1915(i) Plan of Care 1.1.2026 Creation Guide

If your agency is a new 1915(i) provider reach out to nd1915i@nd.gov to ask for any specific trainings you would like, as you create your first 1915(i) Plan of Care (POC).

Accessing the State Oversight Account

All plans of care must be created in the State Oversight Account. As a care coordinator when you first login to Therap, you are in your agencies Internal profile. To get to the State Oversight account, click on your name in the upper right corner. This will bring up a popup, click on External. You are now in the External account, think of this as a hallway you walk through to get to the State Oversight account. In the External account click on your name again, in the popup click on 1915(i) State Plan Amendment Oversight Account (SPA-ND). You are now in the State Oversight Account. You will be able to check this by looking at what is listed after your name in the upper right corner. It should be SPA-ND/your agency's Therap provider code.

Accessing a new plan of care in Therap

In the State Oversight Account click on Assessment and Planning tab. Then in the 1915(i) Plan of Care 1.1.2026 link click on New. You can also come to this line and click on Search to search for a plan of care.

Once you clicked on New, this will list all of the members that are assigned to your caseload in Therap. Find the member that you need to create the plan of care for. Click on the member's name. Once you do that, it will bring up a 1915(i) Plan of Care List. This will list any plans of care that this member has. There can only be one approved plan of care for a time period. However, you can start working on a plan of care and keep it in draft form.

On the 1915(i) Plan of Care List page click on Create New. This will bring up a new plan of care for that member. Until you save the plan of care, it will say New next to 1915(i) Plan of Care 1.1.2026 at the top of the plan of care.

Filling in the Meeting, Start and End Dates

The Meeting date equals the date of the meeting you had with the member when you started making the plan of care with them. Start date is the member's 1915(i) eligibility start date, unless the member is a transfer to your agency. We will talk about transfers in a little bit. The End date is the 1915(i)-eligibility end date. You will find the members' 1915(i) Eligibility start and end dates in the Custom Fields section, under the Go To tab, in the member's Individual Home Page in the State Oversight Account. Review the How to Look up Member Information guide on the 1915(i) Provider Guidance and Policies webpage, in the Therap section, for more details on this.

For transfers of Care Coordination, the Start Date will be different from the 1915(i) Eligibility Start Date, in the Eligibility & Initiation section of the Questionnaire of the plan of care. If this does not apply to what you are working on, skip ahead to the About Me section.

For transfers, 1915(i) admins will change the dates on the previous POC to match the dates the member was with the prior agency. On your new POC the Start Date at the beginning of the POC will be the date the member started services with your agency, this is the initial date of contact. In the Questionnaire section, the Current 1915(i) Start Date and Current 1915(i) End Date will still be the member's 1915(i) eligibility.

For transfers and discharges, the 1915(i) admins will change the Service Date To in the pre-authorizations (pre-auths) in the old POC to match the end date of the old POC. For existing support services, the pre-auths in the new POC will have a Service Date from that matches the Start Date on the new POC. The Service Date To will be the end date of the POC. For any services added to a POC that do not continue from the previous POC, the Service Date From on the pre-auth is the Anticipated Admission Date on the referral. It is still the responsibility of the care coordinator to create the pre-auths on the new POC.

About Me

Ask and fill in the answers to these three questions. These are good questions to get to know the member, and for them to express their needs and wants. With 1915(i) Care Coordination a holistic perspective of the member is the goal.

Legal Decision Makers

If the member has a parental guardian or legal guardian, you will select Add/Remove Legal Decision Maker to add their listed guardian. You can also list the guardian under the Participants section of the POC, but the guardian must be added in the Legal

Decision Makers section of the POC. If you need to check if the member has a guardian, it will be on their 1915(i) application, found in their Document Storage in the Individual Profile in the State Oversight Account.

Questionnaire

The questionnaire has a majority of the plan of care in it. Scroll down the POC and click Open to open the questionnaire. It will appear in a pop-up window. You can begin answering the questions. If you close the pop-up at any point, be sure to save your work first. After that, make sure you also save the Plan of Care itself. When everything is complete, click Submit to send it to the state for review. If you close the questionnaire and are not done with it, and want to come back to work on it more, you will click Save instead of Submit on the bottom of the POC. If you close Therap without saving or submitting the Plan of Care, you will lose any work you have done since your last save.

Sections of the Questionnaire

The Questionnaire of the POC has the following sections to it. We will go through each section individually. To go to each section of the Questionnaire, you will click on the title of the section on the left side. If you change any information in a section of the questionnaire, you will want to click save before you change sections. Once you are done with each section, click on Save & Next to go to the next section of the questionnaire.

- Strength and Preference Assessment
- Conflict of Interest Exemptions
- Eligibility & Initiation
- Member Goals & Services
- Member Goals & Services (cont'd)
- Risk Management/Crisis Plan
- HCBS Setting Assessment Questions
- Plan of Care Reviews - Quarterly and Interim
- Care Coordinator Contact Information

Strength and Preference Assessment

You will always select No for the Administrative Plan of Care update due to billing module implementation question.

The Strength and Preference Assessment section consists of a series of questions that are person-centered. These are designed to help care coordinators work with members to identify plan of care goals and steps/resources needed to achieve the goals. These

questions are broken into subject matter sections. Do the best you can with the member to answer each question.

Conflict of Interest Exemptions

This section is to determine whether a provider is exempted from the federal requirement that members receive care coordination and supportive services from separate provider agencies. Review the Conflict-of-Interest policy on the 1915(i) Provider Guidance and Policies webpage for the two possible conflict-of-interest exemptions. Answer the first question in this section to determine whether you need to answer the following questions. If you answered No, you do not need to answer any more questions in this section.

If you answered Yes to the first question of this section, you must answer all the questions in the conflict-of-interest section, if you are applying for one. If you do not answer in detail, all the questions the POC will be returned to you for more information. You also need to attach any necessary supporting documentation to the POC for the conflict of interest as well. You will not have a conflict-of-interest exemption granted until 1915(i) admins approve it. If granted, the conflict-of-interest exemption lasts for six months from date of approval.

Eligibility and Initiation

This section is where you'll enter information about eligibility, POC meetings, important dates, the member's qualifying assessment score as well as possible duplication of services. You will refer to the information in the Custom Fields, Assessment Lists and Document Storage tabs in the member's individual home page, in the State Oversight Account, for any information you need to fill out in this section. Review the How to Look up Member Information guide on the 1915(i) Provider Guidance and Policies webpage.

Member Goals and Services

Elements of SMART goals have been broken into separate questions so it's easier to write the member's goals as SMART goals. Write the member's goal as something they want to achieve versus the service that will help them achieve it. You will identify the service(s) in this section. For SMART goal trainings, review the available resources on the 1915(i) Provider Trainings & Information Sessions webpage.

Non-Medical Transportation (NMT) Pairs and Supportive Services

NMT is generally not a standalone goal. Peer support could be the goal and NMT may be used to support achievement of the goal. Non-Medical Transportation cannot be used to transport a member to a medical appointment.

Members Goas and Services (cont'd)

If the member has more than two goals, this is the section where you would put goals three and four. A member must have at least one goal on their plan of care.

Risk Management/Crisis Plan

This is where you will enter information about the member's qualifying diagnosis(es), other health information, as well as risk management and crisis planning information. You need to make sure what is put into the emergency contact is a contact that is available twenty-four hours a day, seven days a week. At a minimum, if the member does not have a true 24-hour emergency contact, you should put in 911 and 988. The member's diagnosis is found in the Diagnosis List tab in the individual home page, in the State Oversight Account.

HCBS Setting Assessment Questions

This is where you will verify the member is receiving services in a qualifying home and community-based setting. If you answer No to the first question, Is the member receiving 1915(i) services in a provider-owned or controlled residential setting? Skip the rest of this section, you do not need to fill out anything else. If you answer Yes, to the first question, you need to answer all the questions in the Provider-Owned or Controlled Setting part. If you answered no for any of those questions, you need to answer the questions in the Setting Modifications part. You will need to review the 1915(i) Home and Community Based Settings Policy on the 1915(i) Provider Guidance and Policies webpage to properly fill out the Setting Modifications part

Plan of Care Reviews – Quarterly and Interim

Whenever you have a quarterly review, or an interim review and update of the plan of care, you must document the information about the meeting you had with the member here. When you are completing a Quarterly or Interim Review, use the steps in the Quarterly/Interim Reviews & Individual Plan Agendas guide. If you need to make a change that does not require a Quarterly or Interim Review, use the steps in the Change Form guide instead. Both guides can be found on the 1915(i) Provider Guidance and Policies webpage.

Care Coordinator Contact Information

This is where you enter your information as the care coordinator. This is important because the member and other planning team members receive this plan of care and may use this plan's information listed here to contact you.

Once you have worked your way through this last section of the questionnaire, click on Save. You can then close the questionnaire popup window. It is recommended to now Save the entire POC. You will do this be scrolling down the POC and clicking on Save. If you don't do this after saving the questionnaire, and just exit out of the POC, you will lose all the information just entered into the questionnaire. Once you have Saved the POC, you can click on Back to Form to go right back into the POC to keep on working on it. Now that you have Saved the POC, on the top of the POC it says Draft next to 1915(i) Plan of Care 1.1.2026. The POC is now in Draft status. You can still work on it, as you have not submitted it to the 1915(i) admins for review. To continue to edit the POC, scroll down to the bottom, and click on Edit. Now you can go to whatever section of the POC you wish to keep working on.

Document Checklist

When creating a plan of care for the first time you will need to have the care coordinator and the member (and guardian if they have one) sign the three forms listed below. The rights and responsibilities only need to be signed on an annual basis. The Signatures & Acknowledgment form must be signed anytime you change the plan of care. And the Meeting Attendee Signature page must be signed when you have a quarterly or interim review of the plan of care. The following documents can all be found on the 1915(i) Provider Guidance and Policies webpage.

- Meeting Attendee Signature Page
- 1915(i) Plan of Care Member and Care Coordinator Signatures & Acknowledgements
- Member's Rights and Responsibilities (for members on Traditional Medicaid)
- OR
- Member's Rights and Responsibilities (for members on Medicaid Expansion)

You will click on Add File in the line for the document you wish to upload. Once you have uploaded the initial three needed documents, any other documents can be added to the plan of care by clicking on Attach Other File.

If you have uploaded these documents to the Member's Document Storage you can attach these documents to the POC using the Individual Document Lookup button. You will access this after you have clicked on Add File.

Pre Auth(s)

Care Coordination must have a service authorization, even if there is no Care Coordination Goal on the POC. Each 1915(i) Service on the POC must have a service authorization. For each 1915(i) Supportive Service you must have a complete and closed referral with that agency. See the Referral Guide on the 1915(i) Provider Guidance and Policies webpage.

The first step to adding a service authorization is to save the POC. Once the POC has been saved, and is in a “draft” status, you will then be able to add a pre-auth. Pre-auths become service authorizations once they are acknowledged by the providers.

Steps to create a Pre-Auth

- Click on the Add Pre Auth button.
- Program: Select if the member is on Medicaid or Medicaid Expansion.
- Service: Select which 1915(i) Service this service authorization is for.
- Service From Date: That is the first date that the provider of this service can render services. If the pre-auth is for care coordination, and you submitted the plan of care within 30 days of the date of initial contact, you would put the date of initial contact as the Service From Date. For 1915(i) supportive services, the Service From Date would be the Anticipated Admission Date on the referral sent to the supportive service agency.
- Service to Date: that is the last day the provider can render services. It will usually be their 1915(i)-eligibility end date.
- Non-Shareable: Do not select this.
- Service Provider: That is the provider that is rendering the service for this pre-auth. If it is for a service provider, the referral process must be fully completed for them to populate in this dropdown.
- Once you have entered everything in, click Next.
- Total Units: Enter the total units for the pre-auth. The units cannot be more than the number of units the goal is approved for. But it can be less if that is the business decision the provider wants to make.
- Service Amount, Unit Measure, Frequency, Description are optional.
- Leave Prior Auth Number blank.
- Once you have the Total Units entered, you will click on Add Rate to add the rate to the pre-auth.
- Then you will click Save.

Steps to take once a Pre-Auth is drafted

Once you have saved the pre-auth it will be in Draft status. You will need to click on the pre-auth and open it. You can Edit, Copy, Submit or Delete the pre-auth when it is in a Draft status. If you are good with it, click Submit in the pre-auth.

Once you submit the pre-auth, the Status changes to Pending Approval. If this is a service authorization on a POC that has not been approved by the state (or BCBSND), you cannot approve the pre-auth yourself. When the POC is approved, the pre-auths in a Pending Approval status will become Approved with the POC.

Once a pre-auth is Approved it will be automatically sent to the service provider it is for. It is now the responsibility of the admin for that service provider to review their To Do tab and Acknowledge any Pending Acknowledgements under the Pre Auth Service Authorization line.

Pre-Auths on Approved Plans of Care

If a pre-auth is being added to a POC that has already been submitted and approved by the state (or BCBSND), you as the care coordinator must approve the pre-auth. For an approved POC, if the only thing that you are doing is adding a pre-auth that is for a goal that has already been approved on the POC, and you are making no other changes to the POC, then you only need to Create Change Form to add the pre-auth. In the Change Form you will detail in the Other Reason box that you are adding a pre-auth for a specific goal that is already on the POC. Once you select Activate and Edit Individual Plan in the Change Form, you will be taken to the POC, where you will update the POC.

To add a pre-auth to a POC that is already approved you will click on the Add Pre Auth button. You will add the pre-auth, doing the same steps that you did in the Steps to Create Pre-Auth section.

Once you have saved the pre-auth it will be in Draft status. You will need to click on the pre-auth in Draft status and then Submit it. This will now put the pre-auth into Pending Approval status. Because this POC is already approved, you must click on the pre-auth in Pending Approval status again. This time when you do, you will see that there is an Approve button. Click the Approve button. Once you do this, the pre-auth will be Approved, and it will be sent to the service provider for them to acknowledge.

On approved POCs, until the care coordinator Approves the pre-auth it will stay in Pending Approval status, and it will not be sent to the provider for them to acknowledge.

Submitting a Plan of Care for Approval

All Plans of Care must be approved by 1915(i) administrators prior to rendering services, other than care coordination services rendered to develop and write the POC and provide Care Coordination Crisis Goal service. When you are ready for the POC to be reviewed and approved, click on Submit.

Returned Plans of Care

If a Plan needs changes, the plan will be returned to your work queue, and you will Submit it again, after you made the needed changes.

Review your To Do Tab

An Approved Plan will show up on your To Do tab. Check this tab regularly and click through and Acknowledge plans that need acknowledging. Review Therap's View Update History of Individual Plan guide to see how to review the history of a plans update history.