NORTH Dakota | Health & Human Services
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1915(i) Care Coordination FAQ

What are the qualifications needed to become a 1915(i) Care Coordinator?

Refer to the 1915(i) Care Coordination Policy for both Group and Individual Provider qualifications.

What are the responsibilities of a 1915(i) Care Coordinator?

The role of the Care Coordinator for 1915(i) is administrative. Care Coordinators are responsible for the following:

- Comprehensive assessment and reassessment activities
- Development of Person-Centered Plan of Care
- Crisis Plan development, implementation, and monitoring
- Referrals, collateral contacts, and related activities
- Monitoring and follow-up activities
- HCBS Rule compliance verification
- Eligibility redeterminations

Care Coordinators must attend a 1915(i) Care Coordination Onboarding session prior to providing any 1915(i) Care Coordination and must also attend the State-Sponsored Care Coordination training (offered quarterly) within the first 6 months of becoming enrolled. Refer to the 1915(i) Care Coordination Policy for more detail on the scope of service and expectations.

Can my agency provide 1915(i) Care Coordination as well as 1915(i) Supportive Services for an individual?

Your agency may provide both (i) Care Coordination and 1915(i) Supportive Services (Peer Support, Housing Support, Supported Employment, etc.) however, Medicaid requires the assurance of Conflict Free Case Management. The principle of Conflict Free Case Management dictates the "assessment and coordination of services must be separate from the delivery of services." Providers of 1915(i) supportive services may not also provide Care Coordination or develop the Person-Centered Plan of Care for **the same individual**. Exemptions may be allowable and are considered on a case-by-case basis. Refer to the 1915(i) Conflict of Interest Policy for more detail.

How many times should I try contacting an individual before discharging?

That decision is left up to individual agencies, however the expectation is that it would be made with careful consideration. The target population for 1915(i) services has functional limitations which cause increased difficulty with executive functioning, keeping appointments, time management, and communication. Prior to discharge due to no contact, all reasonable efforts should be made to contact the individual via indirect methods such as their alternate contact, other service providers, or other team-members. If you wish to discharge an individual after all efforts to contact them have failed, complete the 1915(i) Member Discharge Form and submit to nd1915i@nd.gov, and notify the member using any available means. The Discharge Letter Template on the 1915(i) Forms Web Page may be modified as appropriate and utilized.

What do I do if someone wants to transfer to another agency for Care Coordination?

All requests for service providers are made via the Request for Service Provider form, including requests to change Care Coordination agencies. Refer to the 1915(i) Service Authorization Policy for more detail on transfers and terminations.

What are SMART Goals, and how do I learn about the 1915(i) standards for goal development?

SMART Goals are:

- Specific
- Measurable
- Achievable
- Relevant
- Time-Bound

All goals on the Plan of Care must be SMART and relate to the established scope of the service being requested. Refer to the 1915(i) Trainings Web Page for recordings and slides from Technical Assistance sessions on SMART Goals, Plan of Care Development, Quality Services, Referrals, and more.

What do I do if someone I'm providing Care Coordination for is admitted to a setting that does not comply with the Home and Community-Based Settings Rule, such as a hospital or jail?

An individual's eligibility may pause while they are residing in setting that is non-compliant with the HCBS rule for up to 6 months, or until their eligibility span expires, whichever comes first. A Care Coordinator

who is made aware of an individual's move to a setting that is non-compliant with the HCBS rule must contact nd1915i@nd.gov via secure email to coordinate the suspension. If the Care Coordinator does not have the ability to initiate an encrypted email, a request may be made via nd1915i@nd.gov to start a secure email chain through which protected health information (PHI) may be safely exchanged. Upon the individual's return to a residential setting compliant with the HCBS rule, the Care Coordinator should again contact the Department 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 individual'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.