Service Name and Description

Long Term Community Supports

Long Term Community Supports (LTCS) consists 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 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. This service enables Alliance to provide comprehensive and individualized active treatment services to adults with I/DD and related conditions 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 can choose LTCS instead of placement in an ICF-IID, including state institutions, or because they do not have access to an Innovations waiver slot. They can also 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. 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 Alliance coverage was 8 years for an Innovations Waiver Slot before realignment. Many of the individuals may end up in institutions without this alternative.

Day Program is a group or facility-based service that provides assistance developing, retaining, and improving socialization and skills of daily living, and are examples of meaningful day activities. This is done with staff outside the residential program if provided in group homes.

Community activities are also expected as part of Long-Term Community Supports and are activities of a member's choice outside of their residence and incorporates inclusion of people who do not identify as disabled.

LTCS is chosen instead of placement in an ICF-IID or because they do not have access to an Innovations slot.

Each participant in LTCS resides in a home, that they own or rent, a home with family, AFL, or group home. LTCS does include Therapeutic Leave up to 45 days per calendar year for Levels 3,4 and 5.

Procedure Codes

LTCS Level 1 T2016 U5 U1
LTCS Level 2 T2016 U5 U2
LTCS Level 3 T2016 U5 U3
LTCS Level 4 T2016 U5 U4
LTCS Level 5 T2016 U5 U6

Provider Organization Requirements

Long Term Community Support delivered by staff employed by a MH/DD/SA provider organization Credentialed by provider approved in NC Tracks and follows all required by 10 A NCAC 27G. 10A NCAC 27G unless provided by a federally recognized Tribal provider or Indian Health Service (IHS) provider. Those providers must demonstrate substantial equivalency as established in 25 USC 1621t and 1647a.

Staffing Requirements by Age/Disability

Program and Staff Supervision

Direct Service Professional
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

Qualified Professional

Bachelor's Degree and two years with the population. Supervision must be provided according to supervision requirements specified in
10A NCAC 27G.0204 (b) (c) and (f) and according to licensure or certification.

Direct support professionals (DSPs) and Qualified Professionals (QPs)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 assists 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. State Nursing Board regulations must be followed for tasks that present health and safety risks reviewed by their appropriately credentialed care management team member.

Service Type/Setting

Each participant in LTCS must either stay in homes they own, that their family owns or have a lease or roommate agreement in the community. The individuals must also be able to control where they live. LTCS does not include room and board payments. LTCS must be provided in the least restrictive level based on the assessed needs and health and safety of the individual. Alternative Family Living is licensed if more than one individual in the home is receiving AFL services, and Residential Supports at any level is licensed. This service is Home and Community Based Services Compliant.

Program Requirements

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 member 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.

All licensed residential supports must be in compliance with the Medicaid HCBS final rule.

There are five levels:

- LTCS Level 1 is Home Living (living at home with family or friends with no supports) and attend a Day Service to maintain and develop skills of active treatment.
- LTCS Level 2 is Independent and/or Supported Living (living in own apartment no overnight staff but may add virtual monitoring) and Day Service or Supported Employment up to 6 hours per day.
- LTCS Level 3 is Supported Living (paid roommate (must have a roommate agreement) or alternative family) and Day Services or Supported Employment up to 6 hours a day with different staff (AFLs are licensed if more than one person lives there)
- LTCS Level 4 is Residential Supports (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 (licensed AFL or Licensed .5600, see Level 5 requirements, AFLs are licensed if more than one person lives there)
- LTCS Level 5 is Residential Supports (group homes with 4 or less people with overnight staffing or *virtual monitoring, for newly developed programs, and for programs licensed prior to 6/1/2022 group homes with 5-6 people with overnight staffing or virtual monitoring) and Day Services up to 6 hours per day with different staff (Licensed)

  * all licensed facilities must follow licensure rules or have a documented waiver of rule approval from DHSR.

The service 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.

Entrance Criteria & Eligibility Requirements

Adults with intellectual and/or developmental disabilities who are potentially eligible for ICF-IID or Innovations Waiver supports per CCP 8E; 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.

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.
Medicaid eligible
Age 22 or older
Would Meet ICF-IID eligibility criteria.
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 o 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.

Continued Stay Criteria

Member continues to benefit from Long Term Community Supports and meets one of the levels of LTCS.

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

Member is no longer benefiting from LTCS and would benefit from other services.

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.

Service Exclusions

The following services do not occur concurrently:
Any Innovations Waiver Service (ICF-IID, Day Supports)
Individuals may receive (b)(3) Community Navigator concurrently.
Outpatient services, Psycho-social Rehabilitation and Supported Employment are not considered Day Activities associated with LTCS and are authorized and billed separately.
Respite is not included for LTCS Levels 2,4 and 5. (b)(3) respite may be used for LTCS Level 1 and 3.
State Funded residential supports
State Funded Supported Living

Entrance Process
Service Orders are required for each individual service. They may be written by a LPA, LCSW, LMFT, LMHC or Associates, PhD Psychologist, Medical Doctor, Doctor of Osteopathic Medicine, Nurse Practitioner, or Physician Assistant.

Evaluation of Consumer Outcomes and Perception of Care

LTCS will assist in providing supports to keep members in their community, and to prevent them from seeking crisis services in hospitals and emergency departments during disaster, emergencies, or crisis.

LTCS will also assist those members who need access to appropriate supports, but because of disaster or emergency or other crisis do not have access to ICF facilities.

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**.** 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.

Service Documentation Requirements

Minimum standard for frequency of note, i.e., per event, daily, weekly, monthly, etc.
All contacts are documented with standard service note documentation and filed in member chart in accordance with APSM-2.