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

Strategy 1: CMS Annual 1915(i) Evidence Report

Completed By: NDDHHS

Reporting Periods & CMS Annual Report Due Dates:

Initial Reporting Period: February 1, 2021 through September 30, 2021 – Report due to CMS by: 3/31/2023

Future Reporting Periods: October 1st through September 30th. Report due to CMS annually by 3/31.

Purpose: To collect and analyze data from various sources to complete the CMS annual 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 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 CareChecklist 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 of each year beginning January 1, 2022.

Process: See process identified in the 1915(i) Quality Improvement Strategy Process Flow.

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: Medicaid 1915(i) Administrators review DAT's report and compile results.

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

Process: See process identified in the 1915(i) Quality Improvement Strategy Process Flow.

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: Medicaid 1915(i) Administrators review DAT's report and compile results.

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

Process: See process identified in the 1915(i) Quality Improvement Strategy Process Document.

2. Provider Qualification Reviews

Completed by: Medical Services Division

Data collected for measures: 3

Representative Sample: No Sample – 100% Review

Providers to be reviewed: All 1915(i) Group and Individual providers enrolled during the reporting period.

Submission Requirements: Provider agencies shall complete a 1915(i) Provider Agency Review Report and 1915(i) Individual Provider Review Reports annually if enrolled during the review period. 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 representative sample nor part of the 85% compliance findings for the CMS 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 during the reporting period. Medicaid 1915(i) Administrators review all submissions and compile 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 Medicaid 1915(i) Administrator will compile data by April 1st of each year.

The Medicaid 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 Annual Report 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 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 annual 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.