1915i Policy

Care Coordination Service 510-08–65-10

Service Title: Care Coordination Service

Service Definition (Scope)

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

Care Coordinator Role

A. Comprehensive assessment and reassessment activities include:
   - completion of assessments as needed;
   - collecting, organizing, and interpreting an individual’s data and history including the gathering of documentation and information from other sources such as family members, medical providers, social workers, and educators, etc., to form a complete assessment of the individual, initially and ongoing;
   - promoting the individual’s strengths, preferences, and needs by addressing social determinants of health including five key domains (economic stability, education, health and health care, neighborhood and built environment, and social and community context) and assessing overall safety and risk including suicide risk;
   - conducting a crisis assessment and plan, initially and ongoing;
   - guiding the family engagement process by exploring and assessing the participant’s and, 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 Community-Based Settings compliance.

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 WHODAS 2.0 functional needs assessment as part of the initial evaluation and annual reevaluation process. The Care Coordinator must document a need for the service to support a participant’s identified goals in the person-centered plan of care and document the participant’s progress toward their goals.

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

**C. Crisis Plan Development, Implementation, and Monitoring.** The Care Coordination Agency has ultimate responsibility for the development, implementation, and monitoring of the crisis plan. The crisis plan is developed by the Care Coordinator in collaboration with the participant and Person-Centered Plan of Care Team within the first week of initial contact with the member.

**D. Referral, Collateral Contacts, and Related Activities.** This includes scheduling appointments for the individual and connecting the eligible individual with obtaining needed services including:

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

The Care Coordination Service assists participants 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.

**E. Monitoring and Follow-Up Activities.** Activities and contacts necessary to ensure the person-centered plan is implemented and adequately addresses the eligible individual’s needs. These may be with the individual, family members, service providers, or other entities.

**F. HCBS Settings Rule Compliance Verification.** The Care Coordinator’s role includes verification of HCBS Settings Rule compliance.

*See 1915(i) HCBS Settings Rule Policy*

**Service Limits**

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

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.

To avoid service duplication with 1915c 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 plan of care will not include services the member could receive through the 1915c Waiver.

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

**Conflict of Interest**

*See Conflict of Interest Standards Policy applicable to Care Coordination.*

**Remote Support**

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

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

**Provider Qualifications**

Provider Type: North Dakota Medicaid enrolled group provider of Care Coordination Services.

Licensing: None

Certification: None

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

1. Have a North Dakota Medicaid provider agreement and attest to the following:
   - Individual practitioners meet the required qualifications.
   - Services will be provided within their scope of practice.
Individual practitioners will have the required competencies identified in the service scope.

Agency availability 24 hours a day, 7 days a week to clients in need of emergency care coordination services.

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) standards and requirements agency 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.

The individual practitioner (care coordinator) providing the service must:

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

Agencies must have records available for NDDHS review documenting that care coordinators have reviewed the competencies or standards of practice in one of the following:

- 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.

**Verification of Provider Qualifications**

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

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

Service Delivery Method: Provider Managed

Payment Rate

Care Coordination is a 15-minute rate. The rates are published at the State’s website. [http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-fee-schedules.html](http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-fee-schedules.html)

Quality Assurance

The Care Coordination Service providers are required to use the POC checklist to self-monitor their work by completing reviews of their plans and files. A Reporting Template for the Care Coordination provider to report their findings following their reviews is also available on the 1915(i) website. This “self-monitoring” component completed by the provider will be in addition to the quality assurance reviews of plans of care completed by the department and the MCO. See 1915(i) Quality Assurance Policy for specifics.

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

See 1915(i) Medical Records Policy.

Plan of Care Process

See the 1915(i) Plan of Care Policy.

Person Centered Service Delivery

Care Coordination Services must be Person-Centered.

Care Coordination Providers must also have records available for NDDHS review as verification that care coordinators have reviewed NDDHS approved training materials and acknowledge they are competent in the following areas:

- Person-Centered Plan Development and Implementation

See 1915(i) Person- Centered Planning and Self-Assessment Guide.
HCBS Settings Rule Compliance Verification

See 1915(i) HCBS Settings Rule Policy.

Service Authorizations

See 1915(i) Service Authorization Policy.

Claims

See 1915(i) Claims Policy.