# TRANSFERRING AND TERMINATING MEMBER SERVICES

## PURPOSE

This policy instructs providers on what to do when it is necessary to stop providing services to a member. Stopping services can mean transferring them to another provider or ending some/all agency services to a member.

## ELIGIBILITY

This policy applies to all providers rendering care coordination and/or supportive services and supports.

## DEFINITIONS

*Termination of a service* – means when a provider needs to stop providing care coordination or supportive services to a member.

## REQUIREMENTS

It is the responsibility of the provider agency stopping services to notify the member of service termination thirty (30) calendar days before stopping services. Limited exceptions to this requirement apply and are discussed below.

### Termination Notice – 30 Days Prior to Service Termination

The member and/or parent/legal guardian and their 1915(i) care coordinator must be informed of the termination by providing a 30-calendar day advance notice indicating the provider agency will no longer be providing the service(s). The notice must be dated 30-calendar days from the date of mailing.

This requirement ensures that the member's care coordinator has time to work with the member to find another service provider to minimize service disruption for the member. It also ensures the member is informed about service changes.

NOTE: If you are terminating care coordination services, you ~~only~~ need to send written notification of termination to the member and/or their parent/legal guardian. ~~When terminating care coordination services, the member's current care coordinator must send the member a Termination Notice~~. A copy of the written notification of termination of services must be saved in the member's Document Storage in Therap, in the State Oversight account.

### Immediate Termination Notice

There may be situations where a 30-day advanced notice is not possible. In these situations, written notification of service termination from the current provider agency is still required. Reasons for less than 30 calendar days of advanced notice for service termination are listed below.

If a member:

- is deceased ~~(see Member Discharge Form section of this policy)~~
- No provider available within agency to serve member (due to termination or employee terminating employment)
- chooses to terminate services
- cannot be located
- moved from the service area
- transitioned to a setting which does not meet the Home and Community-Based Setting (HCBS) Rule
- no longer meets one or more of the 1915(i) eligibility requirements
- exhibits behavior that poses a risk to others, or the provider. This includes, but is not limited to, threats of violence, physical aggression, or other actions that compromise the safety and well-being of those involved in the members' services. Such incidents must be documented in the member's case notes in Therap, detailing the nature of the behavior, actions taken, and any relevant supporting information.

If a service provider

- terminates employment, or
- a service provider's employment is terminated.

When a member's care coordinator is terminated or terminates employment, the care coordination agency must send a termination notice to the member and submit a Member Discharge Form per the Member Discharge Form section of this policy.

**Sample Termination Notice**

A sample member termination notice is located on the 1915(i) Provider Guidance and Policies website.

**Member Discharge Form**

A Member Discharge Form is only required in the following situations:~~.~~

- Member death.
- Provider termination of care coordination with no care coordination referral accepted (i.e., when you are stopping care coordination and have been unsuccessful in locating another service provider for the member).
    - NOTE: Supportive service providers (i.e. peer supports, housing supports, etc.) must always notify a member's care coordinator when terminating services, the Member Discharge Form is not required in these situations.
- Safety concerns about providers working with member
- Member choosing to terminate services
- Cannot contact/locate member
- Member transition to a non-HCBS-compliant setting
- Member no longer meets 1915(i) eligibility requirements

- It is 30 days post-initial contact and member does not have an approved plan of care

**1915(i) Program Discharge of Member from Provider Due to No Approved Plan of Care**

It is expected that members will have a plan of care in place thirty (30) days after initial contact with a care coordination agency. Members may be discharged from a care coordination agency for failure to have a finalized plan of care in place 30 days post-initial contact.

1915(i) staff will notify the member and care coordination provider using the Member Discharge form. Discharged members will work with a new care coordination agency to develop a plan of care when this occurs.

**Transferring Services to Another Service Provider**

Providers should use the Therap referral process when the member has selected alternate service provider preferences. The provider is linked to a member in Therap when the provider accepts the referral.

**Transferring Care Coordination Services** ~~TRANSFERRING CARE COORDINATION SERVICES~~

Care coordinators who can no longer serve a member should use the 30 calendar days after notifying the member of service termination to assist the member in selecting a new care coordination provider.

Additionally, the current care coordinator should work with the member to identify their preferred care coordination providers and send referral(s) in Therap for a transfer of care coordination. Care coordinators should send a Release Of Information (ROI) to share the member's current plan of care along with the member's plan of care to providers with the Therap referral. Contact nd1915i@nd.gov if that is unable to happen.

Once a new care coordination agency has accepted the request, a Care Coordination Request Report must be submitted so a care coordination transfer can be made in Therap. New care coordination providers cannot bill for care coordination until the «Care Coordination Request Report is processed and the provider is linked in Therap.

A member's new care coordinator must draft and submit a new plan of care in Therap within five (5) business days after accepting the member for care coordination. If the member does not have a current plan of care, the new care coordinator has thirty (30) days after accepting the referral to draft an initial plan of care.

If a new care coordinator has not accepted a referral, please see the Member Discharge Form section of this policy to discharge a member from your agency.

~~TRANSFERRING SUPPORTIVE SERVICES~~**Transferring Supportive Services**

A service provider has notified the member's care coordinator of the need for a new service provider by sending the member's care coordinator a Scomm, in Therap. In this Scomm the service provider will detail the following:

- applicable service the member is being discharged from
- effective date of discharge
- how the member was notified of the discharge
- reason for the discharge. ~~the Discharge Form~~.

Care coordinators are responsible for helping members select new supportive service providers using Therap referrals. Care coordinators will ~~should~~ include a ROI to share the member's current plan of care and send the plan of care to the new service provider in Therap using the Therap referral process. ~~along with the Service Provider Request form~~. ~~Care coordinators must update the member's plan of care within five business days~~.

~~NEW PLANS OF CARE~~**New Plans of Care**

After a transfer of services has occurred as shown by the date of acceptance on a Therap referral, care coordinators must create a new plan of care showing the new service provider within five (5) business days of accepting a referral for transfer of services.

**FAQs**

MEMBER NEEDS A NEW CARE COORDINATOR

**Care coordinator helps member choose new care coordination provider**

Care coordinator sends provider(s) selected by member 1) a referral in Therap 2) along with a ROI to share member's current plan of care and 3) attaches the member's plan of care.

Care coordination provider accepts the referral. Current care coordination provider ensures new provider has the member's plan of care.

New care coordinator submits a Care Coordination Request Report

1915i staff assign the new care coordination provider

New care coordinator drafts and submits new member plan of care in Therap within 5 business days

NOTE: if the member does not have a POC, care coordinators have 30 days from accepting the member to draft and get a POC approved.

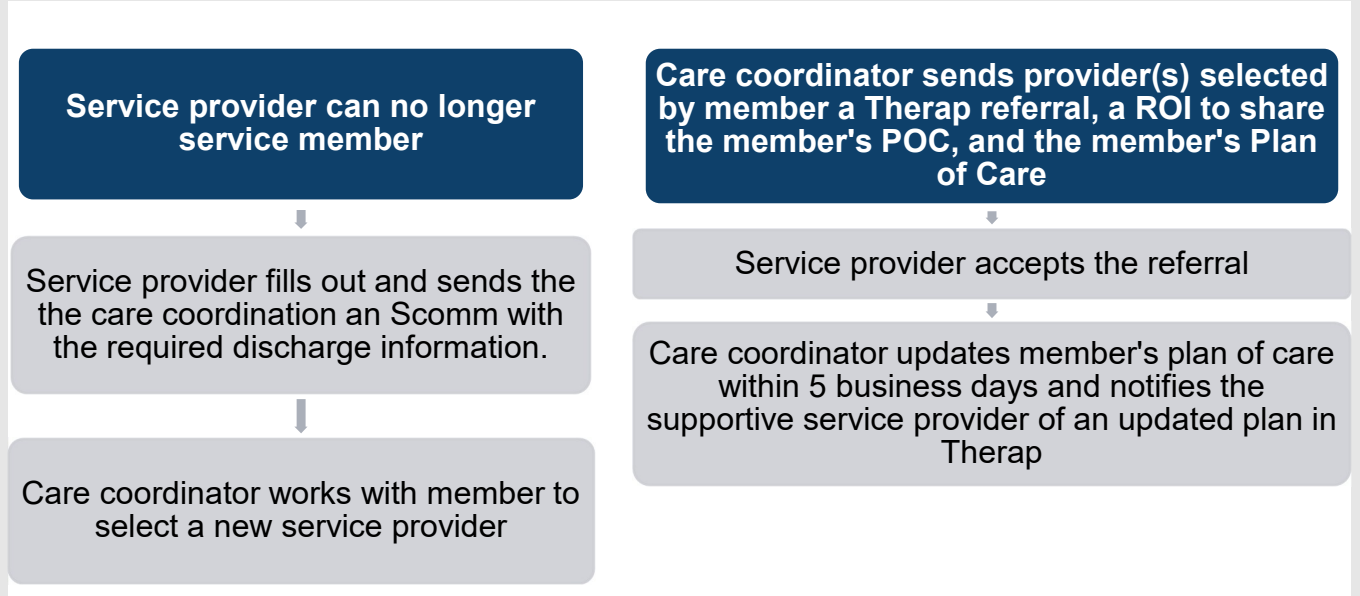
**If no provider accepts the care coordination referral**

Care coordinator fills out and sends member the Discharge Letter.

Care coordinator fills out the Termination of Member Services form on the 1915(i) website.

1915(i) staff will help member navigate to new care coordination agency

MEMBER NEEDS A NEW SERVICE PROVIDER

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