	QI improvement plans/minutes from meetings of discussion of MMBPIS indicators where		

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	not met. These plans should include the cause and action steps taken when these benchmarks are not met for metrics as established.		performance is not met (if applicable)		
4.2	The CMHSP implements a process for reviewing sentinel events as defined by MDHHS and acts upon these events as appropriate. The CMHSP has three business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the CMHSP has two subsequent business days to commence a Root Cause Analysis (RCA) of the event.	MDHHS Medicaid Contract Schedule A-1(K)(2)(a) MDHHS QAPIP Technical Requirement Section VII(A) MDHHS QAPIP TR MSHN QAPIP Plan	Data review-Incident Reports, CMHSP-Primary Source Verification of reported events, Tracking system, and RCA when applicable		
4.3	Persons involved in the sentinel event/root cause analysis must have the appropriate credentials to review the scope of care, for example, sentinel events that involve client death or other serious medical conditions involve a nurse or physician.	MDHHS Medicaid Contract Schedule A 1(k)(2)(a) MDHHS QAPIP TR Section VIII(B) MSHN QAPIP Plan	CMHSP- Primary Source Verification RCA form		
4.4	All unexpected deaths must be reviewed and include: a) Screens of individual deaths with standard information (e.g., coroner's report, death certificate) b) Involvement of medical personnel in the mortality reviews c) Documentation of the mortality review process, findings, and recommendations				

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	d) Use of mortality information to address quality of care e) Aggregation of mortality data over time to identify possible trends Note: "Unexpected deaths" include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.				