# 1915(i) Policy

## Benefits Planning 510-08–65-05

**Service Title:** Benefits Planning Service

## Service Definition (Scope)

Benefits Planning Services offer individuals in-depth guidance about public benefits including Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare, Medicaid, etc. Services are available to individuals considering or seeking competitive employment and can assist individuals with making informed choices regarding public benefits and provide an understanding of available work incentives.

Benefits Planning services include:

- Development of an individualized assessment and benefits analysis. Plan must identify the individuals projected financial goal or actual financial status, explain any current public benefits, and outline of a plan describing how to use work incentives.
- Training and education on work incentives available through Social Security Administration (SSA) and on income reporting requirements for public benefits programs.
- Assistance with developing a Plan to Achieve Self Support (PASS) plan and other work incentives to achieve employment goals.
- Assistance with developing a budget.
- Assist with understanding health care coverage options (Medicaid, Medicaid Expansion, and other State Plan buy-in options).
- Making referrals and providing information about other resources in the community.
- Referrals to Protection and Advocacy for Beneficiaries of Social Security (PABSS) organization.
- Ongoing support and follow-up to assist the individual with managing changes in their benefits, the work incentives they use, negotiating with SSA, and other benefit program administrators.

A participant’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 and annual reevaluation process. The care coordinator must document a need for the service to support a participant’s identified goals in the person-centered plan of care and document the participant’s progress toward their goal(s).

Enrolled Medicaid 1915(i) providers are required to provide the whole scope of service rather than only portions of the service.

The activities contained in the service description is what CMS allows reimbursement for. The following are examples of what is not reimbursable to the provider:

- Services provided not included in the service description including associated costs incurred for providing the service, for example, checking a member's eligibility.
- *Services provided to a non-eligible member*. Providers are responsible for confirming member eligibility prior to delivering each service.
- *Services provided by a non-qualified provider.* Group providers are responsible for ensuring their group and affiliated individual providers meet all qualifications and have completed training.
- Services provided to a member not meeting the specific requirements of the service, such as age.
- Services provided without a valid service authorization.
- Non-valid claims.
- *Client not present*. The client must always be present with the provider for reimbursement to occur for all services other than care coordination.

The provider must provide a written monthly progress update to the care coordinator. The state will not provide a form or specific requirements for the progress update. The care coordinator and the provider will consult to ensure the progress report provides information helpful and unique to the individual's care.

## Service Limits

There is a daily maximum of 8 hours (32 units).

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 NDDHS. All requests to exceed limits must initiate with the care coordinator.

## Service Duplication

1915(i) services cannot be provided to an individual at the same time as another service that is the same in nature and scope regardless of source

including Federal, state, local, and private entities. For the client to be authorized for 1915(i) Benefits Planning services, the care coordinator must first verify that services are not duplicated.

*See 1915(i) Service Duplication Policy.*

**Care Coordinator responsibility to ensure nonduplication with the Rehabilitation Act of 1973 as amended.**

Individuals that have completed the Vocational Rehabilitation (VR) process are technically eligible to receive benefits planning services through Work Incentives Planning and Assistance (WIPA) up to 6 years after the VR case closure.

If the client is not or has not received services through VR, and this is verified by VR, the care coordinator may enter Benefits Planning Services as an option on the 1915(i) Person-centered Plan of Care.

If the individual has (within 6 years of case closure) or is receiving services through VR, the individual cannot access the service through the 1915(i) and would have to access the Benefits Planning Service through WIPA.

Prior to adding the 1915(i) Benefits Planning service on the 1915(i) Plan of Care for service authorization, the care coordinator must obtain a release of information from the 1915(i) member and either fax to Vocational Rehabilitation at 701-328-1884 or send by secure email to dhsvr@nd.gov.

*See the "Avoiding Service Duplication with the Rehabilitation Act of 1973" section of the 1915(i) Service Duplication policy for specific requirements.*

**Care Coordinator Responsibility for ensuring nonduplication with 1915(c) Waivers.**

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

At this time the state has identified no duplication between this service offered in the 1915(i) and services offered in the State's HCBS 1915(c) Waivers.

*See the "Avoiding Service Duplication with 1915(c) Waivers" section of the 1915(i) Service Duplication policy for specific requirements.*

## Conflict of Interest

*See 1915(i) Conflict of Interest Standards Policy.*

## Remote Support

Remote support may be utilized; however, in-person support must be provided for a minimum of 25% of all services provided in a calendar month.

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

## Provider Qualifications

### Provider Type: Group

North Dakota Medicaid enrolled group provider of 1915(i) Benefits Planning Services.

Licensing: None.

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

1. Have a North Dakota Medicaid provider agreement and attest to the following:
   - individual practitioners meet the required qualifications
   - services will be provided within their scope of practice
   - individual practitioners will have the required competencies identified in the service scope
   - agency conducts training in accordance with state policies and procedures
   - agency adheres to all 1915(i) standards and requirements
   - agency adheres to all 1915(i) policies and procedures, including but not limited to, participant rights, abuse, neglect, exploitation,

use of restraints, and reporting procedures are written and available for NDDHS review upon request.

**Provider Type: Individual**

Certification: Individuals must complete one of the following:
1. Certified Work Incentives Counselor (CWIC); or
2. Community Partner Work Incentives Counselor (CPWIC); or
3. SSI/SSDI Outreach Access and Recovery (SOAR).

The individual practitioner providing the service must:
1. Be at least 18 years of age.
2. Be employed by an enrolled ND Medicaid provider or enrolled billing group of this service.

## Verification of Provider Qualifications

Provider Type: ND Medicaid enrolled agency provider of Benefits Planning Services

Entity Responsible for Verification: Medical Services Provider Enrollment

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

Service Delivery Method: Provider Managed

## Payment Rate

The client must be present to bill for this service.

Benefits Planning is a 15-minute rate. The rates are published on the Department's website:

https://www.hhs.nd.gov/medicaid-provider-information/medicaid-provider-fee-schedules

## Quality Assurance

*See 1915(i) Quality Assurance Policy.*

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

*See 1915(i) Medical Records Policy.*

## Person Centered Service Delivery

Benefits Planning service delivery must be person-centered.

Agencies must have records available for NDDHS review documenting that individual providers have knowledge and competency in the following:

- Person-Centered Plan Implementation

*See 1915(i) Person- Centered Care Policy.*

### Person-Centered Plan of Care

*See 1915(i) Plan of Care Policy.*

## HCBS Settings Rule Compliance Verification

Settings must be compliant with the HCBS Settings Rule.

*See 1915(i) HCBS Settings Rule Policy.*

## Service Authorizations

All 1915(i) services must receive prior authorization.

*See 1915(i) Service Authorization Policy.*

## Claims

*See 1915(i) Claims Policy.*