CARE COORDINATION

PURPOSE

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

APPLICABILITY

This policy applies to 1915(i) care coordinators and care coordination agencies.

ELIGIBILITY

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.

DEFINITIONS

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

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

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

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

Telehealth – means 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.

MEMBER CONNECTION WITH CARE COORDINATION AGENCIES

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 may be assigned a care coordination agency to work with.

Members may be assigned 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. See the Conflict of Interest policy for more information on how a provider is the "only willing and qualified" provider in a member's county of residence. In these situations, care coordinators may not need to submit a completed Care Coordination Request form.

COVERED SERVICES AND LIMITS

Care coordinators are key to ensuring that the 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 each discussed in further detail below:

- Comprehensive assessment and reassessment activities
- Development of an individualized person-centered plan of care
- Crisis Plan Development, Implementation, and Monitoring
- Referral, Collateral Contacts, and Related Activities
- Monitoring and Follow-Up Activities
- HCBS Settings Rule Compliance Verification
- Eligibility Redeterminations

ONBOARDING NEW MEMBERS

Below is the care coordination onboarding process for new members. This is the first step a care coordinator takes with members after initial contact.

- Provide the member, and parent/legal guardian, if applicable, with the Member Rights and Responsibilities form for Traditional members «(use the Medicaid Expansion Member Rights and Responsibilities form for Expansion members)» for signature informing them of their right to:
    - 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.
- Arrange needed supports and information to assist the member with directing and being actively engaged in POC meetings
- Identify other services the member receives to avoid duplication and coordinate with other case managers/care coordinators
    - These include 1915(c) Home and Community-Based Services waivers, foster care, vocational rehabilitation, IDEA/IEP services, etc.
- Determine the time, location, and team makeup of POC meeting 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 this service/time.

1) COMPREHENSIVE ASSESSMENT AND REASSESSMENT ACTIVITIES

Care coordinators are responsible for using a member's eligibility assessments (WHODAS/DLA) as well as additional assessments to understand a member's needs and preferences for development of a person-centered service plan. 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 them in the person-centered planning process.

Care coordination duties falling under this responsibility 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;
  - this includes use of the member's 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 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.

A member'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 functional needs assessment as part of the initial evaluation and annual reevaluation process. The care coordinator must document a need for 1915(i) any needed services (peer support, respite, etc.) to support the member's identified goals in the person-centered plan of care and document the member's progress toward their goals.

Reasonable indication of need for services «for continued 1915(i) eligibility»

1915(i) members must meet the following criteria:

1) Need at least one 1915(i) service as documented in the person-centered service plan, and
2) Service must be provided at least quarterly, with monthly monitoring documented in the member's plan of care «and/or in care coordination case notes».

Meeting with members to do assessments and person-centered planning

Care coordinators must meet with members to develop a person-centered plan of care. 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 1915(i) Provider List.
- Review and sign Individual Acknowledgment/Care Coordination Attestation/Signatures.

- Get signatures from all meeting attendees. Meeting Attendee Signatures

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 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 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) are done in the Therap system. This POC template must be used, alternate templates may not be used.

- The «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 **s**pecific, **m**easurable, **a**chievable, **r**elevant, and **t**imely.

Specific – address what the member wants in relation to their assessed need.
Measurable – how are you going to measure the member's progress towards achieving their identified goal?
Achievable/Attainable – the goal must be realistic and the member needs to have access to necessary tools/resources to achieve the goal.
Relevant – the goal needs to make sense and the benefit of achieving the goal must be identified.
Timely – when do you anticipate the member will be able to achieve the goal or what steps are needed and when will they occur?

Example:

Let's say we have a member whose anxiety makes it very difficult for them to leave the house.

The member's goal is to "leave the house more often".

The needs from the member's WHODAS these address are: participation in community activities and interacting with other people. The member scored pretty low in both of these areas.

The member would like 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. Here's why.

- It is not specific – it doesn't say how the member is going to leave the house or define what that means.
- It is not measurable – it doesn't say how often the member will leave the house or define whether there are specific activities they want to participate in when out of the house.
- It is not achievable – because it is too vague and will likely set the member up for failure.
- It is not relevant in that it doesn't explain what benefit the member expects to see from leaving the house more often. I.e., improved social skills, more comfortable leaving the house on their own, etc.
- And finally, it is not timely because there is no timeframe for when the member is looking to see if this goal is achieved or needs revision.

Here's how we can improve the goal:

Goal: Member and their peer support specialist will work each week to identify one community activity for 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. Member will do this for one month.

- Specific – we've added a definition of what "leaving the house" means by explaining the community activity piece.
- Measurable – we've added the measure of one activity and outing per week which is now measurable. We know what "leave the house" means – it means going to a community activity and speaking to at least one person AND we know that will happen once per week.
- Achievable – we've identified that to start, once per week is appropriate as the member rarely leaves their house. We can review this goal as the member achieves it.
- Relevant.- we know this is in line with the member's goal of finding reasons to leave the house more often.
- Time-Bound – we know that at the end of one month we will evaluate the member's progress and determine if they succeeded in achieving this goal. We'll set a new one if so.

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.

> Ensure you are identifying barriers 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 to solve a 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 constantly evaluated as far as reasonableness, progress, and time. Care coordinators should help members set specific achievable goals to work towards. These are great habits for members to develop and maintain for successful community living.

Ensuring there is no 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 funding source, including 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 because the service scopes overlap.

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

SIMILAR SERVICES TO 1915(i)

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 would not be eligible to get respite through 1915(i). This would also apply if a student needs supported education services through their Individualized Education Plan (IEP) they are not eligible to have those services through 1915(i).

SIMILAR 1915(c) HCBS WAIVER SERVICES MUST BE USED BEFORE 1915(i) SERVICES

ND Medicaid currently has the following 1915(c) waivers:

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

To avoid service duplication with 1915(c) Waiver services, the care coordinator will look up the member in MMIS to see if the member is on any of the Medicaid 1915(c) Waivers or any other Medicaid programs which may be duplicative. «Here is how to look up a member in MMIS to see if the member is waiver-eligible.» If services are identified, the care coordinator will reach out to the (c) Waiver case manager to ensure the plan of care will not include services the member could receive through the 1915(c) Waiver.

SERVICE PAYMENTS FOR THE ELDERLY AND DISABLED (SPED) AND EXPANDED SERVICE PAYMENTS FOR THE ELDERLY AND DISABLED (EX-SPED)

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

List of duplicative services

We have developed a list of identified duplicative services listed in this policy. Please use this list to determine if services are duplicative and reach out to nd1915i@nd.gov with any questions.

After the member's person-centered planning meeting

Here are the steps to take after meeting with a member

- Document meeting minutes in the member's file.
- Complete all sections of the POC and sign.
    - Use plain language when writing the plan of care.

«Referrals»

- «Send referrals to 1915(i) service providers in Therap. There are two ways you will potentially do referrals in Therap.
    - If a service provider is not serving a member already with a supportive service, you will send a referral through Therap. Here are instructions on how to send referrals in Therap.
    - If a service provider is already providing a supportive service to a member (i.e. peer support, etc.), you will send a referral via SComm in Therap to the provider listing the service the member wants to receive, the units, frequency, duration, and when you want the services to begin.»
- **If you do not receive a form back from a provider after two full business days you can treat the lack of response as a denial.** Please save your «Scomm» to the provider and document a lack of response as proof of the denial in this case.

«Be specific in your referral if the member has specific requirements/requests for their service provider. Give the referred provider enough information to adequately accept or deny the referral.»

«Submitting the Plan of Care for 1915(i) Staff Approval»

- You submit the Plan of Care in Therap «once you have accepted referrals from supportive service providers. If you do not have an accepted referral, please list TBD in the provider name field.»
    - ALL PLANS OF CARE MUST BE APPROVED BY 1915(i) STAFF **PRIOR TO SERVICE (i.e. peer support, housing support, etc.) RENDERING**.
    - Date of plan of care submission is the date it is submitted to Therap, not the date that the plan of care is approved.

After the member's POC is approved by 1915(i) staff

- Send the POC to the member, their parent/legal guardian if applicable, and all team members.
- Forward the POC and required attachments to all service providers.

- Submit service authorizations (if required) and all required attachments. (See Service Authorization Training for more information on submitting service authorizations.

POC resources/trainings

- Presentation on SMART Goals, Needs, and Services and recording.
- Plan of Care Therap Creation Guide
- Plan of Care and Case Notes Demo

3) **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 member and is done in Therap as part of the POC creation.

4) **REFERRAL, COLLATERAL CONTACTS, AND RELATED ACTIVITIES**

Depending upon what other services the member receives, this may include scheduling appointments for the member 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 member's needs and care for the purposes of helping the eligible member access services, identifying 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 for the services to which access is gained, with care taken to ensure non-duplication of any other existing case management/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 may be with the member, family members, service providers, or other entities.

QUARTERLY REVIEWS

Service progress note reviews

Care coordinators must receive written progress reports from the member's service providers monthly. These progress reports must be reviewed to ensure services:

1) Are delivered as requested and
2) Remain necessary for the member.
    a. If services are no longer necessary, the plan of care must be updated and services must be discontinued.
    b. 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 do an eligibility redetermination. This will include 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 least every 90 days. The purpose of this meeting is to ensure:

1) The member is satisfied with the services they are receiving,
2) Services are meeting the member's needs,
3) Services are being delivered as requested,
4) Services remain necessary for the member, and
5) 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 should likely 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 Review Requirements

Quarterly and interim POC reviews must be documented by creating an Individual Plan Agenda in Therap. Each member goal must be reviewed and documented.

- Discussion of goal
- Whether there has been progress
- What progress occurred and what needs to happen to continue/start making progress during the next quarter
- Whether the goal has been reached. If so, POC needs changing to remove that goal and possibly set another one.
- Action plan for next quarter to help get closer to/achieve goal

Care coordinators will then link action items from the Individual Plan Agenda into the member's updated plan of care.

Quarterly plan updates must result in an updated plan of care. Updated plans of care are then submitted for approval by 1915(i) program staff.

Instructions for the Individual Plan Agenda and submitting a Change Form request for approval of the updated Plan of Care are available here.

6) **HCBS SETTING COMPLIANCE VERIFICATION**

The care coordinator's role includes verification of HCBS Settings Rule compliance. Services must be rendered in a Home and Community-Based 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**

What is an eligibility redetermination?

Eligibility redetermination is the process of a 1915(i) member who is **currently 1915(i) eligible** reapplying for 1915(i) to see if they still meet eligibility requirements. Redetermination cases are when a member's 1915(i) application is submitted within 30 days of the member's 1915(i) eligibility expiration date AND there has been no lapse in their eligibility span.

Applications submitted after a member's eligibility span ends are considered a new 1915(i) application, not an eligibility redetermination. When there has been a break in a member's eligibility, a care coordinator must submit a Care Coordination Request Report and cannot bill for time spent helping a member complete their eligibility application.

For eligibility redeterminations, how does a care coordinator get a member's redetermination eligibility documents? (i.e., the member's application, WHODAS/DLA, etc.).

Please email nd1915i@nd.gov and state "Member (name) was redetermined eligible for 1915(i). I would like their new eligibility documents."

Care coordinators must monitor to ensure completion of a member's annual 1915(i) eligibility redetermination. A completed SFN 741 1915(i) Eligibility Application must be submitted for eligibility redetermination.

Member 1915(i) eligibility is reevaluated prior to their 1915(i) renew dates. Care coordinators must update all sections of the POC and submit it to 1915(i) staff or the MCO's system for approval.

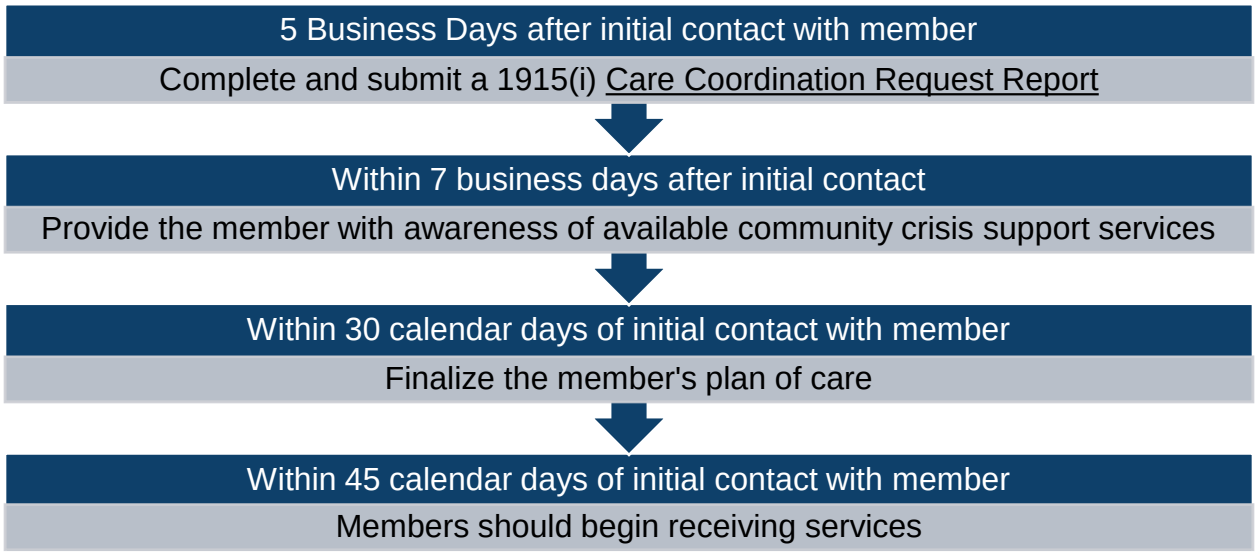
LIMITS

Eight hours (32 units) per day.

SERVICE REQUIREMENTS

There must be at least one face-to-face contact 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 the ND Medicaid. All requests to exceed limits must initiate with the care coordinator.

DOCUMENTATION

Plans of Care must be created in the Therap system. The Therap POC Creation Guide provides details for completing each section of the POC.

See "Documentation Guidelines" section of Provider Requirements policy for Medicaid documentation requirements.

Documentation resources:

- Best Practices presentation
- Therap case notes presentation
- Therap POC Creation Guide
- «Individual Plan Agendas for Quarterly Reviews»

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

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 Telehealth policy for telehealth requirements.

NON-COVERED SERVICES

- Services duplicative of care coordination, including Home and Community-Based Waiver services only if 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 must coordinate services only.
- Services by non-qualified providers
- Social interaction with members
- Texting or electronic messaging members (this is listed as a non-covered service in the Telehealth policy)

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.

PROVIDER QUALIFICATIONS

Group

A group provider of this service must meet all 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 ND Medicaid review upon request.

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;
3. Be knowledgeable and competent in person-centered plan implementation
4. and
5. 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
4. Be supervised by an individual containing these qualifications at a minimum.

Agencies must have records available for ND Medicaid 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*; and
3. State-sponsored care coordination onboarding.

*Care coordinators must complete the State-sponsored care coordination training within the first 6 months of enrollment.

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 in lieu of a bachelor's degree, three (3) years of supervised experience working with special populations.

BILLING AND REIMBURSEMENT

Care coordination is billed in 15-minute increments.

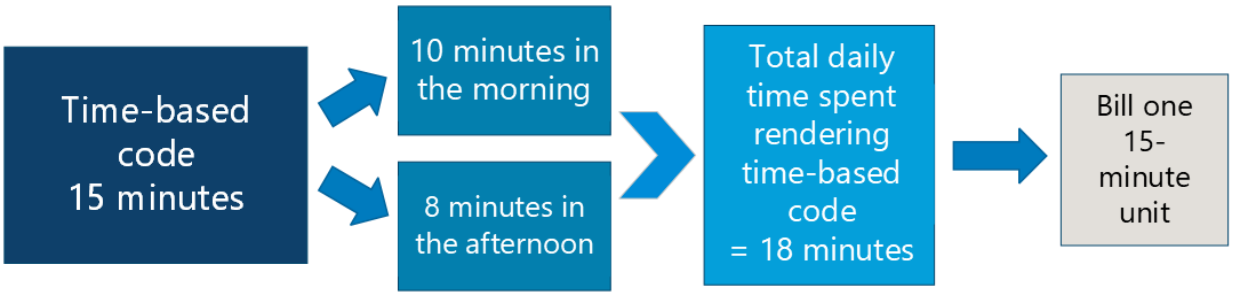
Code	Description
H2015	Care Coordination (per 15 minutes)

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.

FAQs

Q: What do I do if a member needs a new Care Coordination provider?
A: All requests for service providers are made via the Request for Service Provider form, including requests to change Care Coordination agencies. The member's

current care coordinator must notify the member and fill out a Request for Service Provider form and indicate there is a request for transfer of services for care coordination and assist the member in obtaining a new care coordinator. Contact nd1915i@nd.gov if that is unable to happen.

Once a new care coordination agency has accepted the request and sent you the completed Request for Service Provider form, it must be emailed to the nd1915i@nd.gov inbox so the transfer can be made in Therap. The member must also be notified of this change in care coordination provider. New care coordination providers cannot bill for care coordination until the Request for Service Provider form is received and processed by nd1915i@nd.gov.

Service authorization requirements for Medicaid Expansion providers still apply. It is expected these requirements will end January 2025.

Q: What happens 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 happens if the 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. 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 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 attend a 1915(i) Care Coordination Onboarding session prior to providing 1915(i) Care Coordination. In this onboarding, 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.

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 1915(i) Provider Trainings & Information Sessions page.

LIST OF IDENTIFIED DUPLICATIVE SERVICES

Care coordinators must ensure that these services do not duplicate 1915(i) services:

Care Coordination

The 1915(i) State Plan Amendment offers 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
- Home and Community-Based Services (HCBS) Waiver – Age 18+

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 will decide amongst themselves which one of them will bill.

Community Transition Service

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

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 the 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).

Housing Supports

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

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 the other housing service ends.

Non-Medical Transportation

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

- Medically Fragile Waiver – Age 3 to 18
- 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 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
- 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 employment services:

- Individuals with Intellectual Disabilities and Developmental Disabilities (DD) Waiver – Age 18+
- 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 the 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 to check for duplication under IDEA include Supported Education, Supported Employment, and Pre-Vocational Services.

CHILDREN'S FOSTER CARE SERVICES

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

1. supplement maintenance (including room and board) and supervision services; and
2. 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 under 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.