1915(i) Policy

Plan of Care 510-08-80

CMS Requirements for 1915(i) Person-Centered Planning

A 1915(i) Person-Centered Plan of Care (POC) is developed for each individual determined eligible for the 1915(i) State Plan Home and Community Based Setting (HCBS) benefit. The 1915(i) Care Coordination Service provider is responsible for overseeing the person-centered planning process and the development and implementation of the person-centered POC.

The POC is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a) and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

See the 1915(i) Person-centered Planning Guide for additional information and instruction on person-centered planning.

1915(i) Plan of Care

The 1915(i) Plan of Care (POC) is built into the Therap system. The template incorporates all federal requirements and must be used. Other POC templates cannot be substituted. The Therap POC Creation Guide found on the 1915(i) website provides details for completing each section of the POC.

Plan of Care Development

The POC is completed by the 1915(i) Care Coordinator in collaboration with the eligible individual and parent/legal guardian, if applicable, and others of the individuals choosing.

The POC must be completed in its entirety within thirty (30) calendar days of initial contact with the individual. Initial contact is defined as the first call or contact between the individual, or anyone assisting with the initial contact on behalf of the individual, and the care coordination agency.

Updates made as the result of continued meetings with the individual and their team members must be documented on the POC (inclusive of the required 90-day face-to-face meetings, other interim POC reviews, and annual POC reviews upon eligibility reevaluation).

Plan of Care Checklist

1. The individual makes initial contact with the care coordinator.
   - Initial contact is defined as the first call or contact between the individual, or anyone assisting with the initial contact on behalf of the individual, and the care coordination agency.

2. The care coordinator confirms the individual resides in a setting that is compliant with the HCBS Rule. Necessary HCBS compliance verification is completed, if necessary.

3. Signed Releases of Information are obtained.
   a. Human Service Zone: ROI will be obtained to allow the care coordinator to obtain the SFN 741 1915(i) Eligibility Application; WHODAS or DLA assessment; WHODAS scoresheet (if applicable); 1915(i) eligibility dates; whether the individual has Traditional Medicaid or Medicaid Expansion; and any other necessary information required for the POC development from the Human Service Zone.
   b. Team Members, etc.

4. The care coordinator, upon initially meeting with the individual, will ensure they are aware of 24/7 community crisis support services available to them should the care coordination agency not have a 24/7 on-call system to offer. The care coordinator must provide 24/7 emergency contact information to the individual within seven (7) business days from initial contact.
   - Initial contact is defined as the first call or contact between the individual, or anyone assisting with the initial contact on behalf of the individual, and the care coordination agency.

5. The care coordinator provides the individual, and parent/legal guardian, if applicable, with the Member Rights and Responsibilities form for signature informing them of their right to:
   - lead their meetings and be involved in the development of their POC;
   - choose who will attend meeting and be involved in plan development (if the individual is a minor or has a parent/legal guardian, they must be present during the development of the POC). Another case manager involved with the individual and the referral source are also good candidates; and
   - choose the location and time of the meetings.

6. Arrangements are made for whatever supports and information are needed to assist the individual with directing and being actively engaged in the POC meetings.

7. The care coordinator contacts the State Medicaid Agency to inquire if the individual is involved in any of the 1915(c) Waivers. If yes, the care coordinator will follow-up with the other case manager(s) to ensure non-duplication of services and best practice. The care coordinator also asks the individual about their involvement in Foster Care, Vocational Rehabilitation, IDEA, waiver services, etc., to explore team membership options and to avoid duplication of services.

8. The time, location, and team makeup of the POC meeting is determined.

9. The care coordinator schedules the POC meeting. The POC must be completed and submitted in MMIS for authorization within 30 calendar days of initial contact between the individual and the care coordination agency.
   - Initial contact is defined as the first call or contact between the individual, or anyone assisting with the initial contact on behalf of the individual, and the care coordination agency.

10. The care coordinator explains the services available through the 1915(i) North Dakota Medicaid 1915(i) State Plan Amendment by referencing the Accessing Service Next Steps (nd.gov) form available on the 1915(i) website.

11. The individual's strengths, preferences, and needs are identified.

12. Assessed needs from the WHODAS 2.0 Assessment or DLA and goals that relate to the services are documented on the POC.

13. Individual choses service providers from the 1915(i) Provider List available on the 1915(i) website.

14. The care coordinator completes a Request for Service Provider form and sends to each provider chosen by the individual. Each provider has two (2) business days to confirm or deny the request and inform the care coordinator of their decision.

15. Following the confirmation of providers, the care coordinator advises the State of the service providers identified on the POC. The State will connect the service providers to the individual in Therap.

16. If it is determined the individual will receive 1915(i) services outside their residence, then the care coordinator completes any additional necessary HCBS Settings Rule compliance measures.

17. All sections of the POC are completed and signatures obtained.

18. Meeting minutes are taken and maintained in the individual's file.

19. The care coordinator verifies if the individual is a Traditional or Expansion Medicaid member.

20. The service authorization for the care coordination service is submitted with a PDF of the POC and includes all required attachments (see POC Submission and Approval).

21. The POC is sent to the individual, parent/legal guardian, if applicable, and all team members.

Plan of Care Submission and Approval

The initial POC must be completed and submitted in MMIS for authorization within thirty (30) calendar days of initial contact with the individual. Initial contact is defined as the first call or contact between the individual, or anyone assisting with the initial contact on behalf of the individual, and the care coordination agency.

The care coordinator attaches the completed POC, including all required attachments (Individual and Care Coordinator acknowledgment and signature as well as the Meeting Attendee signature page) to the care coordination service authorization request and uploads into MMIS to the State Medicaid Agency (SMA) for Traditional Medicaid individuals or to the Managed Care Organization (MCO) for Medicaid Expansion individuals. Approval of the care coordination service authorization request indicates POC approval.

Upon approval of the care coordination service authorization, the care coordinator forwards the POC, including all required attachments, to all other 1915(i) service providers, who must attach the POC, and required

attachments identified above, to their respective service authorization requests when submitting to the SMA or MCO.

Self-Assessment

The care coordinator will complete the Self-Assessment with the individual and parent/legal guardian, if applicable, and others who care about and know the person best, at least annually. In addition to describing the person, this self-assessment addresses individual experiences that incorporate the CMS HCBS Final Rule regulations to ensure initial and on-going compliance. Items 1 – 12 on the Self-Assessment are regulations from Paragraphs (a)(1)(vi)(A) through (D) of the Home and Community-Based Settings Federal Rule at 42 CFR 441.710 which must be verified as compliant for the individual in the self-assessment. If modifications are required to any of the regulations to be in compliance, then the HCBS Modifications section of the POC must be completed. View the 1915(i) Person-Centered Planning & Self-Assessment Guide and HCBS Rule policy for additional information.

- Other assessments and reports such as the Council on Quality and Leadership (CQL) Personal Outcomes Measures®, Psychiatric, Psychological, PT, OT, Speech, Functional Analysis, Vocational, Educational, etc., determined essential to the person-centered planning process may be completed or requested for reference when determining the individual's needs.

Monthly Monitoring of Services

Monthly monitoring of services is required. This is accomplished by the care coordinator reviewing written monthly progress reports from each service provider to ensure that services are delivered as requested and remain appropriate for the individual.

90-Day Face-to-Face Meeting Requirements & Interim POC Reviews

Care coordinators are required to meet face-to-face with the individual and their parent/legal guardian if applicable, a minimum of every 90 days. This review assures the individual is satisfied with the services they are receiving, that the services are meeting their needs, are being delivered as requested, and that the services remain appropriate for the individual. Provider monthly progress notes are reviewed. The POC is revised/updated if needed. All revised POCs are uploaded into MMIS or the MCO's system.

1915(i) Eligibility Reevaluation Reviews

Each individual must have their 1915(i) eligibility reevaluated, also known as redetermined, by the Zone prior to their 1915(i) review date. The POC must be reviewed and revised as applicable for the new eligibility period. This includes updating all sections of the POC and submitting it in MMIS or the MCO's system for approval along with the new care coordination service authorization request for the new eligibility period. Note that the care coordination service authorization request submitted as the original request expires at the time of the eligibility reevaluation.

The process for interim POC reviews and annual POC Reviews for 1915(i) eligibility redeterminations are the same as the process conducted for newly eligible individuals. See the Plan of Care Checklist and POC Submission and Approval process above for steps which must be re-taken by the care coordinator. Following reapproval of the care coordination service authorization request, the care coordinator uses the Request for Provider form to request any additional services from other providers. Existing providers are also required to submit new service authorization requests for the new eligibility period. The revised POC must be attached to the request.

Qualifications of Persons Responsible for the Development of the POC

The persons responsible for the development of the individualized POC must meet all of the following criteria:

- be at least 18 years of age;
- be employed with an enrolled Medicaid provider of the care coordination service;
- possess NDDHHS required competencies as identified within the care coordination service policy; and
- Have one of the following:
  - have a bachelor's degree from an accredited college or university and 1 year of supervised experience working with special populations; or
  - In lieu of a bachelor's degree, have 3 years of supervised experience working with special populations.

See the Care Coordination Policy for specific care coordination service provider requirements.

Maintenance of the person-centered service plan forms.

45 CFR §74.53 requires POCs be maintained for three years.

Contact the Managed Care Organization for policy relating to 1915(i) Expansion members.