Care Coordination

PURPOSE

Care coordination is the process of assessing a member's need for services, connecting a member with services, and ensuring that services are delivered appropriately. Care coordinators work with the member and individuals of the members' choosing through a person-centered process to create a member's plan of care (POC).

APPLICABILITY

ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled on the date of service with ND Medicaid. Please refer to the 1915(i) provider enrollment webpage for additional details on enrollment eligibility and supporting documentation requirements.

Group

A 1915(i) group provider must meet all the following:

- Have an ND Medicaid provider agreement and attest to the following:
  - Individual practitioners meet the required qualifications;
  - Services will be provided within the practitioner's 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 while providing 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 member 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.
- The agency must conduct trainings in accordance with state policies and procedures;
- The agency must adhere 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 ND Medicaid review upon request.

Individual
The individual practitioner providing 1915(i) services must:

- Be employed by an enrolled ND Medicaid provider or an enrolled billing group for 1915(i) services;
- Be at least 18 years of age;
- Be knowledgeable and competent in person-centered plan implementation;
- Have a bachelor's degree from an accredited college or university and one (1) year of supervised experience working with special populations; or in lieu of a bachelor's degree, three (3) years of supervised experience working with special populations; and
- Be supervised by an individual containing these qualifications at a minimum.

Agencies must keep records showing that their 1915(i) providers have completed the following trainings. These trainings, along with other training resources, can be found on the 1915(i) Provider Trainings and Information Sessions webpage:

- 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
- State-sponsored care coordination training[1]; and
- State-sponsored care coordination onboarding.

Supervision Requirements
Supervisors of care coordination staff, at a minimum must:

- Be employed by an enrolled ND Medicaid provider or enrolled billing group of 1915(i) services;
- Be at least 18 years of age; and
- Have a bachelor's degree from an accredited college or university and one (1) year of supervised experience working with special populations; or in lieu of a bachelor's degree, three (3) years of supervised experience working with special populations.

ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the Automated Voice Response System (AVRS) by dialing 1.877.328.7098.

[1] Care coordinators must complete the state-sponsored care coordination training within the first 6 months of enrollment.

Care coordination is required for all 1915(i) members. Below are key areas of this policy. Use the hyperlinks to navigate to desired sections. Care coordinators are expected to know and understand all responsibilities and requirements within this policy.

Members can connect with a care coordination agency in several ways. Members may choose a preferred care coordination agency, receive assistance from a 1915(i) navigator selecting a care coordination agency, or a member may be assigned a care coordination agency.

Members are assigned to a care coordination agency if there is only one care coordination agency who is willing and qualified to provide care coordination to a member in the member's county of residence. More information is available in the Conflict-of-Interest policy on the 1915(i) Provider Guidance and Policies webpage when a provider is the "only willing and qualified" provider in a member's county of residence.

COVERED SERVICES AND LIMITS

GENERAL PROVIDER POLICIES

The General Provider Policies details basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

The Procedure Code Look-up Tool can be used to identify if a procedure code is covered by ND Medicaid along with code specific details such as ORP requirements, Service Authorization requirements, and current rates. 1915(i) specific codes can be found on this document.

Care coordinators are key to ensuring that a member's (and parent/guardian as applicable) voice, preferences, and needs are central to the person-centered planning process. Care coordinator services fall into seven distinct areas which are discussed in further detail below:

- Comprehensive assessment and reassessment activities;
- Development of an individualized person-centered plan of care;
- Crisis pPlan dDevelopment, iImplementation, and mMonitoring;
- Referral, cCollateral cContacts, and rRelated aActivities;
- Monitoring and fFollow-uUp aActivities;
- Home and Community-Based Services (HCBS) sSettings rRule cCompliance vVerification; and
- Eligibility rRedeterminations.

ONBOARDING NEW MEMBERS

Onboarding a new 1915(i) member is the first step a care coordinator takes with members after the initial contact. This process includes the following:

- Provide the member, and parent/legal guardian, if applicable, with the Member Rights and Responsibilities form for Traditional Medicaid members. The Medicaid Expansion Member Rights and Responsibilities form should be used for Medicaid Expansion members. The member and guardian, if applicable, must sign and attach the signed copy to the Plan of Care (POC). The member and guardian, if applicable, with the help of the care coordinator take the lead on the following tasks~~;~~
    - lead their meetings and be involved in the development of their POC;
    - Choose who will attend meetings 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); and
    - Choose the location and time of the meetings.
    - Determine the time, location, and team makeup of POC meetings and notify meeting invitees.

- The care coordinator a~~A~~rranges needed supports and information to assist the member with directing and being actively engaged in POC meetings;
- The care coordinator i~~I~~dentifies~~y~~ other services the member receives to avoid duplication and coordinate with other case managers/care coordinators including those for:
    - 1915(c) HCBS waivers, foster care, vocational rehabilitation, IDEA/IEP services, etc.~~; and~~
- ~~Determine the time, location, and team makeup of POC meetings and notify meeting invitees.~~

NOTE: if any service providers or case managers attend this meeting, only the 1915(i) care coordinator can bill ND Medicaid for the service.

1. COMPREHENSIVE ASSESSMENT AND REASSESSMENT ACTIVITIES

Care coordinators are responsible for using a member's eligibility assessments such as the World Health Organization Disability Assessment Schedule (WHODAS) and the Daily Living Activities assessment (DLA) as well as additional assessments to understand a member's needs and preferences for the development of a ~~person-centered service plan~~POC. Part of this process is getting to know the member and developing a care coordination relationship with the member and people of the member's choosing who will participate with the member in the person-centered planning process.

Care coordination duties falling under this responsibility include:

- Completing 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, to form a complete assessment of the individual. This should be done initially and as an ongoing process and include the WHODAS and/or DLA assessments;
- 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 an initial risk assessment and developing a crisis plan. This should also be done on an ongoing basis;
- 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.

A member's need for initial and continued services must be discussed at each 1915(i) ~~person-centered plan of care~~POC meeting and formally evaluated during the functional needs assessment as part of the initial evaluation and annual reevaluation process. The care coordinator must document a need for 1915(i) services (peer support, respite, etc.) to support the member's identified goals in the ~~person-centered plan of care~~POC and document the member's progress toward their goals.

1915(i) members must meet the following criteria to remain eligible for continued 1915(i) services:

- Need at least one 1915(i) service as documented in the ~~person-centered service plan~~POC; and
- The service must be provided at least quarterly, with monthly monitoring documented ~~in the member's plan of care and/or in care coordination~~the case notes in Therap.

Care coordinators must meet with members to develop a ~~person-centered plan of care~~POC. Here is what should occur at the initial meeting:

- Assess and~~/or~~ identify the member's strengths, preferences, and needs, including needs identified from the WHODAS 2.0 or DLA. Care coordinators must complete the self-assessment with the member and their parent/guardian if applicable at least annually.
    - The self-assessment should generate discussion on the member's individual outcomes. This assessment drives the process and has outcomes unique to the member.
- Document goals related to services listed on the POC;
- Assist the member in choosing service providers from the Find a Provider page;

- Review and sign Individual Acknowledgment/Care Coordination Attestation/Signatures; and
- Get signatures from all meeting attendees. Meeting Attendee Signatures
- Have the member and guardian, if applicable, sign the Members Rights and Responsibilities for traditional members, and this Members Rights and Responsibilities for Medicaid E~~e~~xpansion members.

2. DEVELOPMENT OF AN INDIVIDUALIZED PERSON-CENTERED PLAN OF CARE

A member's care coordinator is responsible for developing a ~~person-centered plan of care~~POC with the member and for the ongoing monitoring of the provision of services included in the member's plan of care.

PERSON-CENTERED PLANNING

Person-centered planning means that the 1915(i) member directs the planning process and includes representation from anyone the member chooses to participate in this process. Goals and preferences in the ~~person-centered plan~~POC are those identified by the member. The POC assists the member in achieving their identified outcomes in the most integrated community setting and through service delivery that reflects the member's personal preferences and choices.

~~Plans of Care (POCs)~~POCs are done in the Therap system. The Therap template is the only acceptable template for the 1915(i) POC. The Plan of Care Creation guide, on the 1915(i) Provider Guidance and Policies webpage ~~Therap POC Creation and Changes Guide~~ provides details for completing each section of the POC.

SMART GOALS

Goals can be long-term or short-term and must relate to a need identified on the member's WHODAS, DLA, or other assessment tool.

SMART is an acronym explained below. Each goal should be specific, measurable, achievable, relevant, and timely.

Specific:
- Address what the member wants to accomplish in relation to their assessed need.

Measurable:
- How will the members' progress be measured towards achieving their identified goal?

Achievable/Attainable:
- The goal must be realistic, and the member needs to have access to necessary tools and resources to achieve their goal.

Relevant:
- The goal must be clear and the benefit of achieving the goal must be identified.

Timely:

- What is an expected time frame the member will be able to achieve the goal or what steps are needed and when will they occur?

Example:
A member is dealing with anxiety that makes it very difficult for them to leave the house. This member's goal is to "leave the house more often". The WHODAS has identified the members' needs as participation in community activities and interacting with other people. The member also requested a peer support specialist to help them get out of the house more often.

The goal as stated – "leave the house more often" is not a SMART goal because it isn't specific, measurable, lacks a timeframe and does not address how this goal is going to help decrease anxiety with leaving the house. The following explains how this goal can be improved.

Goal: The member and their peer support specialist will work each week to identify one community activity for the member to explore. Exploring a community activity means the member will leave the house, go to the location of the activity, and visit with at least one person while there. The member will do this for one month.

This goal is specific because "leave the house" is defined, measurable, achievable, and relevant to what causes this member's anxiety. It is also timely since there is an end date to establish when this goal should be achieved by.

It's possible this goal might be too much to have the member go to one community activity and talk to one person. You might need to break this apart and start with just going to one activity and then once that goal is achieved introduce the goal of talking to one person. Work with the member to determine what is going to set them up for success.

It is also important to ensure barriers are identified when looking at whether a goal is achievable. If the member has no transportation and their goal is to leave the house to go to the public library which is not within walking distance, a different goal might be needed to solve the transportation issue. If so, be specific with that goal as to what steps and timeframe are reasonable to solve the transportation issue.

Goals are meant to be continually evaluated for reasonableness, progress, and timeliness. Care coordinators must help members set specific achievable goals to work towards helping members develop and maintain successful community living.

DUPLICATION OF SERVICES

1915(i) services cannot be provided to a member at the same time as another service that is the same in nature and scope, regardless of the funding source. This includes federal, state, local, and private entities. For example, the 1915(i) community transition service cannot be rendered at the same time as the Money Follows the Person community

transition service since the service scopes overlap. Please use the list of identified duplicative services to determine if services are duplicative and reach out to nd1915i@nd.gov with any questions.

It is the care coordinator's responsibility to ensure no duplication of services with 1915(i) services occurs.

SIMILAR SERVICES

If a member has access to services similar to 1915(i) through another source, the member should not receive services through 1915(i). For example, if a member can get respite through the Autism Waiver, then the member is not eligible for respite through 1915(i). This also applies to students who are receiving supported education services through their Individualized Education Plan (IEP).

1915(i) services are the services of last resort if the member is receiving services through the following waivers:

- Individuals with Intellectual Disabilities and Developmental Disabilities (IDD/DD) Waiver – Age 0+;
- Medically Fragile Waiver – Age 3 to 18;
- Autism Waiver – Age 0 to 17;
- Children's Hospice Waiver – Age 0 to 22; or
- Home and Community-Based Services (HCBS) Waiver – Age 18+.

To avoid service duplication of 1915(c) waiver services, the 1915(i) care coordinator must look up the member in MMIS to identify if the member is on any Medicaid 1915(c) waivers or other duplicative services. The Member Eligibility document describes how to look up a member in MMIS and identify if the member is waiver-eligible. If services are identified, the care coordinator must reach out to the 1915(c) waiver case manager to ensure the 1915(i) plan of care does not include services the member is eligible to receive through the 1915(c) waiver.

A 1915(i) member is eligible to receive non-duplicative services under Service Payments for the Elderly and Disabled (SPED) and Expanded Service Payments for the Elderly and Disabled (Ex-SPED).

POC DOCUMENTATION

Following any POC meetings with the member:

- Document meeting minutes in the member's ~~file~~case notes; and
- Complete all sections of the POC and sign using plain language.

REFERRALS

All referrals must be sent to 1915(i) service providers in Therap. This can be done in two ways:

- If a member is not currently receiving a supportive service from a service provider, a referral can be sent through Therap. The Referral Instructions provide a guide on sending a referral through Therap.
- If a member is currently receiving a supportive service from a service provider, (i.e. peer support, etc.), a referral can be sent via SComm in Therap to the provider. The referral must include the service the member wants to receive, the units, frequency, duration, and when the services should begin.

If you do not receive a response back from a provider after two full business days you can treat the lack of response as a denial. The communication sent via SComm must be saved and a lack of response documented as proof of the denial.

The referral must include information specific to the member. This will give the service provider adequate information to accept or deny the referral. The referral must include a release of information signed by the member for the service provider, and a copy of the ~~plan of care~~POC.

Once a provider has accepted a referral, the accepting provider must initiate services with the member within five business days of the anticipated admissions date on the referral. If the accepting provider does not have service delivered within this time period, it will be considered a denial of services from that agency. Proof of services will be the case note in Therap from the provider that details the services were rendered.

Submitting the Plan of Care for 1915(i) Staff Approval
The POC may be submitted to Therap once the referrals have been accepted by the supportive service providers. If there is not an accepted referral, ~~please~~ list TBD in the provider name field.

All POCs must be approved by 1915(i) staff PRIOR to services (i.e. peer support, housing support, etc.) are rendered. The date of POC submission is the date it is submitted to Therap, not the date that the POC is approved.

Once the member's POC is approved by 1915(i) staff:
- Send the POC to the member and their parent/legal guardian if applicable, and all team members; and
- Forward the POC and required attachments to all service providers, as a part of the referral process.

3. CRISIS PLAN DEVELOPMENT, IMPLEMENTATION, AND MONITORING

The care coordination agency is responsible for the development, implementation, and monitoring of the crisis plan. The crisis plan is developed by the care coordinator in collaboration with the member and is done in Therap as part of the POC creation.

Within the initial 60 days of a member's enrollment, it is vital to address any crisis situations and the need for stabilization of the members engagement in care coordination

promptly while working to find appropriate long-term services. This ensures the members' immediate needs are met and they feel supported during the transition period. These crisis situations consist of collaborating with healthcare providers, social workers, and other relevant professionals to arrange for crisis care services. By taking these steps, a care coordinator can provide immediate support to a member facing a crisis while simultaneously working to develop the POC, identify and arrange appropriate long-term services. This approach ensures the members' safety and well-being during the critical initial period of enrollment.

The crisis plan will be documented in the POC and submitted to the state within 30 days of enrollment. At the 60 day mark, the care coordinator will update the POC to reflect the services the member is now connected to. If care coordination continues to be needed as a goal beyond the initial stabilization period, the care coordination goal will be revised to align with ongoing requirements outlined in the 1915(i) Care Coordination Policy. Progress will be measured by completion of the crisis plan in Therap within 30 days, documented referrals and provider responses, and weekly (more if needed) check-ins to stabilize the member's needs. This goal ensures the members' immediate safety and supports transition to long-term services.

EXAMPLE OF A CARE COORDINATION GOAL FOR THE FIRST 60 DAYS CRISIS PERIOD

In my first 60 days, I will work with my care coordinator to make a crisis plan, have weekly check-ins (more if needed), and get connected to services. If services are not available right away, my care coordinator will temporarily help fill in the gaps by checking in more often, helping me use natural supports, and linking me to community resources until my long-term services begin. My crisis plan will be in my POC by day 30, and by day 60 my POC will be updated to show the services I am connected to.

4. REFERRAL, COLLATERAL CONTACTS, AND RELATED ACTIVITIES

Depending upon what other services the member receives, this may include scheduling appointments for the member and 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 in engaging culturally relevant community services and supports; and
- Contacts with non-eligible individuals that are directly related to identifying the eligible member's needs and care for the purposes of helping the eligible member access services, identify needs and supports to assist the eligible member in obtaining services, and providing members of the member's team with useful feedback.

The care coordination service assists members 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. Care must be taken to ensure non-duplication of any other existing case management or care coordination services.

5. MONITORING AND FOLLOW-UP ACTIVITIES

Care coordinators are responsible for ongoing service monitoring and follow-up meetings. This part of care coordination includes activities and contacts necessary to ensure the person-centered plan is implemented and adequately addresses the eligible member's needs. These activities may be with the member, family members, service providers, or other entities.

~~QUARTERLY REVIEWS~~Review of Services

Service providers must document all services rendered, and/or attempted services rendered, in case notes in Therap. This will allow the care coordinator to review all services the member is receiving. ~~send monthly progress reports to care coordinators. These progress reports must be reviewed to ensure services~~:

- ~~Are delivered as requested; and~~

~~Remain necessary for the member.~~

If services are no longer necessary, the ~~plan of care~~POC must be updated, and services must be discontinued. If the person-centered planning process leads to questions as to whether the member continues to meet diagnostic and functional need eligibility criteria, the care coordinator will complete an eligibility redetermination. This includes obtaining a new WHODAS or DLA assessment.

Face-to-Face meeting

Care coordinators must meet face-to-face with the member (and their parent(s) or guardian, as appropriate) at a minimum every 90 days. These are the members' quarterly reviews. The purpose of ~~this~~ these meetings is to ensure:

- The member is satisfied with the services they are receiving;
- Services are meeting the ~~member's~~members' needs;
- Services are being delivered as requested;
- Services remain necessary for the member; and
- If there is a conflict-of-interest exemption, the care coordinator must review to ensure that it remains the only willing and qualified provider in the member's county of residence.

Care coordinators must respond to the member's need(s) and work with the member to ensure services are appropriate and are delivered according to the member's plan of care. Care plan goals must be revised as needed and be updated on a quarterly basis.

If there are any changes in a member's household or circumstances such as a new address, etc., the member will need to update their information by either using the Self-Service Portal or calling the Customer Support Center (1-866-614-6005 or 701-328-1000).

Plan of Care Quarterly and Interim Review Requirements
A care coordinator must have a quarterly meeting with the member and if applicable, the guardian every 90 days. Quarterly and interim POC reviews must be documented by creating an Individual Plan Agenda in Therap. Each goal must be reviewed and documented. This includes:

- Discussion about the goal;
- Progress or lack of progress towards the goal;
- Next steps towards goals over the next quarter;
- If the goal has been reached, the POC must be updated to remove the goal and possibly set another one; and
- An action plan for next quarter to help the member achieve their goal.

Care coordinators must link the action items from the Individual Plan Agenda into the member's updated ~~plan of care~~POC. Quarterly plan updates must result in an updated ~~plan of care~~POC and be submitted for approval by 1915(i) program staff.

Please refer to the Quarterly/Interim Reviews & Individual Plan Agendas guide ~~Guidance for Care Coordinators~~ for instructions on submitting the Individual Plan Agenda and Change Form.

6. HCBS SETTING COMPLIANCE VERIFICATION

The care coordinator's role includes verification of HCBS Settings Rule compliance. Services must be rendered in a HCBS setting rather than an institutional setting. Care coordinators are responsible for ensuring that services are rendered in non-institutional settings.

For service settings other than a member's private residence or a community-based non-residential setting, care coordinators should refer to the Home and Community-Based Setting policy to determine whether services will be or are being rendered in a compliant setting.

7. ELIGIBILITY REDETERMINATIONS

Eligibility redetermination is done to ensure current 1915(i) members remain eligible for 1915(i) services. Redetermination applications must be submitted within the 30 day period before the member's 1915(i) eligibility expiration date. Once the member is redetermined as eligible, the care coordinator will submit a Care Coordination Request Report (CCRR), selecting that it is a 1915(i) eligibility renewal.

Applications submitted after a member's eligibility expiration date will be considered a new 1915(i) application, not an eligibility redetermination. If there has been a break in a member's eligibility, a care coordinator must submit a Care Coordination Request

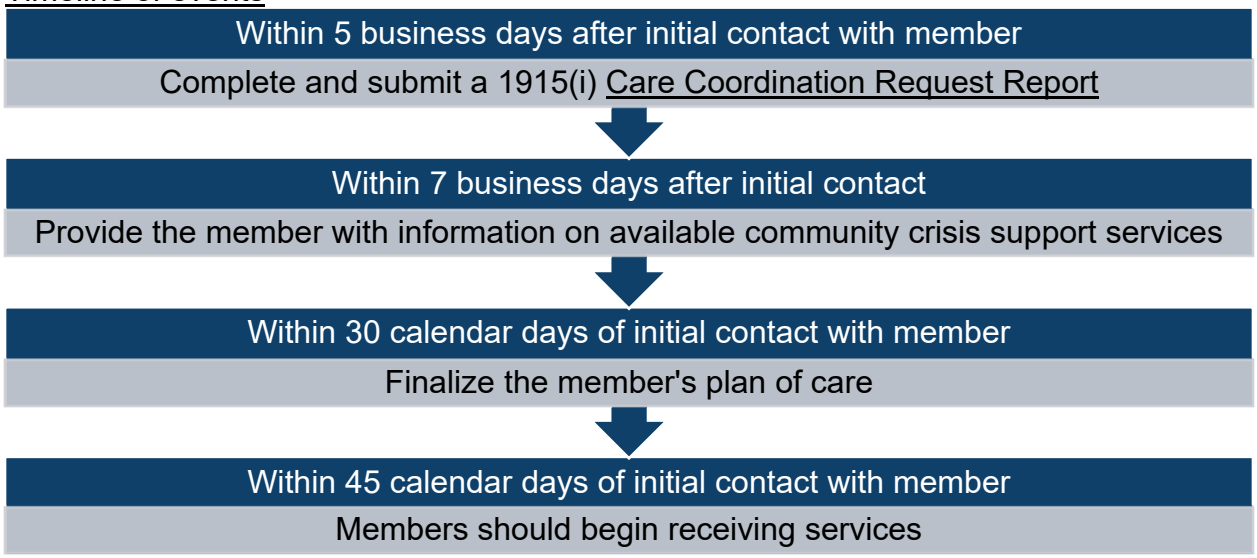
Report ~~(CCRR)~~ selecting that it is not a 1915(i) renewal and they cannot bill for time spent helping a member complete their eligibility application. Once the CCRR is received, the redetermination documents will be upload into Therap by the 1915(i) state team~~.~~

Care coordinators must monitor when a redetermination date is approaching to ensure completion of a member's annual 1915(i) eligibility redetermination before eligibility ends. A completed 1915(i) Eligibility Application (SFN 741) must be submitted for eligibility redetermination. Care coordinators must update all sections of the POC and submit to 1915(i) staff or the MCO's system for approval.

SERVICE REQUIREMENTS AND LIMITS

There must be at least one face-to-face meeting between the care coordinator and the member per quarter. ~~The member is not required to be present to bill for care coordination aside from this requirement.~~

Timeline of events



Initial contact is defined as the first call or contact between the member or the member's guardian and the care coordination agency.

Failure to follow these timelines may result in 1915(i) program staff sharing other available care coordination agencies with the member so there is no delay in services.

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

LIMITS
Eight hours (32 units) per day.

DOCUMENTATION
~~Plans of Care~~POCs must be created in the Therap system. See the "Documentation Guidelines" section of Provider Requirements policy for Medicaid documentation requirements.

Additional documentation resources ~~include~~can be found on the 1915(I) Provider Trainings & Information Sessions and the 1915(i) Provider Guidance and Policies webpages :

- ~~Best Practices presentation~~
- ~~Individual Plan Agendas for Quarterly Reviews~~

Beginning January 6, 2025, care coordinator meetings with members that are not documented in POC~~plans of care~~ or individual plan agendas must occur in Therap using the Care Coordination Case Note.

TELEHEALTH (REMOTE SUPPORT)
Up to 75% of services per calendar month may be conducted via telehealth. In-person support must be provided for a minimum of 25% of all services provided in a calendar month.

See the Telehealth policy for telehealth requirements.

NON-COVERED SERVICES

GENERAL NON-COVERED SERVICES

The Noncovered Services Policy contains a general list of services that are not covered by North Dakota Medicaid.

1915(i) non-covered services include:

- Services duplicative of care coordination, including Home and Community-Based Waiver services if the member is working on the same goals;
- Services exceeding limits which do not have an approved service authorization;
- Services provided in non-HCBS compliant settings;
- Services outside the scope of care coordination – i.e., checking a member's eligibility, providing services in the scope of another 1915(i) service such as peer support, or housing support, aside from short-term stabilization needs within the first sixty (60) days of working with a member;
- Services within the scope of other 1915(i) services;
- Care coordinators cannot render services. They can only coordinate services;
- Services by non-qualified providers;

- Social interaction with members; and
- Texting or electronic messaging members (this is listed as a non-covered service in the Telehealth policy).

DUPLICATIVE SERVICES

CARE COORDINATION

Care coordinators must ensure that other services do not duplicate 1915(i) services. It is allowable for 1915(i) members involved in multiple systems, waivers, and state plan targeted case management services, etc., to receive continued specialized case management from each. For example, a member involved in the 1915(i) to address behavioral health needs may be enrolled in the Developmental Disabilities Waiver, be in the foster care system, and also receiving special education services. Each of these systems offer case management in their areas of expertise and serve an essential role in the member's care.

While the member may receive case management from several areas, Medicaid can only reimburse one provider delivering the same service on the same date and time to the same member. For example, targeted case management cannot be billed for the same date and time for the same member as 1915(i) care coordination. The case managers must decide amongst themselves which provider will bill.

The 1915(i) State Plan Amendment allows for care coordination for Ages 0+. The following North Dakota 1915(c) Waivers offer case management:

- Individuals with Intellectual Disabilities and Developmental Disabilities (DD) Waiver – Age 0+;
- Medically Fragile Waiver – Age 3 to 18;
- Autism Waiver – Age 0 to 17;
- Children's Hospice Waiver – Age 0 to 22; and
- Home and Community-Based Services (HCBS) Waiver – Age 18+.

COMMUNITY TRANSITION SERVICES

Members who previously or are currently receiving community transition services through the DD or HCBS Waivers are not eligible to receive community transition services through 1915(i).

Further, members who previously or are currently receiving community transition services through ND Transition and Diversion Services Pilot Project (TDPP, formerly ADRL) or Money Follows the Person (MFP) are not eligible to receive community transition services through the 1915(i).

The 1915(i) State Plan Amendment offers community transition for Age 0+. The following North Dakota 1915(c) Waivers offer community transition:

- Individuals with Intellectual Disabilities and Developmental Disabilities (DD) Waiver – Age 0+; and
- Home and Community-Based Services (HCBS) Waiver – Age 18+.

HOUSING SUPPORTS

ND Rent Help and Housing Stabilization supportive services end once a member is connected to a 1915(i) housing supports provider. Housing supports may be offered to recipients of ND Rent Help funding.

To ensure nonduplication of services and continued support, a 1915(i) member can have their plan of care developed and their 1915(i) housing provider approved to begin services after their previous housing service ends.

The 1915(i) State Plan Amendment offers housing supports for Age 17.5+. The following North Dakota 1915(c) Waiver offers a community transition service that is duplicative of 1915(i) housing supports:

- Home and Community-Based Services (HCBS) Waiver – Age 18+.

The following services are duplicative of 1915(i) housing supports and cannot be rendered at the same time:

- Housing facilitation;
- Money Follows the Person (MFP) Community Transition Service;
- ND Transition and Diversion Services Pilot Project (TDPP, formerly ADRL) Community Transition Service:
    - TDPP offers funding and pre-tenancy support but does not provide tenancy services. Tenancy supports may be offered to TDPP recipients living in a HCBS compliant setting.
- Home and Community Based Services (Aging) Community Transition Service.

NON-MEDICAL TRANSPORTATION SERVICES

The 1915(i) State Plan Amendment offers non-medical transportation for Age 0+. The following North Dakota 1915(c) Waivers offer duplicative transportation services:

- Medically Fragile Waiver – Age 3 to 18; and
- Home and Community-Based Services (HCBS) Waiver – Age 18+.

PRE-VOCATIONAL TRAINING

The 1915(i) State Plan Amendment offers pre-vocational training for Age 17.5+, or receipt of a high school diploma or GED, whichever comes first. The following North Dakota 1915(c) Waiver offers prevocational services:

- Individuals with Intellectual Disabilities and Developmental Disabilities (DD) Waiver – Age 18+.

RESPITE CARE

The 1915(i) State Plan Amendment offers respite for Age 0 to 20. The following North Dakota 1915(c) Waivers offer duplicative respite services:

- Individuals with Intellectual Disabilities and Developmental Disabilities (DD) Waiver – Age 0+;
- Medically Fragile Waiver – Age 3 to 18;
- Autism Waiver – Age 0 to 17;
- Children's Hospice Waiver – Age 0 to 22; and
- Home and Community-Based Services (HCBS) Waiver – Age 18+.

SUPPORTED EMPLOYMENT

The 1915(i) State Plan Amendment offers supported employment for Age 14+. The following North Dakota 1915(c) Waivers offer duplicative employment services:

- Individuals with Intellectual Disabilities and Developmental Disabilities (DD) Waiver – Age 18+; and
- Home and Community-Based Services (HCBS) Waiver – Age 18+.

INDIVIDUALS WITH DISABILITIES EDUCATION IMPROVEMENT ACT OF 2004 (IDEA)

If services are available to a student through IDEA, they may not receive 1915(i) services that are duplicative of the services or supports identified in the student's Individual Education Plan (IEP). 42 CFR Section 441.720(a)(7).

To ensure duplication does not occur, the 1915(i) care coordinator must coordinate efforts with the student's IEP team. Prior to entering any services on the 1915(i) plan of care, justification that services are not otherwise available to the member through an IEP must be documented in the member's record and kept on file.

1915(i) services that may be duplicative of IDEA include Supported Education, Supported Employment, and Pre-Vocational Services.

CHILDREN'S FOSTER CARE SERVICES

1915(i) services may be delivered to children in foster care living arrangements but only to the extent that 1915(i) services:

- Supplement maintenance (including room and board) and supervision services; and
- Are necessary to meet the identified needs of the child.

1915(i) funds are not available to pay for maintenance and supervision of children who are in the state's custody, regardless of whether the child is eligible under Title IV-E Prevention Services. The costs associated with maintenance and supervision are considered a state obligation.

Title IV-E Prevention Services
When 1915(i) services are furnished to children in foster care who are eligible for Title IV-E funding, the 1915(i) service provider must ensure their claims do not include costs that are charged as Title IV-E administrative expenses.

REHABILITATION ACT OF 1973
If services are available to a member through the Rehabilitation Act, they may not receive 1915(i) services that are duplicative of the services or supports provided through the Rehabilitation Act. 42 CFR Section 441.720(a)(7)

To ensure duplication does not occur, the 1915(i) care coordinator must coordinate efforts with the Vocational Rehabilitation Agency. Justification that services are not otherwise available to the member under Section 110 of the Rehabilitation Act of 1973 must be documented in the member's record and kept on file.

1915(i) services to check for duplication under the Rehabilitation Act and through Vocational Rehabilitation include Benefits Planning, Supported Employment, and Pre-Vocational services.

CONFLICT-FREE CARE COORDINATION
Care coordination providers, with few exceptions, generally cannot also be service providers for the same members. See the Conflict-of-Interest policy for more information and to determine if an exemption applies. ~~Providers who have been granted an exemption must verify on a quarterly basis that the exemption still applies.~~

REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS

TIMELY FILING

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The Timely Filing Policy contains additional information.

THIRD-PARTY LIABILITY

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. ~~Providers must pursue the availability of third-party payment sources.~~ The Third Party Liability Policy contains additional information.

CLIENT SHARE (RECIPIENT LIABILITY)

Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The Client Share Policy contains additional information.

REIMBURSEMENT

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

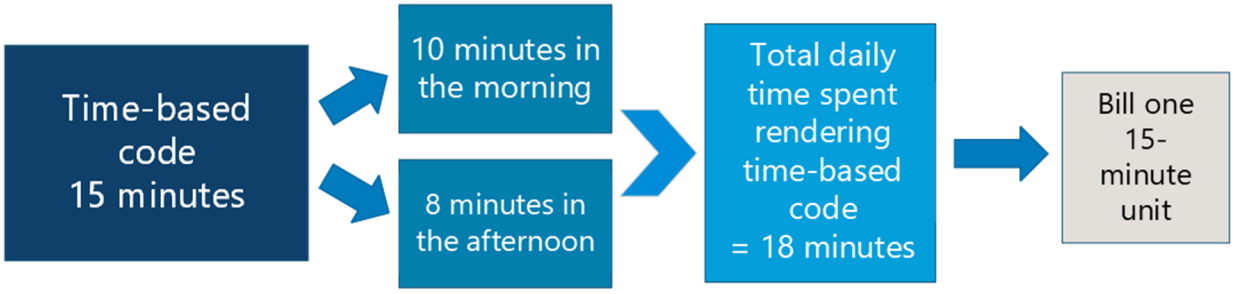
Care coordination is billed in 15-minute increments.

Code	Description
H2015	Care Coordination (per 15 minutes)

15 Minute Units
Providers can bill a single 15-minute unit for services greater than or equal to 8 Minutes. Services performed for less than 8 minutes should not be billed. Minutes from the same day, with the same Place of Service (POS) code, and for the same member can be combined and billed when adding up to at least 8 minutes.

1 unit: ≥ 8 minutes through 22 minutes
2 units: ≥ 23 minutes through 37 minutes
3 units: ≥ 38 minutes through 52 minutes
4 units: ≥ 53 minutes through 67 minutes
5 units: ≥ 68 minutes through 82 minutes
6 units: ≥ 83 minutes through 97 minutes
7 units: ≥ 98 minutes through 112 minutes
8 units: ≥ 113 minutes through 127 minutes

The pattern remains the same for times exceeding 2 hours.



Fee schedules can be found at https://www.hhs.nd.gov/healthcare/medicaid/provider/fee-schedules.

DEFINITIONS

Care coordinator - the professional responsible for plan of care development and coordinating access to needed services.

Crisis - A time of intense difficulty, trouble, or danger.

Home and Community Based Setting (HCBS) - a member's private residence or community location rather than an institution or other isolated setting.

Initial contact - the first call or contact between the member or the member's guardian and the care coordination agency.

Institutional setting – settings include nursing facilities (NF), intermediate care facilities for individuals with intellectual disabilities (ICF/IID), Qualified Residential Treatment Programs (QRTPs), Psychiatric Residential Treatment Facilities (PRTF), hospitals, and jails/prisons.

Person-centered planning – a planning technique emphasizing member preferences, strengths and choices and providing an opportunity to fully participate in the process.

Plan of care - a document that identifies the supports and services provided to a member to address their needs.

Telehealth –the use of telecommunications and information technology to provide access to physical, mental, and behavioral health care across distance. Services must occur in real-time with the member present via telecommunications or information technology.

FREQUENTLY ASKED QUESTIONS

Q: What do I do if a member needs a new Care Coordination provider?
A: If a member needs to be transferred from one care coordination agency to another, the same referral process is followed that is done for service requests, except for one difference. The agency that the member is transferring from will send the referral request to the accepting agency's care coordination profile in Therap, and not their service provider profile. The care coordination profile will start with "CC." Then the accepting provider will submit a Care Coordination Request Report form, which can be found on the 1915(i) webpage.

Q: What if a member doesn't want to or isn't ready to select and work with a service provider (i.e. peer support specialist, etc.)? How do I handle this in their plan of care?

A: Refer to this section of the above policy **REFERRAL, COLLATERAL CONTACTS, AND RELATED ACTIVITIES.** Related activities might be setting a goal with the member to select and begin working with a service provider. This should be a time-limited goal with specific steps identified to get the member to their goal of receiving 1915(i) services. The care coordinator would document this as a goal on the member's plan of care and document progress towards that goal and their work with the member.

Q: What if a care coordinator identifies urgent needs for the member and there are no readily available service providers to fill that gap?

A: The role of care coordinator is to help assess member needs and work with the member to identify SMART goals, connect to service providers, and oversee services to ensure they are meeting the member's needs. Care coordinators, under "related activities" and "referrals" can get members connected to other services that may fill temporary gaps like helping them apply for needed services. The intent here is not for the care coordinator to step into the role of a service provider and be offering the scope of services of a 1915(i) service provider like housing support providers. It would be reasonable for a care coordinator to help a member fill out an application for an apartment, for example, if that is an emergent need that could not wait for connection to a housing support provider.

Q: What if I submit a plan of care within 30 days of initial contact with the member but the plan of care isn't approved until after the 30-calendar day point? Will I potentially be discharged as the member's care coordinator?

A: If a plan of care is submitted within 30 calendar days from initial contact with the member, you should not be discharged if the plan of care is approved after the 30-calendar day point. The purpose of the 30-day requirement is to ensure that a plan of care is developed and submission of a plan of care for approval is proof that is occurring.

Q: What do I do if someone I'm providing Care Coordination for is admitted to a non-compliant setting, such as a hospital or jail?

A: A member's eligibility may suspend (pause) while they are residing in a non-compliant setting for up to 6 months, or until their eligibility span expires, whichever comes first. If you find out a member has been incarcerated, reach out to the 1915(i) team. You can send them a secure message via Scomm in Therap. Or you can reach out to them via email at nd1915i@nd.gov asking for a secure email to be sent to you. Once you have received the secure email, respond to it with the member's status information. ~~Members should report this change to the Customer Support Center. Care coordinators may also be able to report this information on behalf of the member.~~

Upon the member's return to a compliant residential setting, the Care Coordinator should contact the 1915(i) admins ~~ND Medicaid~~ to initiate the end of

the suspension. The Care Coordinator should subsequently inform any applicable 1915(i) Supportive Services providers of pauses and resumptions. A 1915(i) Care Coordinator may assist with coordinating the submission of the member's eligibility redetermination while they are residing in the non-compliant setting, should that be necessary, however the time spent doing so would not be billable.

Q: How do we know what to put in the Plan of Care?
A: There is a template that must be used for the 1915(i) Plan of Care in our online documentation platform, Therap Services. Each Care Coordinator must complete the online ~~attend a~~ 1915(i) Care Coordination Onboarding ~~session~~ training prior to providing 1915(i) Care Coordination. In this ~~onboarding~~training, resources, instructions, and other important information on the Care Coordination/Plan of Care process is shared. It is also recommended that those serving in 1915(i) administrative roles (billing, supervisors, etc.) ~~attend an onboarding session~~complete this training.

Q: Are there recorded trainings available?
A: ~~It's required that 1915(i) Care Coordination Onboarding training is **attended in-person at this time. We are working towards making this training on-demand and available at the**~~ Any recorded trainings are available on the ~~-~~1915(i) Provider Trainings & Information Sessions page webpage.~~.~~

CONTACT

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POLICY UPDATES

Section	Summary
Comprehensive Assessment and Reassessment Activities	Added in "Have the member and guardian, if applicable, sign the Members Rights and Responsibilities for traditional members, and this Members Rights and Responsibilities for Medicaid Expansion members."
Crisis Plan Development Implementation and Monitoring	Added in language about actions care coordinator can take in first 60 days of enrollment and the example of a SMART goal.
Monitoring and Follow-up Activities	Added in "document all services rendered, and/or attempted services rendered, in case notes in Therap. This will allow the care coordinator to review all services the member is receiving."

Plan of Care Quarterly and Interim Review Requirements	Added in specific language about when quarterly reviews are to happen
Definitions	Added a definition for crisis
FAQ	Added in specifics of how to report when a member is incarcerated