Title:	Long-Term Community Supports	**Code:**	T2016-U5-L1; T2016-U5-L2; T2016-U5-L3; T2016-U5-L4; T2016-U5-L5
Type:	In-Lieu Of Medicaid Service	**Group Code:**	N/A
Effective Date:	7/1/2019	**Units:**	One unit per day for Levels 2-5 Up to 5 units per week for Level 1.

Service Description

Long Term Community Supports (LTCS) consist of a broad range of services for adults with developmental disabilities who, through the person-centered plan (PCP) process choose to access active treatment to assist them with skills to live as independently as possible in the community.

LTCS is an innovation, community-based, comprehensive service for adults with intellectual and/or developmental disabilities (I/DD). LTCS is an alternative definition in lieu of ICF-IID under the Medicaid benefit. This service enables Partners to provide comprehensive and individualized active treatment services to adults with I/DD to maintain and promote their functional status and independence. This is also an alternative to home and community-based waiver services for individuals that potentially meet the ICF-IID level of care.

Individuals who choose LTCS instead of placement in an ICF-IID, including state institutions, or because they do not have access to an Innovations waiver slot, choose to live in their own homes or homes where they control the lease for the room in the home along with the choice of agency or other people who support them. Each of these individuals will have the option of receiving the 1915(b) Community Guide service. The Community Guide service will provide information on affordable housing options, sources of financial support such as Supplemental Security Income (SSI) and oversight of their overall needs**.** For many adults LTCS is a best practice and is far more cost effective than ICF-IID and more readily available that the current Innovations Waiver with limited slots. The average waiting time in the Partners catchment area is 8 years for an Innovations Waiver Slot. Many of the individuals may end up in institutions without this alternative.

Each participant in LTCS must either stay in homes they own; their family owns or have a lease in the community. The individuals must also be able to control where they live. LTCS does not include room and board payments. LTCS does include Therapeutic Leave for up to 45 days per calendar year, for Levels 3, 4 and 5.

Population to Be Served

Adults with intellectual and/or developmental disabilities who are potentially eligible for ICF-IID or Innovations Waiver supports; age 22 and over. Available only for individuals in need of and receiving active treatment – aggressive, consistent implementation of a program of specialized and generic training, treatment and integrated health services.

Entrance Process

Each beneficiary meeting admission criteria shall have a Person-Centered Plan (PCP) completed. The amount, duration, and frequency of the service must be included in a beneficiary's Person-Centered Plan.

Service Order Requirement

Service Orders are required for each individual service (e.g. Residential, Day Supports, SE) and may be written by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Licensed Psychologist (PhD), Nurse Practitioner (NP), or a Physician Assistant (PA). A service order must be in place prior to or on the day that the service is initially provided to bill Medicaid for the service. Even if the individual is retroactively eligible for Medicaid, the provider cannot bill Medicaid without a valid service order.

Admission Criteria

- Individual is an adult, age 22 years or older.
- Eligibility for ICF- IID Functional Eligibility is documented.
- Individual is experiencing difficulties in at least one of the following areas:
    - Crisis intervention/diversion/aftercare needs

  OR
    - At risk for placement outside the natural home setting

- The individual's level of functioning has not been restored or improved and may indicate a need for clinical interventions in a natural setting if **any of the following apply*:***
    - At risk of out of home placement, hospitalization, and/or institutionalization due to symptoms associated with diagnosis
    - Presents with intensive verbal and limited physical aggression due to symptoms associated with diagnosis, which are sufficient to create functional problems in a community setting
    - At risk of exclusion from services, placement or significant community support systems because of functional behavioral problems associated with diagnosis
    - Requires a structured setting to foster successful integration into the community through individualized interventions and activities

  OR

- The individual's current residential placement meets any one of the following:
    - The individual has no residence
    - Current placement does not provide adequate structure and supervision to ensure safety and participation in treatment
    - Current placement involves relationships which undermine the stability of treatment
    - Current placement limits opportunity for recovery, community integration, and maximizing personal independence

  OR

- The individual has been previously funded through adult day services, Independent living, alternative family living, supervised living or group living setting.

Utilization Management

Continued Stay Criteria:

Continued authorization is indicated by **ALL** of the following:

- The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the individual's person-centered plan or the individual continues to be at risk based on history or the tenuous nature of the functional gains

OR Any one of the following apply:

- Individual has achieved initial service plan goal and additional goals are indicated.

- Individual is making satisfactory progress toward meeting goals and continues to need intervention to achieve.
- Individual is making some progress, but the service plan (specific interventions) need to be modified so that greater gains which are consistent with the individual's premorbid level of functioning are possible or can be achieved, this is not a long-term maintenance service but active treatment.
- Individual is not making progress; the service plan must be modified to identify more effective interventions two or more periods of no progress will indicate the service is not appropriate.
- Individual is regressing; the service plan must be modified to identify more effective interventions or appropriate level of care.

Discharge Criteria:
Termination of continued authorization is indicated by **1 or more** of the following:

- Individual's level of functioning has improved with respect to the goals outlined in the service plan, or no longer benefits from this service, as evidenced by:
- Individual has achieved service plan goals; discharge to a lower level of care is indicated as evidenced by; individual chooses to continue to live in the current level, but no longer needs or benefits from the supports and instead becomes a boarder paying rent and room and board to remain in the current setting.
- Individual is not making progress or is regressing, and all realistic treatment options within this modality have been exhausted and/or the individual chooses to retire from active treatment but wants to continue to live at this level of support as a boarder paying room and board and receive personal care supports.
- Individual no longer desires the service

Eligibility Criteria

Adults with intellectual and/or developmental disabilities who are potentially eligible for ICF-IID or Innovations Waiver supports; age 22 and over. Available only for individuals in need of and receiving active treatment – aggressive, consistent implementation of a program of specialized and generic training, treatment and integrated health services.

Service Exclusions

Service Exclusions
Member may not receive any State funded service. Individual may not receive Medicaid state plan Personal Care. Individual may receive b3 Community Guide, Outpatient services, etc.

Treatment Program Philosophy, Goals, and Objectives

LTCS provides active treatment through a continuous and consistent implementation of a program of specialized and generic training, treatment, and integrated health or related services directed toward helping the consumer function with as much self-determination and independence as possible. LTCS is a comprehensive community living support benefit for eligible IDD adults with Medicaid.

LTCS can be provided in licensed facilities and/or settings that do not require licensure based on the needs of the individual.

LTCS provides for services, including integrated health care services and nutrition, as a part of the active treatment and may include nursing support when needed based on the person-centered plan. The service needs are based on

an evaluation and the person-centered plan is developed with the person with input from their chosen provider agency and team.

LTCS has Five Levels:

LTCS Level 1 is Home Living (living at home with family or no supports) and attend a Day Service or Supported Employment to maintain and develop skills of active treatment up to 6 hours per day.

LTCS Level 2 is Independent Living (living in own apartment no overnight staff but may include virtual monitoring) and Day Service or Supported Employment up to 6 hours per day

LTCS Level 3 is Companion Living (paid roommate or alternative family) and Day Services or Supported Employment up to 6 hours a day with different staff

LTCS Level 4 is Supervised Living (3 or less people no overnight staffing required but may include virtual monitoring) and Day Service or Supported Employment up to 6 hours a day with different staff

LTCS Level 5 is Group Living (group homes with 6 or less people with overnight staffing or virtual monitoring) and Day Services up to 6 hours per day with different staff

LTCS services includes:

- Choosing direct support professionals and/or housemates
- Acquiring household furnishings
- Common daily living activities and emergencies
- Choosing and learning to use appropriate assistive technology to reduce the need for staffing supports
- Becoming a participating member in community life
- Managing personal financial affairs, as well as other supports

The service is implemented through direct intervention with the person. Coordination also occurs with other systems – such as work, adult education, primary care physicians, family and friends. LTCS incorporates crisis services and support into the model and the person-centered plan.

Goals of the service include but are not limited to the following:

- Enable stable living in the community at the least restrictive level of care
- Provide active treatment to enable the development of necessary skills to live as independently as possible in the community
- Bring an increase in functional skills affecting community functioning
- Provide support so that level of functioning is restored or developed so that member can reach highest level of functional capacity
- Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability

Services include both direct face-to-face, virtual monitoring and indirect contacts, and collaboration with other systems. However, most of contacts are direct – with the individual.

The service intensity is varied based on the level of LTCS and is increased or decreased based on individual needs. The intent of the lowest level is to validate that the interventions have been effective and that outcomes are likely to be maintained upon service discharge.

Expected Outcomes

LTCS help individuals exercise meaningful choice and control in their daily lives, including where and with whom to live while working toward complete independence. LTCS is designed to foster individual's nurturing relationships, full membership in the community, work toward their long-range personal goals, and avoid institutionalization. Because these may be life-long concerns, LTCS is offered for as long and as often as needed, with the flexibility required to meet an individual's changing needs over time, and without regard solely to the level of disability.

LTCS participants may work in the community, with supports, or participate in vocational or other meaningful day activities outside of the residence and engage in community interests of their choice. These activities are often collectively referred to as a Day Service. The LTCS provider is responsible for all activities, including Day Services**.** The concept of active treatment is that all aspects of support and service to the individual are coordinated towards specific individualized goals in the person-centered plan.

Any person that is living in a licensed facility, group home, supervised living setting, alternative family living arrangements or any other setting that they or their family do not own must have a lease agreement in place with the owner/provider to receive LTCS.

Staffing Requirements

Provider Qualifications:

- Provider enrolled in Partners Behavioral Health Management's (Partners) network
- State Nursing Board regulations must be followed for tasks that present health and safety risks to the member as directed by Partners' Medical Director or designee
- Upon enrollment as a provider, the agency must have achieved national accreditation with at least one of the designated accrediting bodies

Verification for Provider Qualifications:

- Partners Behavioral Health Management

Frequency of Verification:

- Partners verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by Partners, no less than every three (3) years

Professional Competency:

- Staff are at least 18 years of age and meet the following requirements –
  - If providing transportation, have a valid driver's license or other valid driver's license, a safe driving record and acceptable level of automobile liability insurance
  - Criminal background check presents no health and safety risk to member
  - Not listed in NC Health Care Abuse Registry
  - Qualified in CPR and First Aid
  - Qualified in the customized needs of the member as described in the PCP
  - High school diploma or equivalency (GED)
  - Paraprofessionals providing this service must also be supervised by a QP –

- Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) and (f) and according to licensure or certification requirements of the appropriate discipline.

- By December 31, 2018, direct support professionals (DSPs) have competency in the following areas:

- Communication – the DSP builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.

- Person-Centered Practices – the DSP uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.

- Evaluation and Observation – the DSP closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.

- Crisis Prevention and Intervention – the DSP identifies risk and behaviors that can lead to crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.

- Professionalism and Ethics – the DSP works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.

- Health and Wellness – the DSP plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.

- Community Inclusion and Networking – the DSP helps individuals to be a part of the community through valued roles and relationships and assist individuals with major transitions that occur in community life.

- Cultural Competency – the DSP respects cultural differences and provides services and supports that fit with an individual's preferences.

- Education, Training and Self-Development – the DSP obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

    - Verification of Staff Qualifications: Provider Agencies
    - Frequency of Verification: Provider verifies employee qualification at the time employee is hired.

Targeted Length of Service

Yearly re-evaluation of level of care.