



Title:	Long-Term Community Supports	Code:	T2016 U5 U1 T2016 U5 U2 T2016 U5 U3 T2016 U5 U3 TL T2016 U5 U4 T2016 U5 U4 TL T2016 U5 U6 T2016 U5 U6 TL
Type:	In-Lieu Of Medicaid Service	Benefit Plan:	Tailored Plan
Effective Date:	7/1/2024	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/ISP) process choose to access active treatment to assist them with skills to live as independently as possible in the community. LTCS is an innovative, 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. A “Day Program” is defined as an individual/ group, facility-based service and/or a community based periodic service that aids the individual with acquiring, retaining, and improving socialization and daily living skills. “Community Activities” are furnished in a community-based setting, separate from the member’s place of residence and/or provider’s facility. Members engage in community interests and activities of their choice with persons who are not disabled. Individuals may choose LTCS instead of placement in an ICF-IID (including state institutions) or because they do not have access to an Innovations waiver slot. Members 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. Individuals receiving LTCS will have the option of receiving Tailored Care Management. Tailored Care Management 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 option, is far more cost effective than ICF-IID and more readily available than the current Innovations Waiver with limited slots. The average waiting time in the	



Partners catchment area is 8+ years for an Innovations Waiver Slot. Some individuals may end up in institutions without this alternative.

Each member in LTCS resides in the community in one of the following settings; a home that s/he owns or rents, a home with his/her family, an alternate family living (AFL) arrangement, or a licensed group home setting. LTCS does not include room and board payments.

Therapeutic Leave:

Each Medicaid member who is occupying a Long-Term Community Supports Level 3, Level 4 or Level 5 residential bed for which the NC Medicaid Program is then paying reimbursement shall be entitled to take up to 45 days of therapeutic leave in any calendar FY year from any such bed without the facility in which the bed is located suffering any loss of reimbursement during the period of leave. Therapeutic leave is also limited to no more than 15 days within one calendar quarter (three months).

- The taking of such leave must be for therapeutic purposes only and must be agreed upon by the member's treatment team. The necessity for such leave and the expectations involved in such leave shall be documented in the member's treatment plan and the therapeutic justification for each instance of such leave entered into the member's record maintained at the residential facility's site.
- Therapeutic leave shall be defined as the absence of a member from the residential facility overnight, with the expectation of return, to participate in a medically acceptable therapeutic or rehabilitative facility as agreed upon by the treatment team and documented on the treatment plan.
- Facilities must reserve a therapeutically absent member's bed for them and is prohibited from deriving any Medicaid revenue for that member other than the reimbursement for that bed during the period of absence. Facilities shall be reimbursed at their full current Medicaid bed rate for a bed reserved due to therapeutic leave. Facilities shall not be reimbursed for therapeutic leave days taken which exceed the legal limit.
- No more than five consecutive days may be taken without the approval of the member's treatment team.
- Facilities must keep a cumulative record of therapeutic leave days taken by each member for reference and audit purposes. In addition, members on therapeutic leave must be noted as such on the facility's midnight census. Facilities shall bill Medicaid for approved therapeutic leave days as regular residence days.
- The official record of therapeutic leave days taken for each member shall be maintained by the State or its agent.
- Therapeutic leave is not applicable in cases when the therapeutic leave is for the purpose of receiving inpatient services or any other Medicaid covered service in the facility of current residence or in another facility. Therapeutic leave cannot be paid when Medicaid is paying for any other 24-hour service.
- Transportation from facility to the site of therapeutic leave is not considered to be an emergency; therefore, ambulance service for this purpose shall not be reimbursed by Medicaid. Medicaid shall not cover non-emergency transportation.

Population to Be Served

Adults with intellectual and/or developmental disabilities, ages 18+ (out of school), who are potentially eligible for ICF-IID or Innovations Waiver supports.



Eligibility Criteria

Adults with intellectual and/or developmental disabilities who are potentially eligible for ICF-IID or Innovations Waiver supports per CCP 8E; age 18+ and out of school. 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. Potential members must be eligible for Tailored Plan Medicaid Managed Care.

This service is not coverable under EPSDT.

Entrance Process

Each member meeting potential eligibility criteria shall have a unified Person-Centered Plan (PCP) or ISP completed. The amount, duration, and frequency of the service must be included in a member's Person-Centered Plan. **If the member has more than 1 service (e.g supported employment and LTCS), all providers must be reflected on one unified plan. The goals in the plan should reflect each part of the LTCS service level the member is receiving (e.g. residential goals and goals related to meaningful day activities) as well as any other service the member is receiving.**

Service Order Requirement

Service Orders are required for each individual service (e.g. Residential, Day Supports, SE). Initial Service Orders may be written by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Licensed Psychologist, 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. Providers should follow all rules regarding PCP/ISP signatures.

Service orders are valid for one year from the date of last required signature entered on a Person Centered Plan (PCP/ISP). Medical necessity must be reviewed, and services must be ordered at least annually based on the date of the plan. Refer to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) Person Centered Planning Instruction Manual and the DMHDDSAS Records Management and Documentation Manual for additional information on service orders signatures and the date of plan.

Note: Initial service orders require licensed staff signatures outlined above, annual/continued service orders can be signed by a QP.

Psychological Evaluation Requirements:

If a member has been diagnosed with an intellectual disability, a **current** Psychological Evaluation (within 5 years) must be submitted for the individual, indicating Functional Eligibility for ICF-IID per CCP 8E. The evaluation needs to reflect the members current functioning. An evaluations should be completed by a Licensed Psychologist, Licensed Psychological Associate, or physician. If prior evaluations are available but not within the above timeframes, the licensed psychologist or licensed psychological associate may review the evaluation(s) and supplemental documentation to assure accuracy of diagnoses, report previous test results, submit a concurrency statement, and/or complete additional testing and interpretation as needed.

In addition to current clinical documentation of active functional deficits and any relevant diagnoses/related conditions, evidence of an IDD occurring before adulthood (before age 22) may include:

- Psychological testing showing a current DSM diagnosis of ID (Intellectual Disability) by a qualified clinician;
- Reliable report(s) of significant delay in achieving developmental milestones;
- Inclusion in special education programs (these may have different labels) during the developmental period;
- Never having lived independently;
- Reliable information that the individual has never been successfully employed or had other accomplishments that;
- Would be uncommon in a person with an IDD without supports;
- Eligibility for Social Security Disability benefits before adulthood for reasons related;
- A substantiated diagnosis of Autism Spectrum Disorder (ASD), even in adulthood;
- Absence of mental health disorders that might better account for intellectual and/or functional impairments;
- Absence of medical conditions that might better account for intellectual and/or functional impairments;
- The presence of Down syndrome or other genetic disorders that, if present as an adult, presumably were present since birth;
- Assignment of guardianship or payee to manage affairs and funds.

Utilization Management

Admission Criteria

- A. Individual is an adult, age 18 (if out of school) and over.
- B. Potential Eligibility for ICF- IID Functional Eligibility is documented in the current psychological evaluation
 - 3 substantial functional limitations
 - Adaptive and cognitive testing supports the diagnosis
 - I/DD diagnosis or closely related condition
 - Closely related conditions (Cerebral Palsy, Epilepsy, related medical conditions) need to include physician records in addition to assessments of functional behavior.
- C. NCSNAP or SIS
 - LTCS Level 1-2 – NCSNAP min level 1 or SIS level A-C
 - LTCS Level 3-5 – NCSNAP min level 2 or SIS level D-G
- D. Individual is experiencing difficulties in at least one of the following areas:
 1. Crisis intervention/diversion/aftercare needs

OR

 2. At risk for placement outside the natural home setting

At least one of the following criteria must be met for admission:

- A. The individual's level of functioning may indicate a need for clinical interventions in a natural setting if **any of the following apply:**
 1. At risk of out of home placement, hospitalization, and/or institutionalization due to symptoms associated with diagnosis
 2. 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



3. At risk of exclusion from services, placement or significant community support systems because of functional behavioral problems associated with diagnosis
4. Requires a structured setting to foster successful integration into the community through individualized interventions and activities

OR

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

OR

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

AND

- D. The requested service is individualized, specific, and consistent with symptoms or confirmed diagnosis under treatment, and does not exceed the member's needs
- E. The requested service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide
- F. The requested service is furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider

Continued Stay Criteria:

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

- A. 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:

- B. Individual has achieved initial service plan goal and additional goals are indicated.
- C. Individual is making satisfactory progress toward meeting goals and continues to need intervention to achieve.
- D. 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.
- E. 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.
- F. Individual is regressing; the service plan must be modified to identify more effective interventions or appropriate level of care.



AND

- G. The requested service is individualized, specific, and consistent with symptoms or confirmed diagnosis under treatment, and does not exceed the member's needs
- H. The requested service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide
- I. The requested service is furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider

Discharge Criteria:

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

- A. 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:
- B. 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.
- C. 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.
- D. Individual no longer desires the service

Service Exclusions

- LTCS members may not be concurrently authorized for:
 - Any non-Medicaid funded residential services
 - 1915(i) Community Living and Supports (for LTCS Level 2-5)
 - Non-Medicaid funded periodic I/DD service
 - ICF
 - CAP-C or CAP-DA
 - TBI Waiver services
 - 1915(c) Innovations Waiver services.
- Respite may be used to provide temporary relief for LTCS Level 1 and 3 members.
- LTCS may not be provided by a relative (by blood, marriage, fostering, or adoption) who resides in the home of the member or by a legal guardian of the member
- Outpatient services, Psychosocial Rehabilitation and Supported Employment are not considered coverable meaningful Day Activities of LTCS and are **billed separately from LTCS**

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 and/or legal guardian choice.

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 Service Levels:

LTCS Level 1 is a Home Living arrangement (i.e private family home or non-Medicaid funded home such as Adult Care Home or Family Care Home) and participation in a Day Activity (i.e. Day Program and/or Community Activity) for a minimum of 1 day each calendar week (i.e. Sunday to Saturday) and a minimum of 3 hours per day to maintain/ develop skills of active treatment as outlined in the member's PCP/ISP. This level does not include services /support provided in the home and is intended for meaningful day activities only (can include facility group activities, but must include Individual community-based, inclusion and integrated activities too). Maximum number of 6 hours per day and 5 days per week = 30 hours.

LTCS Level 2 is Independent Living/Supported Living (living in own apartment no overnight staff but may include virtual monitoring) and a meaningful day service up to 6 hours per day. (Supported Employment billed separately). This level does not require separate staffing for day service.

LTCS Level 3 is Companion Living (paid roommate or alternative family) and a meaningful day service up to 6 hours a day, 5 days a week with different staff. (Supported Employment billed separately)

LTCS Level 4 is Supervised Living (3 or less beds, overnight staffing required but may include virtual monitoring) and Day Service up to 6 hours a day, 5 days per week with different staff. (Supported Employment billed separately)

LTCS Level 5 is Group Living (group homes with 6 or less people with awake overnight staffing or virtual monitoring) and meaningful day service up to 6 hours per day, 5 days per week with different staff. (Supported Employment billed separately)

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 members 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 meaningful Day Service. The LTCS provider is responsible for all activities, in some instances including Day Services. The concept of active treatment is that all aspects of support and service to the individual are coordinated towards specific goals, based on member choice. Individualized goals must be reflected in the unified 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
- Unlicensed residential providers will be provided a quality check sheet prior to member being placed

Billing Units: Providers bill this service on a per diem unit basis. 1 unit = 1 day. Specific to Level 1, an individual must receive 3 hours before the 1 day unit may be billed for LTCS Level 1

**Verification for Provider Qualifications:**

Providers must be enrolled in NCTracks as a Medicaid eligible provider.

Frequency of Verification:

Providers must maintain NCTracks enrollment as a Medicaid eligible provider.

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/ISP
 - 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.
 - Within 60 days of hire, 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.

Documentation Requirements: LTCS services shall be properly and contemporaneously documented in accordance with the *DMH/DD/SAS Records Management and Documentation Manual 45-2 (RMDM)* **prior** to seeking reimbursement from Partners. LTCS requires a daily service note, which includes items 1 through 12, under



Contents of a Service Note, Chapter 7 of the RMDM. Regardless of the service type, significant events in an individual's life that require additional activities or interventions are to be documented over and above the minimum frequency requirements.

Documentation must meet all required elements of a note as defined in the APSM 45-2 Records Management and Documentation Manual.

Targeted Length of Service
Yearly re-evaluation of level of care.