



NC Department of Health and Human Services

Joint DMH/DD/SAS & DHB Provider Webinar

Transitioning 1915(b)(3) Services to 1915(i) Authority

Service Providers

January 5, 2023

Agenda

- Deep Dive: 1915(i) Requirements
  - Care Management/Care Coordination
  - 1915(i) Service Providers
  - Network Adequacy
  - Quality
- Q&A

Recap: 1915(i) Service Requirements

Process Flow: Accessing 1915(i) Services in Tailored Plans

1 Beneficiary Need Identified

- Beneficiary visits PCP, BH, I/DD, or other provider.
- PCP, BH, I/DD, or other provider identifies that the beneficiary needs a 1915(i) service.
- PCP, BH, I/DD, or other provider refers beneficiary to their care manager to determine eligibility.

2 Independent Assessment

- The beneficiary's care manager, either at a Tailored Plan or AMH+/CMA, conducts the independent assessment in order to identify the beneficiary's needed services and supports, inform the independent evaluation of 1915(i) eligibility, and inform a Care Plan/ISP.

3 Independent Evaluation

- Tailored Plan conducts the standardized independent evaluation to determine if beneficiary meets needs-based eligibility criteria for 1915(i) services.

4 Care Plan/ISP

- The care manager assists the beneficiary in identifying 1915(i) service provider(s).
- The care manager develops the Care Plan/ISP with the beneficiary and other identified representatives.
- The care manager ensures the Care Plan/ISP reflects the beneficiary's:
  - Needed services and supports
  - Preferences for the delivery of services, and
  - Name of the service provider.

5 Prior Authorization

- The care manager submits completed Care Plan/ISP to the beneficiary's Tailored Plan for review.
- The beneficiary's Tailored Plan conducts prior authorization of the 1915 service(s).

6 Service Delivery & Care Coordination

- The care manager follows up with 1915(i) service provider(s) to implement the authorized 1915(i) service(s) according to the Care Plan/ISP.
- The care manager provides ongoing care coordination.

1915(i) Service Requirements

The Department has established requirements for Tailored Plans, services providers, and AMH+/CMAs for delivery of 1915(i) services that comply with relevant federal rules and regulations.

Key Requirements

This presentation will provide an overview of requirements in the following key areas:

- Care Management/Care Coordination
- 1915(i) Service Providers
- Network Adequacy
- Quality

The Department has made efforts to ***align 1915(i) requirements with the 1915(c) Innovations and TBI waiver requirements,*** where applicable, in order to simplify processes for service providers

Care Management/Care Coordination

1915(i) Care Coordination Components: Person-Centered Planning

All beneficiaries receiving 1915(i) services will receive care coordination from a care manager at a Tailored Plan or AMH+/CMA. Members engaged in Tailored Care Management will receive 1915(i) care coordination through their existing care manager.

Person-Centered Planning

As part of care planning to to determine the 1915(i) services needed by a beneficiary, care managers will:

- **Independent Assessment.** Conduct an independent assessment for beneficiaries and incorporate results into the beneficiary's Care Plan/ISP.
- **Care Team Meeting:** Explain options regarding the 1915(i) services available to the beneficiary (e.g., service duration) and convene a person-centered planning meeting to complete the Care Plan/ISP.
- **Facilitate Choice of Service Provider.** Assist members with choosing 1915(i) service providers (e.g., provide information about providers, arrange provider interviews).

1915(i) Care Coordination Components: Service Authorization

Care managers will submit the beneficiary's Care Plan/ISP to the Tailored Plan for service authorization. Tailored Plans will review and approve/deny the Care Plan/ISP.

Service Authorization

- **Service Authorization.** Tailored Plans must review and approve/deny a beneficiary's initial Care Plan/ISP within 60 Days of 1915(i) eligibility determination.
- **Service Initiation.** Tailored Plans must ensure 1915(i) services begin within 45 days of Care Plan/ISP approval.
- **Immediately Needed Services.** In the event a 1915(i) service is "immediately needed", care managers may complete and submit an interim plan of care to the Tailored Plan so that services may be approved.
    - Care managers must subsequently complete the full Care Plan/ISP within 60 days of eligibility determination for 1915(i) services.

"Immediately needed" 1915(i) services are defined as services that a beneficiary needs in order to:

- Facilitate discharge from an inpatient setting
- Prevent inappropriate placement in an inpatient setting
- Prevent placement outside the person's current living arrangement
- Address behavioral health/psychiatric conditions that place the person or others at risk of harm
- Prevent imminent loss of competitive integrated employment or offer of such employment

Care Management: Intersection of 1915(i) Care Coordination & Tailored Care Management

All beneficiaries eligible for 1915(i) services are eligible for Tailored Care Management. Accordingly, Tailored Care Management will incorporate all required 1915(i) care coordination activities so that a person can obtain 1915(i) care coordination through their assigned care manager.

Beneficiaries Engaged in Tailored Care Management

Responsible Entity: The beneficiary's assigned care manager, whether at a Tailored Plan or AMH+/CMA, will provide care coordination for 1915(i) services.

Beneficiaries who have Opted Out of Tailored Care Management

Responsible Entity: The beneficiary's Tailored Plan will provide care coordination for 1915(i) services (e.g., conducting independent assessment, completing Care Plan/ISP).

For beneficiaries engaged in Tailored Care Management, The Tailored Plan must:

- **Notify** the beneficiary's organization providing Tailored Care Management the beneficiary has been determined eligible for 1915(i) services,
- **Share** the results of the independent evaluation for 1915(i) services with the beneficiary's organization providing Tailored Care Management

1915(i) Care Coordination Components: Ongoing Care Coordination

1915(i) care coordination is required regardless of whether a beneficiary engages in Tailored Care Management. The beneficiary's assigned care manager, whether at a Tailored Plan or AMH+/CMA, will provide ongoing care coordination for 1915(i) services.

Ongoing Care Coordination

As part of care planning to to determine the 1915(i) services needed by a beneficiary, care managers will:

- Assist in choosing a qualified provider to implement 1915(i) service(s) (e.g., providing a list of available providers and arranging provider interviews)
- Monitor Care Plan/ISP goals
- Maintain close contact with the beneficiary, providers and other members of the care team
- Promote the delivery of services and supports in the most integrated setting that is clinically appropriate for the beneficiary
- Monitor service delivery

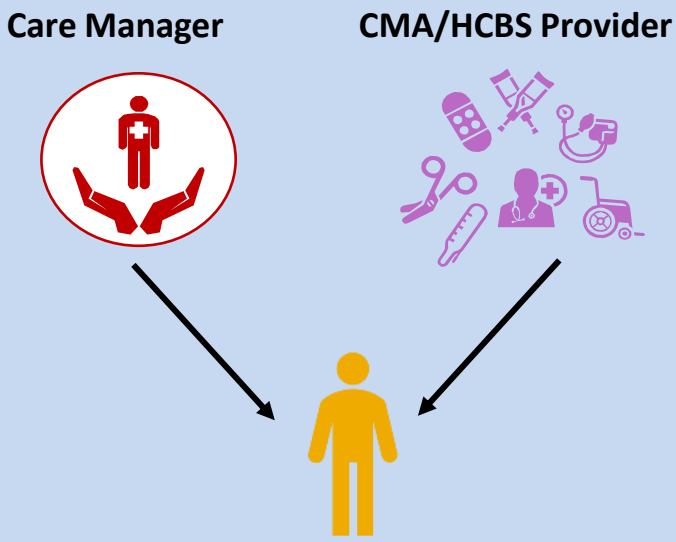
1915(i) Service Providers

Requirements for Conflict-Free Care Management

1915(i) service providers and Tailored Care Management providers must comply with federal conflict of interest requirements, including conflict-free care management, in order to promote consumer choice and limit bias by a care manager when identifying HCBS needs and developing plans to access services.

Conflict-Free Care Management Requirements

A behavioral health or I/DD provider acting as a CMA **cannot deliver both Tailored Care Management and HCBS**, including 1915(i) services, to the **same beneficiary**.



Requirements for 1915(i) Service Providers

1915(i) service providers must meet provider qualifications required by the Department, as outlined in the 1915(i) SPA.

1915(i) Service Providers

All providers delivering 1915(i) services, with the exception of those delivering Community Transitions, must:

- Be enrolled in NC Medicaid;
- Meet provider qualification policies, procedures, and standards established by the Department;
- Fulfill the requirements of 10A-NCAC 27G;
- Comply with all applicable federal and state requirements (e.g., statutes, rules, policies, communication bulletins and other published instructions released by the Department); and
- Meet national accreditation within one year of enrollment.*

Providers delivering the Community Transitions 1915(i) services must:

- Meets applicable state and local regulations for type of service that the provider/supplier is providing as approved by the Tailored Plan.

*Accreditation by the Council on Accreditation (COA), the Council on Quality and Leadership (CQL), the Council on Accreditation of Rehabilitation Facilities (CARF), or The Joint Commission

Network Adequacy

Network Adequacy

Tailored Plans have responsibility for ensuring there are sufficient 1915(i) service providers to meet the following network adequacy requirements:

	≥ 2 service providers within each Tailored Plan Region	≥ 2 service providers within 45 minutes of the beneficiary's residence	Not subject to standard
Community Living and Support	✓		
Individual and Transitional Support	✓		
Supported Employment	✓		
Respite	✓ *Out-of-home respite*	✓ *In-home respite*	
Community Transition			✓

Quality

Quality

Tailored Plans have responsibility to report 1915(i) quality measures in the following seven domains, in line with federal requirements:

Eligibility Requirements

- Evaluation for 1915(i) eligibility is provided to all applicants with reasonable indication that 1915(i) services may be needed
- State uses processes and instruments described in the SPA to determine 1915(i) eligibility
- 1915(i) eligibility is reevaluated at the frequency specified in the SPA (at minimum annually)

Abuse, Neglect, Exploitation

- State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation

Service Plans

- Address assessed needs of 1915(i) participants
- Are updated annually
- Document choice of services and providers

Financial Accountability

- State maintains financial accountability for services that are authorized and furnished to 1915(i) participants

Providers

- Meet required qualifications

Oversight

- State retains authority and responsibility for program operations and oversight

HCB Settings

- Meet requirements specified in the SPA and federal regulation

Questions and Answers

Comments, questions and feedback are welcome at:

BHIDD.HelpCenter@dhhs.nc.gov

Medicaid.Transformation@dhhs.nc.gov