1915(i) Policy

Quality Assurance 510-08-85

All stakeholders play a role in quality assurance for the 1915(i). The North Dakota Department of Health and Human Services (NDDHHS) Quality Improvement Strategy is evolving. This policy contains the current strategies.

- Strategy 1: CMS 1915(i) Evidence Review Report
- Strategy 2: Managed Care Organization (MCO) Contract Oversight

Strategy 1: CMS 1915(i) Evidence Review Report

Completed By: NDDHHS

Reporting Periods & CMS 1915(i) Evidence Review Report Due Date:

Reporting Period: The benefit year or reporting period depends on the effective date of the SPA. The original SPA effective date was 10/1/20 establishing a reporting period of October 1st through September 30th. Each subsequent SPA renewal must have an effective date of 10/1 to continue this reporting period.

CMS 1915(i) Evidence Review Report Due Date: The report collects data from benefit Years 1-3 and is due to CMS 39 months after the SPA effective date or by January 1st. The report only needs to be submitted to CMS after Year 3, not annually. The State is not required to report benefit Years 4 and 5 on the report; however, the State is required to perform quality reviews for these years. After each SPA renewal (every 5 years), the clock starts over and the benefit years are considered Years 1, 2, 3 (not Years 6, 7, etc.). The same process will be followed, and the report is due to CMS 39 months after the SPA effective date (*see table below for due dates*).

State Plan HCBS Benefit Review Cycle	
Action	**Timeframe**

DHCBSO issues Evidence Request Letter and Evidence Request Report Template	**36 months after SPA effective date**
Evidence due from State	**39 months after SPA effective date**
DHCBSO sends Draft Report	**43 months after SPA effective date**
State response due	**46 months after SPA effective date**
DHCBSO sends Final Report	**48 months after SPA effective date**
DHCBSO begins a new review cycle following the above steps	**48 months after Final Report was issued**

Purpose: To collect and analyze data from various sources to complete the CMS evidence review report addressing the required measures. Based on findings, the NDDHHS is required to develop a Quality Improvement process to address all measures rating below 85% compliance. Data is collected and analyzed from three areas:

1. Plans of Care
2. Paid Claims
3. Provider Enrollment

1. Plan of Care (POC) Reviews

Completed by: Behavioral Health Division and Managed Care Organization

Data collected for measures: 1, 2, 4, & 7

Representative Sample created by: DAT (Same sample used for claims. Sample includes both Traditional & Expansion POCs.)

POCs to be reviewed: The most recent POC with a completion date falling within the reporting period for each individual in the representative sample.

Submission Requirements: One (1) completed 1915(i) Plan of Care Checklist for each Plan of Care in the representative sample plus one (1) 1915(i) Plan of Care Report (consisting of results of all POC

Checklists in representative sample), submitted to the 1915(i) Administrator, Medical Services Division.

Submission Deadlines: January 1st for benefit Years 1, 2, 4 and 5; and December 1st for benefit Year 3.

2. Paid Claims Review

Completed by: Medical Services Division and Managed Care Organization

Data collected for measure: 6

Representative Sample created by: DAT (Same sample used for POC reviews. Sample includes both Traditional & Expansion POCs.)

Claims to be reviewed: All 1915(i) claims paid within the reporting period for individuals in the representative sample.

Submission Requirements: Medical Services 1915(i) Administrator reviews DAT's report and compiles results.

Submission Deadlines: January 1st for benefit Years 1, 2, 4 and 5; and December 1st for benefit Year 3.

3. Provider Enrollment Reviews

Provider enrollment reviews contain two parts:

1. Provider Enrollment Reviews; and
2. Provider Qualification Reviews

1. Provider Enrollment Reviews

Completed by: Medical Services Division

Data collected for measures: 3 & 5

Representative Sample created by: DAT. Sample includes "049" 1915(i) Group and Individual Providers with an initial enrollment date or 5-year re-enrollment date occurring within the reporting period.

Providers to be reviewed: All 1915(i) Group and Individual providers with an initial enrollment date or 5-year re-enrollment date within the reporting period for each provider in the representative sample.

Submission Requirements: Medical Services 1915(i) Administrator reviews DAT's report and compiles results.

Submission Deadlines: January 1st for benefit Years 1, 2, 4 and 5; and December 1st for benefit Year 3.

2. Provider Qualification Reviews

Completed by: Medical Services Division

Data collected for measures: 3

Representative Sample: DAT. Sample includes "049" 1915(i) Group and Individual Providers from the beginning of the program (10/1/2020) until the end of the reporting period.

Providers to be reviewed: All 1915(i) Group and Individual providers from the beginning of the program (10/1/2020) until the end of the reporting period in the representative sample.

Submission Requirements: Provider agencies shall complete a 1915(i) Provider Agency Review Report and 1915(i) Individual Provider Review Reports annually if identified in the representative sample. The reports are submitted via email to the State Medicaid Agency's 1915(i) Administrator at nd1915i@nd.gov.

Submission Deadlines: January 1st of each year beginning January 1, 2022.

Purpose: These reviews are part of the overall 1915(i) Quality Improvement Strategy process, but do not become part of the 85% compliance findings for the CMS evidence review report.

Process: Provider agencies will use the 1915(i) Provider Agency Review Report and 1915(i) Individual Provider Review Report to review their agency and all 1915(i) individual providers affiliated with their agency identified in the representative sample.. The Medical Services 1915(i) Administrator reviews all submissions and compiles data.

1915(i) Provider Agency Review Report frequently asked questions:

Q: *If just an agency is enrolled during the reporting period, and no individual providers, does the agency need to complete a Provider Agency Review Report?*
A: *Yes. The agency will need to complete the Provider Agency Review Report if enrolled during the reporting period. If the agency has no enrolled individual providers during the reporting period, no Individual Provider Review Report need to be completed.*

Q: *What if an agency was enrolled during the reporting period but did not provide any services. Does a Provider Agency Review Report need to be completed?*
A: *Yes. If an agency was enrolled during the reporting period, a report must be completed.*

1915(i) Individual Provider Review Report frequently asked questions:

Q: *Does an Individual Provider Review Report need to be completed if the individual provider was enrolled during the reporting period, provided services, and is no longer employed by the agency?*
A: *Yes. If an individual provider was enrolled during the reporting period, a report must be completed. Provider enrollment termination must be submitted for individual providers no longer employed with an agency.*

Q: *What if an individual provider was enrolled during the reporting period but did not provide any services. Does an Individual Provider Review Report need to be completed?*

A: *Yes. If an individual provider was enrolled during the reporting period, a report must be completed.*

Q: *Does an Individual Provider Review Report need to be completed if the individual provider was enrolled during the reporting period, never provided services, was terminated from provider enrollment, and is no longer employed by the agency?*
A: *Yes. If an individual provider was enrolled during the reporting period, a report must be completed.*

Q: *Does an Individual Provider Review Report need to be completed if the individual provider was enrolled during the reporting period, never provided services, and is no longer employed by the agency?*
A: *Yes. If an individual provider was enrolled during the reporting period, a report must be completed. Provider enrollment termination must be submitted for individual providers no longer employed with an agency.*

Q: *How does the State want the required supervised experience reported?*
A: A narrative containing a description of the individual provider's supervised experience, description of the setting the services were provided in, and dates services were provided must be submitted to the State for review. If a resume contains this required information, attach it to your submission as your agency's documentation.

Data Compilation, Analysis, and Improvement Strategy

The Medical Services 1915(i) Administrator will compile data by April 1st of each year.

The Medical Services 1915(i) Administrator will schedule quarterly Quality Improvement Strategy meetings with the Medical Services Division, Behavioral Health Division, and MCO to develop a written plan for CMS submission addressing all performance measures trending near or below 85% compliance. Recurrent meetings occur in January, April, July, and October of each year.

The Behavioral Health Division will lead quality improvement efforts for Measures 1, 2, 4, and 7. The Medical Services Division will lead quality improvement efforts for Measures 3, 5, and 6. The MCO will lead quality improvement efforts for Expansion-related compliance issues in each of the measures.

Remediation efforts may include changes in provider education, training, policy, and sanctions as allowed under NDAC Chapter 75-02-05 Provider Integrity; 75-02-05-05 Grounds for Sanctioning Providers.

CMS Evidence ReviewReport Required Quality Measures

See Quality Improvement Strategy section of the 1915(i) State Plan Amendment for specifics on quality measures.

Strategy 2: MCO Contract Oversight

After conclusion of data collection for the CMS Evidence Review Report, the Medical Services 1915(i) Administrator will separate Traditional results from Expansion results and share with the MCO. The claim and plan of care review results will be separated; however, provider enrollment review results will not as the MCO utilizes the same providers as the State.

The MCO will participate in quarterly Quality Improvement Strategy meetings with the Department and will lead quality improvement efforts for Expansion-related compliance issues in each of the measures.

CMS evidence review reports, including the identified Quality Improvement strategies, will be shared with the NDDHHS Medical Services Division MCO Contract Manager, and if deemed necessary, additional correction or data may be requested from the MCO.