1915(i) Policy

Managed Care Organization 510-08-105

The Managed Care Organization (MCO) is responsible for implementation of the Medicaid 1915(i) State Plan Amendment as outlined in the MCO contract. Key areas of implementation are identified as follows:

1. Planning and Implementation
   - Schedule meetings as needed with the Department for implementation.
   - Identify a contract administrator and/or key 1915(i) staff.
   - Define roles/responsibilities of contract administrator and/or key 1915(i) staff.
   - Implement the 1915(i) per the State Plan Amendment and federal and state rules, policies, and regulations.

2. 1915(i) Policy Development
   - Develop MCO 1915(i) policy as determined necessary.

3. Home and Community-Based Settings (HCBS)
   - Become familiar with the Home and Community-Based Services Settings Rule at 42 CFR 441.710(a)(1)-(2) to ensure compliance with the requirements to complete required quality improvement reviews and strategies.

4. 1915(i) Eligibility Report
   - Inform the Department what personal identifying information is necessary to identify eligible 1915(i) expansion individuals for inclusion in a daily electronic eligibility report.

5. Provider Enrollment
   - MCO shall share enrolled providers with the Department.
   - MCO shall establish "modified" contracts or amend existing contracts with providers to factor in 1915(i) services along with reimbursement as applicable.
   - Implement provider enrollment requirements as informed by the Department's provider enrollment division.
   - MCO shall utilize the State 1915(i) provider list on the 1915(i) website to identify 1915(i) providers.

6. Fiscal Agent
   - Provide fiscal agent services for community transition services and training/support for unpaid caregiver services.

7. System Development
   - Determine how MCO will comply with 1915(i) requirements, including making any applicable revisions of their choice to their electronic systems to accommodate 1915(i) requirements.

8. Billing, Claims, and Service Authorizations
   - MCO shall utilize the ND Medicaid Fee Schedule for 1915(i) services.
   - Establish internal process and policy relating to MCO billing and claims for expansion clients.
   - MCO shall utilize existing billing codes and taxonomies.
   - Develop a plan on how to receive plans of care for expansion clients for prior service authorization.
   - Establish internal process and policy relating to service authorizations for expansion clients.
   - Provide provider training and technical assistance on billing, service authorizations, etc. for expansion clients.

9. 1915(i) Training Needs for MCO Staff
   - Identify 1915(i) related training needs for the contract administrator and/or key 1915(i) staff.

10. MCO Contract Oversight
    - Follow requirements as outlined in the MCO contract.

11. Quality Strategy Improvement
    - Develop internal process and policy addressing how 1915(i) related quality improvement reviews, data, and reporting requirements will be met for the expansion group.

Electronic Visit Verification

The respite service is the only 1915(i) service with electronic visit verification (EVV) requirements.

Respite is only provided to individuals Age 0-21; therefore, the MCO will not provide the respite service and EVV requirements do not apply.

Quality Improvement Strategy

The North Dakota 1915(i) Medicaid Quality Improvement Strategy is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes to coordinate, assess, and continually improve the delivery of quality care and services to enrollees in the 1915(i) Medicaid program. The Quality Improvement Strategy provides a framework for the Department to ensure compliance with federal CMS requirements.

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.

Person-Centered Plan of Care Reviews

Plan of care reviews are necessary to obtain data to provide to CMS for the required annual quality improvement strategy report. Plan of care reviews are to be completed by the Managed Care Organization (MCO) for expansion clients. The number of required reviews will be provided to you by the Department and is determined by a representative sample of the population.

A 1915(i) Plan of Care Checklist will be completed for each Plan of Care in the representative sample, and the data from the checklists will be compiled into the 1915(i) Plan of Care Review Report. The report is submitted to the Behavioral Health 1915(i) Administrator by January 1st following the end of each reporting period.

See Quality Assurance policy.

Claim Reviews

Review of paid 1915(i) claims is necessary to obtain data to provide to CMS for the required annual quality improvement strategy report. The number of required reviews will be provided to you by the Department and is determined by a representative sample of the population.

Data is compiled and submitted to the Medical Services 1915(i) Administrator by January 1st following the end of each reporting period.

See Quality Assurance policy.