1915(i) Policy

Care Coordination Service 510-08–65-10

Service Title: Care Coordination Service

Service Definition (Scope)

Care Coordination is a required component of the 1915(i) and assists individuals with gaining access to needed 1915(i) services. The individual has a right to choose their care coordination provider. The care coordinator ensures that the individual's (and parent/guardian as applicable) voice, preferences, and needs are central to the person-centered planning process.

Care Coordinator Role

A. Comprehensive assessment and reassessment activities include:

- completion of assessments as needed;
- collecting, organizing, and interpreting an individual's data and history including the gathering of documentation and information from other sources such as family members, medical providers, social workers, and educators, etc., to form a complete assessment of the individual, initially and ongoing;
- promoting the individual's strengths, preferences, and needs by addressing social determinants of health including five key domains (economic stability, education, health and health care, neighborhood and built environment, and social and community context) and assessing overall safety and risk including suicide risk;
- conducting a risk assessment and developing a crisis plan, initially and ongoing;
- guiding the family engagement process by exploring and assessing the individual's (in the case of a minor the family's) strengths, preferences, and needs including overall safety and risk, including suicide risk, initially and ongoing; and
- ongoing verification of home and community-based settings compliance.

An individual's need for initial and continued services shall be discussed at each 1915(i) person-centered plan of care meeting, and formally evaluated during the WHODAS 2.0 functional needs assessment as part of the initial evaluation and annual reevaluation process. The care coordinator must document a need for the service to support the individual's identified goals

in the person-centered plan of care and document the individual's progress toward their goals.

B. Development of an individualized person-centered plan of care including the crisis plan component based on the information collected through the assessment. The care coordinator is responsible for the development of the plan of care and for the ongoing monitoring of the provision of services included in the individual's plan of care. Services must be identified in the plan of care and service authorization obtained.

C. Crisis Plan Development, Implementation, and Monitoring. The care coordination agency has ultimate responsibility for the development, implementation, and monitoring of the crisis plan. The crisis plan is developed by the care coordinator in collaboration with the individual. At a minimum, the care coordinator provides the 24/7 emergency contact information to the individual within seven (7) business days of 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.

D. Referral, Collateral Contacts, and Related Activities. Depending upon what other services the individual receives, this may include scheduling appointments for the individual and engaging in other ways of connecting them with needed services including, but not limited to:

- support in the areas of health, housing, social, educational, employment, and other programs and services needed to address needs and achieve outcomes in the plan of care;
- support to engage in culturally relevant community services and supports; and
- contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, and providing members of the individual's team with useful feedback.

The care coordination service assists individuals in gaining access to needed 1915(i) and other state plan services, as well as medical, social, educational, and other services regardless of the funding source for the services to which access is gained, with care taken to ensure non-duplication of any other existing case management/care coordination services.

E. Monitoring and Follow-Up Activities. Activities and contacts necessary to ensure the person-centered plan is implemented and

adequately addresses the eligible individual's needs. These may be with the individual, family members, service providers, or other entities.

F. HCBS Settings Rule Compliance Verification. The care coordinator's role includes verification of HCBS Settings Rule compliance.

See the 1915(i) HCBS Settings Rule Policy.

G: Eligibility Redeterminations. Monitoring to ensure completion of an individual's annual 1915(i) eligibility redetermination. The individual seeking to maintain their 1915(i) eligibility, or the individual properly assisting the individual to maintain their eligibility, and the individual's care coordinator, are responsible for providing the Zone 1915(i) Eligibility Worker with the completed SFN 741 1915(i) Eligibility Application.

See the 1915(i) Eligibility Policy.

Connecting with the Care Coordination Agency

The care coordination agency must complete and submit the 1915(i) Care Coordination Request for Service Report, found on the 1915(i) website, to the State within five business days from the date of 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.

If the 1915(i) Care Coordination Request for Service Report is not submitted within five business days, the State will inform the 1915(i) individual of other care coordination agencies available in their area to ensure services are not delayed.

Service Limits

There is a daily maximum of 8 hours (32 units) for this service and a minimum of one face-to-face contact between the care coordinator and individual per quarter is required.

Service authorization requests exceeding the maximum limit which are deemed necessary to prevent the individual's imminent institutionalization, hospitalization, or out of home/out of community placement will be reviewed by the NDDHHS. All requests to exceed limits must initiate with the care coordinator.

Service Duplication

1915(i) services cannot be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities.

To avoid service duplication with 1915(c) Waiver services, the care coordinator will contact the State Medicaid Office to inquire if the individual has any eligibility spans for any of the C Waivers in MMIS. If yes, the care coordinator will reach out to the C Waiver authority and do due diligence to ensure the 1915(i) Plan of Care will not include services the individual could receive through the 1915(c) Waiver.

See the 1915(i) Service Duplication Policy as well as the service duplication section of each of the specific 1915(i) service policies for additional requirements for the care coordinator to ensure nonduplication of services.

Conflict of Interest

See the 1915(i) Conflict of Interest Standards Policy applicable to care coordination.

Remote Support

Remote support may be utilized for up to 25% of all care coordination services provided in a calendar month.

See the 1915(i) Remote Support Service Delivery Policy for requirements.

Provider Qualifications

Provider Type: Group

North Dakota Medicaid enrolled group provider of 1915(i) Care Coordination Services.

Licensing: None

Certification: None

A group provider of this service must meet all of the following:

1. Have a North Dakota Medicaid provider agreement and attest to the following:
    - Individual practitioners meet the required qualifications.
    - Services will be provided within their scope of practice.
    - Individual practitioners will have the required competencies identified in the service scope.
    - Agency availability, or a back-up resource available, 24 hours a day, 7 days a week to clients in crisis.
        - Providers must have a policy stating how they will meet this requirement with the goal of keeping the client in their home and community and provide alternatives to prevent inappropriate use of emergency rooms, inpatient psychiatric placement, incarceration, institutional placements, or other more restrictive, non-home and community-based placements. Provider agencies will ensure the individuals they serve have access to emergency services twenty-four (24) hours a day, seven (7) days a week. The provider and individual will develop a Risk/Safety/Emergency/Crisis plan during the Person-Centered Plan of Care process ensuring the individual has access to 24/7 emergency coordination services either directly by the provider, or through the use of natural supports and/or resources available within their community.
    - Agency conducts training in accordance with state policies and procedures.
    - Agency adheres to all 1915(i) policies and procedures including, but not limited to, individual rights, abuse, neglect, exploitation, use of restraints, and reporting procedures are written and available for NDDHHS review upon request.

Provider Type: Individual

The individual practitioner providing the service must:

1. Be employed by an enrolled ND Medicaid provider or enrolled billing group of this service; and
2. Be at least 18 years of age; and
3. Have a bachelor's degree from an accredited college or university and one (1)* year of supervised experience working with special populations; or
4. In lieu of a bachelor's degree, three (3) years of supervised experience working with special populations; and

5. Be supervised by an individual containing these qualifications at a minimum.

*One (1) year of supervised experience working with special populations became effective on November 1, 2022, with approval of a state plan amendment. Individual providers enrolled and providing care coordination prior to November 1, 2022, can waive this requirement as long as they remain actively providing care coordination services.

Agencies must have records available for NDDHHS review documenting that care coordinators have reviewed or completed the following:

1. The Substance Abuse and Mental Health Services Administration (SAMHSA) Core Competencies for Integrated Behavioral Health and Primary Care; or The Case Management Society of America standards of practice; and
2. State-sponsored care coordination training*.

*Care coordinators must complete the State-sponsored care coordination training within the first 6 months of enrollment. The required State-sponsored care coordination training became effective on May 22, 2023, with approval of a state plan amendment. Individual providers enrolled and providing care coordination prior to May 22, 2023, are required to complete the required training within 6 months.

Supervision Requirements

Supervisors of care coordination staff, at a minimum:

1. Be employed by an enrolled ND Medicaid provider or enrolled billing group of this service; and
2. Be at least 18 years of age; and
3. Have a bachelor's degree from an accredited college or university and one (1)* year of supervised experience working with special populations; or
4. In lieu of a bachelor's degree, three (3) years of supervised experience working with special populations.

*One (1) year of supervised experience working with special populations became effective on November 1, 2022, with approval of a state plan amendment. Individual providers enrolled and providing care coordination prior to November 1, 2022, can waive this requirement as long as they remain actively providing care coordination services.

Verification of Provider Qualifications

Provider Type: ND Medicaid enrolled agency provider of Care Coordination Services

Entity Responsible for Verification: Medical Services Provider Enrollment

Frequency of Verification: Provider will complete an "Attestation" as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least once every five (5) years.

Service Delivery Method: Provider Managed

Payment Rate

The client is not required to be present to bill for this service.

Care coordination is a 15-minute unit rate. The rates are published on the Department's website.
https://www.hhs.nd.gov/medicaid-provider-information/medicaid-provider-fee-schedules

Quality Assurance

See the 1915(i) Quality Assurance Policy.

Medical Records Requirements including Documentation Requirements, Signatures, Confidentiality, and Availability of Records

See the 1915(i) Medical Records Policy.

Plan of Care Process

See the 1915(i) Plan of Care Policy.

Person Centered Service Delivery

Care coordination service delivery must be person-centered.

Agencies must have records available for NDDHHS review documenting that individual providers have reviewed NDDHHS approved training materials and acknowledge they are competent in the following areas:

- Person-Centered Plan Development and Implementation; and
- HCBS Settings Rule

See the 1915(i) Person- Centered Planning and Self-Assessment Guide and the 1915(i) Person-Centered Care Policy.

HCBS Rule Compliance Verification

Settings must be compliant with the HCBS Rule.

It is the responsibility of the care coordinator to verify initial and on-going compliance.

See the 1915(i) HCBS Rule Policy.

Service Authorizations

All 1915(i) services must receive prior authorization.

See the 1915(i) Service Authorization Policy.

Claims

See the 1915(i) Claims Policy.